Abstract

This paper is part of the American College of Physicians' policy framework to achieve a vision for a better health care system, where everyone has coverage for and access to the care they need, at a cost they and the country can afford. Currently, the United States is the only wealthy industrialized country that has not achieved universal health coverage. The nation's existing health care system is inefficient, unaffordable, unsustainable, and inaccessible to many. Part 1 of this paper discusses why the United States needs to do better in addressing coverage and cost. Part 2 presents 2 potential approaches, a single-payer model and a public choice model, to achieve universal coverage. Part 3 describes how an emphasis on value-based care can reduce costs.

In this position paper, the American College of Physicians (ACP) proposes coverage and cost-of-care–related strategies to achieve a better U.S. health care system. The ACP's vision, outlined in an accompanying call to action (1), includes 10 vision statements, 5 of which are particularly relevant to the policies discussed in this paper (Figure). The companion papers address improving payment and delivery systems (2) and social determinants of health and reducing barriers to care (3). Together, these papers provide a policy framework to achieve ACP's vision for a better U.S. health care system.

The American College of Physicians envisions a health care system where everyone has coverage for and access to the care they need, at a cost they and the country can afford.

The American College of Physicians envisions a health care system where spending is redirected from unnecessary administrative costs to funding health care coverage and research, public health, and interventions to address social determinants of health.

The American College of Physicians envisions a health care system where clinicians and hospitals deliver high-value and evidence-based care within available resources, as determined through a process that prioritizes and allocates funding and resources with the engagement of the public and physicians.

The American College of Physicians envisions a health care system where primary care is supported with a greater investment of resources; where payment levels between complex cognitive care and procedural care are equitable; and where payment systems support the value that internal medicine specialists offer to patients in the diagnosis, treatment, and management of team-based care, from preventive health to complex illness.

The American College of Physicians envisions a health care system where patients and physicians are freed of inefficient administrative and billing tasks, documentation requirements are simplified, payments and charges are more transparent and predictable, and delivery systems are redesigned to make it easier for patients to navigate and receive needed care conveniently and effectively.

Figure. American College of Physicians vision statements related to coverage and cost of care.

Although the United States leads the world in health care spending, it fares fa
than its peers on coverage and most dimensions of value. Cost and coverage are intertwined. Many Americans cannot afford health insurance, and even those with insurance face substantial cost-related barriers to care. Employer-sponsored insurance

is less prevalent and more expensive than in the past, and in response, deductibles have grown and benefits have been cut. The long-term solvency of U.S. public insurance programs is a perennial concern. The United States spends far more on health care administration than peer countries. Administrative barriers divert time from patient care and frustrate patients, clinicians, and policymakers. Major changes are needed to a system that costs too much, leaves too many behind, and delivers too little.

Part 1 of this paper discusses why the United States needs to do better in addressing coverage and cost. Part 2 presents 2 potential approaches to achieve universal coverage. Part 3 describes how an emphasis on value-based care can reduce costs.

Methods

The Health and Public Policy Committee of the ACP, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties, drafted this paper. The Committee reviewed available studies, reports, and surveys on health care coverage options and the cost of health care in the United States, identified by searching PubMed, Google Scholar, news articles, policy documents, proposals for coverage expansion, and other sources. Sources published before 2009 were largely excluded, with the exception of contextual resources and references to ACP policy papers. On the basis of this review, the Committee drafted recommendations with input from the ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and related recommendations were reviewed and approved by the Health and Public Policy Committee in July 2019 and the Board of Regents on November 2019. The ACP operating budget was the sole source of funding for development of this position paper.

Part 1: Why Does the United States Need to Do Better in Addressing Coverage and Cost?

Too Many Americans Are Uninsured or Underinsured

The United States is the only wealthy industrialized nation without universal health coverage, a crucial component to ensuring quality health care for all without financial burden that causes delay or avoidance of necessary medical care. The Patient Protection and Affordable Care Act of 2010 (ACA) led to historic reductions in the number of uninsured persons, yet nearly 30 million remain uninsured, millions more are underinsured, and the number of uninsured persons is expected to grow (4, 5). In part, this is the result of congressional policy decisions, including the prohibition on premium tax credits to undocumented immigrants and limiting eligibility for premium tax credits and cost-sharing reduction assistance to people with incomes under 400% of the federal poverty level (FPL), as well as some states' decisions not to broaden Medicaid eligibility after a 2012 U.S. Supreme Court decision that made expansion optional (6). The ACP has offered recommendations for improving the ACA's coverage provisions (7). Yet, the ACA remains politically contentious and has been subject to numerous repeal attempts, court challenges, and regulatory changes that may undermine its effectiveness and viability.

U.S. Health Care Spending Is High and Unsustainable

The United States spends far more per capita on health care than other wealthy countries, and spending is increasing at an unsustainable rate (8, 9). In 2018, nearly 18% of the nation's gross domestic product—$3.6 trillion—was directed to health care. Hospital services accounted for 33% of spending, physician and clinical services for 20%, prescription drugs for 9%, and other professional services for 3% (10). Japa Organization for Economic Cooperation and Development (OECD) country m similar in population size to the United States (127.7 and 327.2 million, respectively), spends less than half per capita on health care as the United States, averaging $4717 per person annually (11, 12). The pricing of health care goods and services is

substantially higher in the United States than in other developed nations. A 2003 analysis of OECD data showed that health care utilization in the United States did not exceed that of other countries, and price was the key driver of spending differences (13). More recent analyses support this argument and show that, except for imaging services, U.S. utilization rates are similar to those of peer countries (11). A systematic review found inconsistent associations, but generally low to moderate whether positive or negative, between cost and quality (14). Available evidence suggests that health care prices are an important driver of the high U.S. spending compared with other countries. However, it is important to recognize that utilization is growing and represents a larger share of spending, with more people being insured in the wake of the ACA and state Medicaid expansion (15).

The United States Pays More for Hospital Services

Inpatient hospital prices increased 42% between 2007 and 2014, and hospital-based outpatient care grew 25% over the same period (16). The Health Care Cost Institute reports that even though total inpatient utilization decreased 5% between 2013 and 2017, average per inpatient spending increased 16% during the same period, including price increases in all subcategories of inpatient admissions (17). Spending on outpatient services has also increased, including observation visits, which jumped from 6% between 2013 and 2016 to 13% in 2017, resulting in 20% spending growth between 2013 and 2017 (17). Comparatively, spending for physician and clinical services is expected to grow from $734 billion to $1.1 trillion over the same period (18). The Health Care Cost Institute reports that although total inpatient hospital utilization decreased 5% between 2013 and 2017, the average spending per hospitalization increased 16%, with price increases in all admission categories (17).

Although hospital services drive a large share of health care spending, many h
are operating with very close margins between revenue and cost. A 2019 report from the Medicare Payment Advisory Commission (MedPAC) found that the most efficient hospitals still have a negative margin of –2% compared with other hospitals. The

margin was –1% the previous year. Despite losing money on Medicare patients, most payment adequacy indicators, such as access to care or quality of care, are positive (19).

The United States Pays More for Prescription Drugs

Compared with peer countries, the United States spends about 200% more per capita on prescription drugs. In 2016, the United States spent approximately $329 billion on prescription drugs, a number likely to grow (20). Recent OECD data show that Americans spend about $1200 per capita on prescription drugs per year (21). Despite the higher rate of generic drug dispensing in the United States than in other countries (84% compared with 30% for Australia, the country with the lowest rate), overall per capita pharmaceutical spending is highest among OECD countries. Unlike most peer nations, the United States does not have a centralized government body that negotiates drug prices or determines which drugs government programs will cover. The U.S. regulatory environment enables pharmaceutical companies to raise prices by any amount without justification. Although some new drugs offer therapeutic innovation and improvement, price increases for established brand-name drugs contribute substantially to growing prescription drug spending (22).

The United States Spends More on Administration

In large part owing to its pluralistic financing system, the United States spends more on administration of health care than peer countries. One study estimated that in 2012, the United States spent $471 billion on billing and insurance-related costs—$375 billion (80%) more than in a “simplified financing system,” such as Canada's single-payer model (23). Another study concluded that administrative costs were 31% of total U.S. health care expenditures, nearly double those of Canada (24). In 2010–2012, administrative costs varied with type of insurance market: 20% in nongroup ar large-group markets (25). Average administrative costs for private insurers are 12.4%, substantially higher than Medicare administrative spending, which accounts for around 2% of total program costs (26, 27).

Physicians and hospitals in the United States spend much more than their counterparts elsewhere on administrative activities. Physician practices in the United States spend $61 000 more per physician per year dealing with insurers than their Canadian counterparts (28). Hospital administrative costs make up 25% of total U.S. hospital spending, compared with 20% in the Netherlands, 16% in England, and 12% in Canada (29). Insurance premiums reflect high administrative costs. Analysts project that administrative costs account for 30%, or roughly $5700, of the approximately $19 000 annual premium for an average employer-sponsored health family insurance plan (30), slightly less than the average annual amount that workers pay toward insurance ($6015) (31).

Health Care Outcomes in the United States Often Compare Unfavorably With Those in Other Countries

High U.S. health care spending has generally not yielded gains in health or productivity (9). Looking at health care expenditures in the absence of contextual factors, such as quality of care and social determinants of health, does not capture the complexity of the U.S. system and subsequent impact on costs to government payers and individuals (32). An estimated 80% of an individual's health is tied to socioeconomic factors, physical environment, and health behaviors (33). For example, living in a food swamp with greater access to fast-food establishments, convenience stores, or other stores lacking nutritious food increases an individual's risk for obesity (34). The cost of obesity in the United States rose from approximately $212 billion in 2005 to $315 billion in 2010 and is expected to rise (35). Without addressing the complex factors contributing to health care spending as part of broader reforms to health care coverage and financing, the United States will continue to spend substantial amounts of money on health care without seeing measurable improvements in health.

The United States excels in some health care process measures, such as prevention and patient preferences, and 30-day mortality rates for heart attacks and stroke are lower than those in peer countries (36, 37). However, despite higher spending, the

United States generally has less favorable outcomes than other countries. In a Commonwealth Fund comparison of 2017 health system performance of 11 industrialized countries, the United States ranked last or near-last in access, administrative efficiency, equity, and health care outcomes (36). According to the OECD, the United States ranked second to last in the percentage of the population that had coverage for a core set of health care services in 2015 and performed poorly on consultations and medications skipped owing to cost (38). Life expectancy is lower and chronic disease rates are higher than those of peer countries (39). Infant mortality ranked 26 out of 29 in 2010, even after adjustment for reporting differences (40, 41). The United States has a higher mortality rate for medical conditions for which there are recognized health care interventions than Germany, the Netherlands, Japan, France, and Australia (37).

Health Care in the United States Is Unaffordable for Many

Affordability of coverage is a common reason for remaining uninsured (42). Factors that contribute to the affordability of health care include prices of goods and services, premiums, copayments, deductibles, coinsurance, type of health care coverage (employer-based, third party, or government), and benefits included with the plan. Premiums vary with enrollee mix, insurer administrative costs and profits, generosity of coverage, and prices of goods and services (25).

The share of workers with employer-sponsored insurance dropped from 67.3% in 1999 to 55.9% in 2014, with a slight increase to 58.4% in 2017, possibly due to the ACA and improved economy (43). Family premiums for employer-sponsored insurance have increased 54% since 2009, outpacing inflation (31). In 2019, the average annual premium for employer-sponsored coverage was $20 576 for a family and $7188 individual and had risen over the previous year (31, 44). The 2019 Milliman Med Index found that total health care costs (including employer subsidy, employee contribution, and employee out-of-pocket cost at time of service) for a typical American family of 4 with an employer-sponsored preferred provider organization insurance plan exceeded $28 000 (45). The Congressional Budget Office predicts that

over the next decade, premiums will continue to outpace wages, decreasing the prevalence of employee-based coverage (46). Evidence suggests that more low-income families, who generally spend a larger proportion of income on employer-based insurance than wealthier counterparts, enrolled their children in public insurance plans to relieve the burden of employer-sponsored insurance costs (47, 48).

As insurance costs rise, many employers offer insurance with high cost sharing (49). The Kaiser Family Foundation reports that 82% of workers have an annual deductible, and since 2009, the deductible burden has increased 162% (31). Since 2006, total cost sharing has grown at a higher rate than wages (50). Of employer-sponsored insurance enrollees who were continuously insured throughout the year, 28% were underinsured in 2018, compared with 10% in 2003 (51).

Market conditions affect affordability, with monopolies associated with higher premiums. The ACA marketplace–based insurance premiums were on average 50% higher in areas with a single insurer than in those with robust payer competition, and locally dominant health systems can demand higher payments from certain insurers, which are reflected in premiums (52–54). In competitive markets, insurers can select clinicians to include in a network and clinicians can choose whether to contract with an insurer, but it is unclear whether savings gleaned from insurers' negotiations with clinicians translate to lower premiums or more benefits for consumers. Consequently, the ACA requires spending 80% to 85% of premiums on care and quality improvement (55).

Part 2: Potential Approaches to Achieving Universal Coverage

There are several models for health insurance systems (56–58), and the U.S. sys includes aspects of each of the models outlined in the Table. The Veterans Health Administration reflects the Beveridge model, Medicare reflects the national health insurance model, employer-based insurance the Bismarck and private insurance

models, and the out-of-pocket model reflects direct patient contracting models (concierge, retainer fees) and being uninsured (56).

Table. Health Insurance System Models

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Category	Description and Financing	Service Delivery	Examples
Beveridge system (national health model)	Universal health coverage for all citizens paid for by government Financed by taxes	Government runs most hospitals, employs or contracts with clinicians	United Kingdom Denmark Italy U.S. Veterans Health Administration
National health insurance model	Government ensures universal coverage and acts as single payer Financed by taxes, and in some systems cost sharing and premiums	Private hospitals and clinicians	Canada Taiwan U.S. Medicare
Bismarck system (social insurance model)	In general, compulsory enrollment and coverage provided by nonprofit, private employer-based health insurance plans and in some cases individual and private insurance sickness funds Financing may come from payroll contributions or other areas	Private hospitals and clinicians	Germany France Some aspects of U.S. employer-sponsored insurance
Private insurance and out-of-pocket model	Health coverage is employer-based or purchased by individuals Financing from employers or individuals	Private hospitals and clinicians	Some aspects of U.S. system Cambodia Other developing countries

The ACP believes that universal coverage is essential. Critics of universal coverage argue that it would lead to rationing; lower pay for physicians, hospitals, and other sources of care; and higher out-of-pocket costs for patients (59). Universal coverage alone does not ensure access to high-quality, affordable care—the goal should be both universal coverage and access—yet lack of health insurance coverage is associated with higher preventable mortality (60). Dimensions of universal access include physical accessibility; affordability; indirect costs, such as transportation; and acceptability of services to patients (61). Critics also assert that the price controls associated with universal coverage lead to long waits and delays in care. Yet, a the United States performs above average on certain measures, such as wait t a specialist appointment, many countries with universal coverage outperform the United States on timely access to care (36).

Because many universal coverage proposals include a compulsory coverage element through taxes or mandates, some argue that universal coverage compromises individual freedom by forcing individuals to purchase something they may not want (62). The ACP believes that to achieve true universal coverage, coverage must be compulsory. A Beveridge- or Bismarck-style system would probably mandate participation, because financing relies on general or payroll taxes. Adverse selection and uninsured "free riders," who access free or low-cost care despite being able to afford health insurance, are a concern in health care systems where private insurance coverage is voluntary (63, 64). Such mechanisms as automatic enrollment or premium penalties for delaying enrollment are alternative mechanisms to encourage enrollment and stabilize the risk pool in a voluntary system (65). According to the World Health Organization, "Because of adverse selection and the exclusion of the poor, no country in the world has managed to come close to [universal health coverage] by using voluntary insurance as its primary financing mechanism" (66).

ACP Policy Positions and Recommendations: Universal Coverage

The following section provides ACP's recommendations and policy positions for achieving universal coverage. The background and rationale follow each recommendation.

1. The American College of Physicians recommends that the United States transition to a system that achieves universal coverage with essential benefits and lower administrative costs.

a. Coverage should not be dependent on a person's place of residence, employment, health status, or income.

b. Coverage should ensure sufficient access to clinicians, hospitals, and other s of care.

c. Two options could achieve these objectives: a single-payer financing approach, or a publicly financed coverage option to be offered along with regulated private

insurance.

Single-Payer Model Option

Federal and state governments have taken an incremental approach to extending coverage, including Medicare for seniors, Medicaid for poor persons, the Children's Health Insurance Program (CHIP) for middle-income children, and the ACA for lower- and middle-income uninsured persons. Yet, support for a single-payer system has grown in in recent years (67).

“Single-payer” is often confused with other concepts or goals, such as universal coverage, administrative efficiency, and better affordability. Critics and proponents of single-payer health care often describe it as a Beveridge-style, socialized system where the government pays for services, operates hospitals, and employs physicians and other health care professionals (68, 69). However, according to Liu and Brook (70), the term “single-payer” originated to differentiate the Canadian system of government financing and private delivery from that of the United Kingdom, where, for the most part, the government is responsible for both, and now is often used to describe financing by a single public entity irrespective of delivery type. Single-payer systems do not necessarily prohibit private insurance. For example, many Canadians have private insurance to cover supplemental benefits not included among guaranteed benefits, such as prescription drugs (71). In Denmark's single-payer system, 39% of people have private supplemental insurance to finance such services as physical therapy (72). Other countries permit the sale of complementary coverage for faster access to covered benefits or acute care services from private sector professionals (73).

Liu and Brook (70) reviewed 25 U.S. federal and state single-payer proposals and found that most included provisions on comprehensive benefits, patient choice of “providers,” little or no cost sharing, guidelines and standards, electronic medical records, billing, formularies, and payment reform. (In this paper, ACP uses the word “provider” only when citing sources that use the term to describe health care facilities and clinicians that include physicians, in which case we put it in quotation marks. The

ACP itself does not use “provider” to describe physicians because it is an economic term that devalues their skills, training, and contributions to patient care). Common physician payment scenarios include a fee-for-service model where reimbursement is negotiated by a rate-setting panel and “provider” representatives, salaries, or capitation arrangements (70). Global budgets for hospitals are also common.

Supporters see government-run, single-payer systems as models where insurance is more affordable, portable (not dependent on place of residence, employer or employment), administratively simple, and devoid of corporate interest. Compared with the existing multipayer system, a single-payer could achieve lower prices by using its bargaining monopsony power, reduce administrative costs and burdens, and ensure uniform benefits (74, 75).

Opponents see single-payer as government overreach, leading to long wait times for care, tax increases, and a damper on innovation (76, 77). They also worry that higher demand for services could lead states to broaden the scope of practice for nonphysician professionals (78). However, peer countries with single-payer, universal coverage struggle with some of the same issues that the United States confronts. Cost concerns have prevented Canada from including prescription drugs in the basic benefit package, and general practitioners in the United Kingdom's National Health Service complain of heavy workloads and paperwork (79, 80).

Transforming the current pluralistic U.S. system to one that is government-financed would probably cause major disruption in the health care industry and create winners and losers. For physicians, a single-payer system could lessen administrative burden and free time for direct patient care. Uncompensated care costs resulting from lack of insurance or unpaid cost sharing would no longer be a concern. However, thes
benefits may come at the expense of physician autonomy and increased dem
care (81). Many single-payer proposals would base payments to physicians on Medicare's flawed payment system, which encourages volume over value, undervalues cognitive services and primary care, overvalues procedures, and bases payments on the input costs of each billable service rather than on value to patients. As discussed in

the companion ACP paper “Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms” (2), any system of universal coverage should not perpetuate the existing flawed Medicare payment system. Most primary care physicians in particular probably could not afford to accept current Medicare rates for all of their patients.

For patients, a single-payer system may affect choice. Taiwan's experience in adopting a single-payer system provides some context; as Cheng (82) wrote, “For Taiwan's citizens, freedom of choice among providers of health care trumped freedom of choice among insurance carriers and contracts. These citizens' high satisfaction with their health system suggests that they still endorse that choice.” Equitable single-payer coverage would help to eliminate racial, ethnic, and income-related health care disparities.

Transition to a single-payer model could be politically difficult and strain the federal budget, because taxes would probably replace premiums and private insurers would have a reduced role or be eliminated altogether. The U.S. public is generally skeptical of centralized government, particularly when it comes to health care (83). A U.S. single-payer system could be structured in a way that considers these factors. For example, the federal government could provide the bulk of funding and set minimum standards to guide state operations. States could administer coverage and perform oversight and regulation of supplemental plans offered by private insurers, which could provide such benefits as financial assistance for direct primary care practice costs. Such an approach could ensure access and equitable benefits (federal funding and standards), promote federalism (states operate and regulate), and patient choice (access to all participating physicians, clinicians, hospitals; private supplemental insurance, and administration). Private sector physicians, other clinicians, and [illegible] would continue to deliver most care, alleviating concerns about government c[illegible] However, the experience of current federal–state programs, such as Medicaid, suggests a need for caution in recommending such an approach. Many states have imposed strict conditions on eligibility (including strict income limits and work

requirements) on their Medicaid programs, pay very low fees to physicians, and contract with managed care plans that may divert financing from patient care to their own profitability. A single-payer system that gives states considerable flexibility in designing and implementing their programs could experience similar problems.

A single-payer financing approach could achieve ACP's vision of a system where everyone will have coverage for and access to the care they need, at a cost they and the country can afford. It also could achieve our vision of a system where spending will have been redirected from health care administration to funding coverage, research, public health, and interventions to address social determinants of health.

A single-payer financing approach could also achieve other key policy objectives, including portability, lower administrative costs and complexity, lower premiums and cost sharing, lower overall health care system costs, better access to care, and better health outcomes, depending on how it is designed and implemented.

Yet, adopting a single-payer system would be highly disruptive and could lead to price controls that would perpetuate flaws in the current Medicare payment system, including the undervaluation of primary care. If prices are set too low, it could lead to shortages and longer wait times for services. Without sufficient cost controls, however, the cost of a single-payer system could be too high to be feasible. Accordingly, in addition to a single-payer system, ACP believes that a public choice model should also be considered that can help achieve our vision of better health care for all.

Public Choice Model Option

Polls have found that most Americans are dissatisfied with health care costs and believe the U.S. health care system is in a “state of crisis” or “has major problem are pleased with the coverage and quality of their health care (84, 85). Separat surveys suggest that Americans with employer-based health insurance are generally satisfied with their coverage (86, 87), but those with high-deductible plans are less satisfied than those with low-deductible plans and 4 in 10 reported difficulty paying

for care before meeting the deductible (88). Yet, Americans' concerns over proposals to replace existing insurance with something new contributed to the demise of President Clinton's health care reform initiative (89) and inflamed opposition to the ACA (90).

Depending on its structure and implementation, a public choice (or public option) model available to all could help to achieve universal coverage, better access, and improved outcomes without the disruption of a single-payer approach. Under a public choice approach, those covered by employer-sponsored insurance can choose to enroll in the public insurance plan or remain in their existing plan. The public plan would be available nationwide, ensuring portability from state to state. Elements of this approach are reflected in the German and Swiss health insurance schemes, both of which use a social insurance/managed competition structure to extend coverage to all.

The ACP has offered recommendations for a public option that would be available alongside private insurance in the ACA marketplaces to inject competition into areas underserved by private insurers and reduce premiums. The ACP also supports a Medicare buy-in option for persons aged 55 through 64 years (91). Evidence shows that areas with a single insurer have faster premium growth than those with multiple insurance options (53). Although the number of ACA marketplace insurers grew overall in 2019 and insurers appear to be profiting, participation is less robust than in the program's early years in some areas (92, 93).

In 2019, 75% of employers offering coverage offered only 1 plan type, although nearly 64% of workers who had employer-based insurance had more than 1 plan available to them (31). Employers that offer a single plan generally provided a preferred pr organization plan, but 27% of workers only had an offer of a high-deductible h plan. People with affordable, comprehensive employer-sponsored insurance are ineligible for subsidized marketplace-based coverage under the ACA. This means most nonelderly Americans are restricted to the health insurance plan offered by their employer, or unsubsidized individual coverage inside or outside of the health

insurance exchange. A public choice approach would provide choice to those with few or undesirable private options. A nationwide public plan would be portable and people would not need to remain in a job solely to maintain health insurance coverage (94). The public choice plan's benefits may be greatest for low-income uninsured and underinsured persons. Roughly 2.5 million people are eligible for expanded Medicaid but live in a nonexpansion state and earn too little to qualify for subsidized marketplace-based insurance (95). A public choice approach would ensure access to coverage for such individuals. Some public choice proposals include benefits not typically found in employer-sponsored or traditional Medicare plans, such as dental care and hearing and vision aids.

Safeguards would be necessary if the United States were to introduce a public choice model. Financial subsidies and regulations to make the public plan affordable would need to be made available to a wider array of people than in the ACA marketplace. Employer-sponsored insurance would need to be required to meet new benefit and regulatory standards to prevent adverse selection, ensure a level playing field, and promote equitable coverage. Robust risk adjustment mechanisms would need to be adopted. Employers would need to financially contribute to the public plan when employees choose it over the employer-sponsored plan. Alternatively, employers could choose to pay to enroll their employees in the public plan rather than offering a private plan.

Public option proposals also have noteworthy disadvantages. Continuing the multipayer system would require more complex regulatory structure and stricter oversight and result in fewer savings from lowering overall administrative costs than a single-payer model, and still would probably require substantial controls over prices to keep coverage affordable. If physician payments in the public plan were based Medicare rates, physician practices could face financial difficulties that would undermine participation, especially in areas with workforce shortages. Such price controls could perpetuate undervaluation of primary care. Without sufficient controls, however, costs could make a public plan infeasible.

A public choice approach would be unlikely to achieve the same degree of reductions in prescription drug prices and wasteful spending expected with a single payer. The administrative burden associated with the existing multipayer system could remain unless most people and their employers migrated to the public plan. Access to physicians, hospitals, and other health professionals may be restricted if insurance plans formed limited "provider" networks. Folding ACA marketplace plans, Medicaid, and other forms of coverage into a new public plan could disrupt care continuity. Automatically enrolling certain populations, such as newborns, into the public choice plan would put it at a competitive advantage over private payers, reducing their ability to compete. Medicare Advantage provides a cautionary experience of what can happen in a system where private and public entities compete, underscoring the need for strong regulatory oversight and a level playing field. The U.S. Government Accountability Office and MedPAC have called for improvements in the program, where private insurers are contracted to provide Medicare benefits as an alternative to the Medicare fee-for-service program, after finding questionable risk coding practices (96, 97), narrowing "provider" networks and inaccurate directories (98), and evidence that beneficiaries in poor health were more likely than beneficiaries in better health to disenroll because of problems related to getting needed care and accessing their preferred doctor or hospital (99).

A public choice approach could potentially achieve ACP's vision of a system where everyone will have coverage for and access to the care they need, at a cost they and the country can afford, with less disruption than a single-payer system. A public choice approach also could partially address ACP's vision of a redirecting administrative spending to fund coverage, research, public health, and interventions to address social determinants of health.

Depending on how the program was designed and implemented, this approa achieve other key policy objectives, including portability, lower premiums and cost sharing, lower overall health care system costs, better access to care, and better health outcomes. Expanding availability to all Americans of an enhanced Medicare-like

program represents a promising path toward achieving universal coverage that could evolve to a single-payer system, should most Americans choose to enroll in public coverage over private insurance, or employers choose to spend their contribution to health insurance by subsidizing their employees' enrollment in a public plan.

Before deciding on a single-payer or public choice approach, ACP examined a variety of alternative approaches. We found that market-based approaches would not achieve key policy objectives, including reducing administrative costs and associated burdens on clinicians and patients, ensuring that coverage is portable, ensuring that essential benefits are included, guaranteeing that patients are not discriminated against or charged higher premiums because of health status or poor health, and ensuring that all Americans have coverage for the care they need—that is, they would not achieve universal coverage. Our review of other peer countries' health systems found none that have achieved universal coverage through a purely market-based approach, although some have elements of market competition and heavily regulated “insurance”-type plans. As noted earlier, the World Health Organization found that “no country in the world has managed to come close to [universal health coverage] by using voluntary insurance as its primary financing mechanism” (66). Although the social insurance/Bismarck model of regulated insurance-type programs (similar to public utility regulation) could achieve universal coverage, it would require that the federal government impose an entirely different regulatory structure on insurers, including converting them to nonprofit entities, setting or controlling the rates they can charge, and determining the rules under which they would administer health care benefits. We found little in the available literature on how such a model might specifically be developed for the United States.

The ACP concludes that of the currently available approaches that have been extensively modeled and researched, either a single-payer or public choice mo offers the best opportunity to achieve our vision of universal coverage at a cost the patient and the country can afford, while recognizing that each has advantages and disadvantages. The ACP acknowledges concerns about giving government too much

control over health care but notes that the current system gives insurers, many of whom act like or are for-profit companies, too much control, while the government already has a substantial role in regulating and financing health care. Implementation of any system, whether single-payer or a public choice approach along with regulated insurance, must be designed to protect and ensure that patients can get, and physicians are able to provide, the care they need consistent with evidence-based guidelines, essential guaranteed benefits determined with patient and physician input, and overall available resources.

The ACP remains open to considering other ideas to achieve our vision of making coverage and access available to all at a cost the patient and the country can afford. Finally, ACP also supports continued improvements in the current pluralistic system, including the ACA, even as the United States transitions to new approaches to achieve universal coverage.

2. The American College of Physicians recommends that under either a single-payer or public choice model, coverage must include an essential health care benefit package that emphasizes high-value care, preferably based on recommendations from an independent expert panel that includes the public, physicians, economists, health services researchers, and others with expertise.

Whether a single-payer or public choice model, the U.S. system must guarantee coverage of essential health care services for a diverse population. The ACP supports mandatory coverage of essential health services, including primary care and prescription drug benefits. The ACP supports maintaining the ACA's essential health benefit package, which requires certain insurance plans to cover 10 service categories, ranging from such foundational services as hospitalizations and ambulatory c more specialized areas, such as rehabilitative or habilitative benefits. Before th requirements, many individual market plans did not cover vital services, such as maternity care, behavioral health treatment, or prescription drugs (100).

Prominent single-payer proposals base the benefit package on an existing program, such as Medicare, Medicaid, or the ACA's categories of essential health benefits, or require coverage for all medically necessary services. A single-payer or public choice program based on Medicare would have to be expanded to cover services for a wider range of populations with differing needs. This includes extending coverage of nonemergency transportation services and Early and Periodic Screening, Diagnostic, and Treatment benefits to those eligible for Medicaid in the current system.

Most long-term services and supports, such as nursing facility and home health services, currently are covered by public payers. Medicaid paid for 42% of long-term services and supports in 2016 (101). A single-payer system or a public choice model that replaces the Medicaid program would have to incorporate these services, which will drive up demand and government spending. In England, most long-term services and supports are paid for by local or private entities, whereas in Canada, provincial and territorial governments may provide this care (102). The ACP believes that a sustainable strategy for long-term services and supports should be developed, especially as the baby boomer generation matures and demand for services grows. In the interim, whether a single-payer or public choice approach is adopted, Medicaid should continue to cover the bulk of this care.

According to MedPAC, "[L]ow-value care has the potential to harm patients by exposing them to the risks of injury from inappropriate tests or procedures and may lead to a cascade of additional services that contain risks but provide little or no benefit" (103). The delivery of low-value care occurs in traditional fee-for-service Medicare, Medicaid, and commercial insurance plans; however, fee-for-service Medicare is statutorily prohibited from considering cost-effectiveness when determining whether a service or item should be covered. In designing an ess benefit package for a single-payer system or public choice program, high-valu should be emphasized.

In 2011, at the Department of Health and Human Services' (HHS) request, the Institute of Medicine (IOM) (now the National Academies of Medicine, Engineering, and

Science) developed criteria and methods to determine benefits to include in the ACA's essential health care benefits package while balancing coverage and cost. The IOM encouraged the government to consider population health needs, be evidence-based, emphasize the judicious use of resources, and improve value and performance (104). To achieve this, IOM recommended that benefits be based on an annually updated premium target and be continuously updated by using a public process and considering costs to be fully evidence-based and promote value (105). A national benefits advisory council and the public would provide input. Ultimately, HHS took a different approach, basing essential health benefits on a private sector or government employee benchmark plan, which led to some variation among states.

In some health care systems, expert commissions develop evidence-based recommendations on what goods and services to include in the benefit package. For example, the United Kingdom's National Institute for Health and Care Excellence (NICE) considers the clinical effectiveness and cost-effectiveness of new diagnostic and therapeutic services to determine whether to make them available to patients. About 40% of NICE's published appraisals are for cancer-related technologies (106). The Oregon Health Evidence Review Commission evaluates treatment effectiveness and other factors to prioritize services for the state's Medicaid and CHIP programs (107). Categories are prioritized by rank. For example, maternity and newborn health are ranked first, and inconsequential care is ranked last. Treatments within each category are then ranked on the basis of a formula that includes the category rank and impact on such factors as healthy life-years, suffering, effectiveness, and the need for service. Oregon factors in cost only when needed to break a tie. The state legislature determines at what priority level services should be funded, but access to unfunded services may be granted via such processes as waivers. In a 2011 poli (108), ACP recommended that multiple criteria should be considered to priorit health care resources. These criteria included patient need, preferences, and values; potential benefit; safety; societal priorities that include fiscal responsibility, public health, and equitable access; quality of life gained, consistent and compliant with the Americans with Disabilities Act; and impact on families and caregivers, and achieving

a balance between cost and clinical effectiveness to minimize adverse economic consequences on current and future generations.

As stated in the ACP Ethics Manual (109), physicians' ultimate duty is to their patients. The ACP believes that clinical effectiveness and cost-effectiveness should be incorporated into designing a patient-centered, high-value essential benefit package. However, nondiscrimination language, an appeals process, and other safeguards must be established to ensure that all can access the care they need. The development of a benefits package should include a formal process for patient and physician input and be free of conflicts of interest. According to the ACP Ethics Manual (109), “Stakeholders, including physicians, other health care professionals, patients, patient advocates, insurers, and payers, should participate together in decisions at the policy level; should emphasize the value of health to society; should promote justice and fairness in health care; and should base allocations on medical need, efficacy, cost-effectiveness, and proper distribution of benefits and burdens in society.”

Private Insurance in a Single-Payer System.

Most single-payer systems in other countries are administered by national or state/provincial government, but private insurers may play a role in administering coverage at the local level or offer special coverage. Canada, France, Australia, and other nations that have achieved universal coverage allow the sale of voluntary private coverage that covers services not included in the basic insurance package (supplemental); out-of-pocket costs (complementary); or the same services, but with different hospitals, clinicians, or service levels (duplicative) (110). A U.S. analogue would be the Medigap program, which provides Medicare beneficiaries coverage for cost sharing (111) and, before implementation of Part D in 2006, some prescription d benefits (112).

If a single-payer approach is pursued, private insurers could offer regulated supplemental insurance for services outside the essential benefits package or complementary coverage for out-of-pocket costs, although the latter may enable use

of limited-value care (113). States could choose to cover additional benefits at their expense. RAND estimates that out-of-pocket costs under a national Medicare-for-all proposal would exist for "elective services" outside of the basic benefit package, such as cosmetic surgeries, infertility treatment, adult orthodontics, and over-the-counter medications (114). Similar to Medigap, states and the federal government could regulate supplemental or complementary plans.

Allowing the sale of private insurance may raise concerns about equity and access, particularly if it duplicates government coverage. In Australia, private coverage pays for extra benefits and a broader choice of private hospitals and specialists than public insurance. However, concerns have been raised that private insurance is being used to pay for public hospital care, despite the hope that private insurance would relieve demand on the public hospital system (115). Those with private coverage may have far shorter wait times for certain services, such as knee replacement surgery, than those with public insurance (116).

The ACP opposes the sale of duplicative coverage, owing to concerns that it may create a "2-tiered" system that could exacerbate health care disparities. However, if it is marketed, it is imperative that private insurance be carefully regulated to balance choice with equity and prevent discrimination and exclusion of vulnerable patients. Relevant regulations, such as guaranteed issue and renewability, community rating, medical loss ratios, and prohibitions on preexisting condition exclusions, should be established.

Private Insurance in a Public Choice System.

A public choice model should be required to adhere to regulations that ensure access, equity, and affordability. Permanent risk adjustment and reinsurance program[s] [must] be established to prevent adverse selection.

The Role of Cost Sharing and Premiums

3. The American College of Physicians believes that, whether a single-payer or public choice model, cost sharing that creates barriers to evidence-based, high-value, and essential care should be eliminated, particularly for low-income patients and patients with certain defined chronic diseases and catastrophic illnesses. In general, when cost sharing is required for some services, it should be income-adjusted through a subsidy mechanism and subject to annual and lifetime out-of-pocket limits. In a public choice model, premiums should be income adjusted and capped at a percentage of annual income.

Cost sharing can temper utilization and reduce costs by steering enrollees to high-value services. Single-payer proposals typically feature limited or zero cost sharing, which could increase demand for care. For example, Canada does not apply cost sharing or other fees for primary care or hospital services, a difference from U.S. trends toward higher deductibles and cost sharing (117) and patient anxiety about surprise out-of-network bills (118).

Over the past decade, enrollment in low-deductible health plans has decreased while enrollment in high-deductible health plans has grown for adults in employer-based plans (119). In the RAND Health Insurance Experiment, cost sharing reduced utilization of both effective and ineffective services (120). Low-income, sick patients in plans with zero cost sharing had better hypertension and vision outcomes than those with cost sharing, but those with cost sharing had fewer restricted-activity days and worried less about their health (120). Despite the potential benefits of cost sharing, the RAND study suggests that cost sharing should be minimal or nonexistent for low-income individuals. Evidence shows that even very low Medicaid copayments are associated with decreased use of necessary care (121). High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis. One study that switching from a low-deductible to a high-deductible employer-based pl associated with delays in breast cancer diagnosis and chemotherapy initiation among women, regardless of income (122).

These observations lead ACP to recommend zero cost sharing for essential services, particularly for low-income individuals (at a minimum, 138% of the FPL) as well as those with special health care needs, serious illnesses, and chronic conditions. Taiwan, Germany, and Switzerland are examples of countries that cap or eliminate cost sharing on the basis of income, service category, or health condition (123). For higher-income enrollees, cost sharing should be structured to direct patients to effective, patient-centered, high-value care. Value-based insurance design proposals, supported in concept by ACP, reduce or eliminate cost sharing for high-value services and have been shown to increase use of mammography (124) and adherence to medications (125–127).

Most single-payer systems are financed with revenue from payroll, income, or other taxes and do not charge premiums. An exception is Taiwan, which applies a payroll-based premium. A public choice option would probably incorporate premiums and cost sharing. Under a single payer, household health care spending could change depending on how the program is structured and financed. A New York State single-payer proposal (Appendix) is estimated to reduce health care spending for most New Yorkers, with those with household income less than the 75th percentile (up to $185 200) paying on average $3000 less per person on health care and those with household income in the 90th to 100th percentile paying more owing to the progressive tax rate financing structure (128).

The ACP recommends that a public choice model include income-adjusted premium and cost-sharing subsidies. The ACP has recommended extending the ACA marketplace's premium tax credits to people with incomes over 400% of the FPL and enhancing their generosity to make insurance more affordable (7). Prominent public option proposals would cap annual premiums to a percentage of income and cost sharing.

Payments and Availability of Health Care Services

4. The American College of Physicians recommends that that in either a single-payer or public choice model, payment rates to physicians and other clinicians, as well as to hospitals and other facilities that offer health care services, must be sufficient to ensure access to needed care and should not perpetuate disparities in current payment methods.

a. Current Medicare payment rates generally are insufficient to achieve the objectives of universal coverage.

b. Physician payment policies must ensure robust participation and not undervalue primary care and cognitive services, including the primary, preventive, and comprehensive care provided by internal medicine physician specialists.

Some single-payer and public choice proposals rely on a fee schedule to determine physician reimbursement. For example, the Physicians for a National Health Plan single-payer proposal (Appendix) would negotiate a fee schedule between the plan and regional physician representatives, with salaries for facility-based physicians. In general, it is estimated that under most single-payer proposals, overall physician compensation would decrease, administrative burdens would be relieved, and demand for services would rise.

A prominent Medicare-for-all proposal would base payment on a fee schedule similar to Medicare's, and independent evaluations make different assumptions on physicians and other clinician payment. The Mercatus Center (129, 130) estimates that "provider" payment would be level with current Medicare rates (estimated to be 40% lower than private payer reimbursement rates), and Thorpe (131) assumes a blended payment rate of 105% of costs. The Urban Institute (132) assumes that physician reimbursement would be at Medicare rates, but notes that "payment rates may in fact have to be higher, at least initially and perhaps indefinitely, to be acceptable to providers," which would also raise federal spending and could temper utilization owing to insufficient capacity. RAND (114) estimates that under national single-payer health plan payment changes, "providers' willingness and ability to provide health care services—including

the additional care required by the newly insured and those benefiting from lower cost sharing—would most likely be limited."

Berenson and colleagues (133) concluded that if physician compensation was based on the Medicare fee schedule instead of the multipayer mix, median annual compensation would decline by 12%, with large variations by category and specialty. Primary care internists would see their mean annual compensation drop by about 8%. The impact of uniform Medicare rates and increased billable hours would vary for different specialties. Some nonsurgical, nonprocedural practices (such as endocrinologists and nephrologists) may experience higher incomes, whereas surgeons and radiologists may see lower compensation. However, the immediate impact on compensation may depend on physicians' current patient mix: A physician who cares for a disproportionate number of Medicaid patients may see compensation rise, whereas those who care for mostly privately insured patients may see compensation drop (134). According to the American Medical Association 2016 benchmark survey, the average general internal medicine physician patient share was 38% Medicare, 11.9% Medicaid, 40.4% commercial health insurance, 5.7% uninsured, and 4.1% other payer (135).

The health systems in some countries allow physicians to charge certain patients an amount on top of the public fee, similar to the balance billing that U.S. Medicare allows for nonparticipating physicians. The ACP believes that, whether a single-payer or public choice option, the U.S. system should reimburse at rates sufficient to ensure robust participation that makes balance billing largely unnecessary. If permitted, balance billing should be limited so as not to discourage care, especially among low-income patients. The growth of balance billing in France has raised concerns about access to specialists for those unable to pay additional fees (136).

Other policies should be adopted to ensure physicians are available to meet the higher demand for medical care. In a set of recommendations for a state-based single-payer program, Hsiao and colleagues (137) recommended including medical malpractice reform (specifically the no-fault administrative compensation system that ACP

supports pilot testing [138]), enhanced loan repayment programs, and community hospital improvements.

Primary Care and Payment Reform

The U.S. shortage of primary care physicians impedes access to high-quality care (139). Medicare beneficiaries are more likely to have trouble finding a primary care physician than a specialist (140). Racial and ethnic minority beneficiaries report longer wait times and higher rates of forgoing care than non-Hispanic white beneficiaries. The U.S. Medicare fee schedule undervalues primary care compared with specialty services (141). In 2017, according to MedPAC, median primary care compensation was much lower than specialty care, raising concerns about fee schedule mispricing primary care (140). The Center for American Progress' Medicare Extra for All proposal (Appendix) would provide a modest boost to primary care physicians, but it is unclear whether it would reverse the primary care shortage or balance the primary care–specialist pay disparity (142). Countries with universal coverage also experience primary care shortages. In the 2000s, Canada raised reimbursement and increasing hospital funding to reverse physician workforce shortages and long waits for surgery (143).

In a public choice system, the continued existence of commercial employer plans, which typically pay physicians more than Medicare, may help to offset lower public plan pay rates, but this is not guaranteed. Medicare Advantage rates closely track Medicare fee-for-service rates (144). Proponents of public choice proposals, including Medicare Part E developer Jacob Hacker, believe that adopting Medicare rates will cause commercial rates to drop. Likewise, the Medicare Extra for All proposal would extend Medicare-based payment rates to employer-sponsored plans. The public choice approach, in addition to not having the administrative efficiencies of a single-payer system, could reduce access if payments are reduced to an extent that makes practices unsustainable. As stated previously, any system that the United States implements should not adopt the imperfections of the existing Medicare fee-for-service model that rewards high-volume, procedure-oriented specialties over complex

cognitive care delivered by primary care physicians. The ACP has long supported the patient-centered medical home, a primary care delivery model that promotes team-based, coordinated care. Early evidence on the Nuka System of Care, a patient-centered medical home model designed to provide integrated, multidisciplinary care for the Alaska Native and American Indian population, indicates that emergency care use (including for asthma) declined after implementation (145, 146). The value of primary care is discussed further under recommendation 8.

The ACP believes that, whether a single-payer or public choice model, physician participation should be voluntary and physicians should not be required to be employed by the government, as in the United Kingdom's National Health Service. The Medicare for America Act (Appendix) would allow enrollees to see any physician that participates in the Medicaid or Medicare programs. ACP policy supports a public option in which physicians' participation is voluntary, as it is in the current Medicare system. The ACP opposes clauses in insurer contracts that obligate the physician to participate in any plan offered by an insurer.

Mandatory Versus Voluntary Coverage

5. The American College of Physicians believes that an automatic and mandatory enrollment mechanism should be developed under either a single-payer or public choice option system. In a public choice system, employers should be required to offer comprehensive coverage to their employees (and families) that is at least as generous as the public insurance option or pay a portion of the cost of their employees' public insurance plan coverage (that is, "pay or play").

To achieve universal coverage, enrollment in any new U.S. system must be mandatory or automatic as it is in most countries, including those with social insurance or managed competition structures (147). Most single-payer proposals involve governmental administration, are funded by taxes, prohibit the sale of substitutive or duplicative private insurance, and include an automatic enrollment mechanism. Automatic enrollment could also be a feature of a public choice system.

In a public choice system, employers could opt to subsidize their employees' public insurance or offer their own coverage. This may require new regulations for employer-sponsored insurance plans, including actuarial value requirements. For example, the Medicare for America legislation (Appendix) would mandate that large employers that offer insurance ensure that it has an actuarial value of 80%, equivalent to a gold-level marketplace-based plan, and has benefits resembling the new Medicare program. Without these important safeguards, the more generous public insurance plan would attract a disproportionate share of sicker people, which would increase claims and premiums. Employers should be required to provide information on the public choice insurance program to employees during open enrollment.

Currently in the United States, immigration status affects eligibility for government-subsidized health insurance. Undocumented immigrants are generally ineligible for federal insurance programs, such as Medicaid, and are barred from buying marketplace-based insurance. Many eligible noncitizen legal residents can enroll in Medicaid after a waiting period and may be eligible for subsidized marketplace-based insurance. United States immigration law has long sought to restrict lawful permanent residence for noncitizens who may become eligible for certain government services (public charges), and the Trump Administration has extended this policy to Medicaid and other health programs (148). Although immigration status barriers for public health insurance programs may help ensure that the country's resources are being spent on its citizens, they deny the public and personal health benefits of coverage (149, 150). For example, undocumented immigrants are unable to access Medicare coverage for standard dialysis (151). One study shows that undocumented immigrants with chronic kidney disease who receive emergency dialysis have higher mortality and spend more days as inpatients than patients who receive standard dialysis (152). Undocumented individuals living in the United States are nearly 5 times as likely citizens to be uninsured, even though about 85% are working or have a family member who is employed (153).

In 1982, the U.S. Supreme Court ruled that denying a child the right to attend public school on the basis of immigration status violates the Equal Protection Clause of the 14th Amendment. The court concluded that the societal harms of denying these children access to public education outweighed concerns about finances or impact on the quality of education for citizen children. It is unclear whether this precedent would apply to noncitizen eligibility for public health insurance, but ACP recognizes that there are public health and societal benefits of ensuring that all persons residing in the United States, regardless of immigration status, have access to health care services. In the 2011 position paper "National Immigration Policy and Access to Health Care" (154), ACP recommended that "[a]ccess to health care for immigrants is a national issue and needs to be addressed with a national policy." Immigration policy should not interfere with health care professionals' obligation to care for sick persons and should not foster discrimination in the provision of health care. At a minimum, whether in a single-payer or public choice approach, undocumented immigrants and other ineligible populations should be permitted to buy unsubsidized public insurance. The ACP also recommends adequate funding of programs that serve the noncitizen uninsured population.

Administrative Requirements and Costs

6. The American College of Physicians believes that relief from health care system administrative requirements should be a priority under either a single-payer or public choice model. To the furthest extent possible, billing and quality measure reporting should be standardized and streamlined.

Physicians in the United States face a barrage of administrative tasks related to billing, electronic health records, and performance measurement. Administrative bur
contribute to physician burnout, which is costly (155) and may raise the risk for
error (156). Physician practices in the United States spend much more than their
Canadian counterparts on administrative activities (24).

Some U.S.-trained physicians choose to practice in Canada in part because of frustration in dealing with administrative burdens in the pluralistic U.S. system (157). A benefit of a single-payer system is a reduction in these burdens and associated costs could offset any reductions in pay. A survey of Massachusetts physicians found that a majority would trade a 10% reduction in income for a substantial reduction in paperwork (158). The Congressional Budget Office notes that administrative costs would be lower in a single-payer than in a multipayer system (102). Recommendation 9 also addresses administrative costs.

One analysis of a Medicare-for-all proposal estimates that physicians would have an average of 4 hours of freed time per week to direct to billable patient care (159). The same analysis estimates that average annual physician compensation would decline by 7% to 9%, but be somewhat offset by an 8% increase in billable hours. An evaluation of a different national Medicare for All proposal estimates that total clinician administrative spending would drop by 32.6% (114).

Financing of Coverage and Treatment of Special Populations

7. The American College of Physicians recommends that a single-payer or public choice model be financed through government spending, employer contributions, progressive taxes on income, tobacco and alcohol excise taxes, value-based cost sharing, reallocation of savings from reduced spending on administration, and system-wide savings and efficiencies described in this paper.

a. Health care programs that serve special populations, including the Veterans Health Administration, Medicaid long-term services and supports, and Indian Health Service, should continue to operate alongside the new program.

Estimates vary about whether a national single-payer system would save or co than current national health expenditures. The majority of national health expenditures would shift from a mix of public, employer, enrollee, and other spending sources to the federal government. RAND estimated that if a national single-payer system was implemented in 2019, total national health care spending would increase

by 1.8%, but assumed that there would be unfulfilled demand owing to a constrained supply of physicians and hospitals and coverage of long-term care (114). The increase in federal spending results from its absorption of current spending by state and local governments, employers, and individual households (114). Single-payer proponents argue that savings will accrue from lower administrative costs, prescription drug spending, and reimbursement rates. However, these savings are likely to be offset by the expanded benefit package and higher demand.

The ACP believes that a single-payer system could garner savings with judicious cost sharing, prescription drug price negotiations, and a benefits package that focuses on high-value care. Furthermore, financing should be progressive with contributions dependent on income. Explicit means-testing of programs (denying high-income individuals access to the program) should be discouraged. Single-payer financing decisions may have broader economic ramifications. The Congressional Budget Office has noted, “The choice of tax structure would also have different implications for the labor supply and people's consumption of goods and services” (102).

The ACP recommends that public programs that cover special populations, including the Veterans Health Administration and the Indian Health Service, continue to operate alongside the new model. As mentioned elsewhere in this paper, Medicaid should continue to provide long-term services and supports. As a result, state Medicaid programs would still have a financial and administrative responsibility in the new system.

Transitioning to Universal Coverage

If the United States adopts a single-payer system, policymakers would need to develop and implement a transition process that minimizes confusion and disruption while ensuring stable coverage. Funding for public insurance programs, including traditional Medicare, a portion of Medicaid, and CHIP, would probably be consolidated into the new single-payer plan. The health insurance industry employed nearly 540 000 people as of January 2019 (160), and private insurers will see their roles diminished or

eliminated. Although specific policies are outside the scope of this paper, transition plans should consider supporting those in the current insurance workforce with resources for career retraining, transition to similar employment in the new system, or other initiatives.

Roughly 160 million people would lose existing employer-based health coverage if the United States adopts a single-payer system, but major health care system transformation is not without precedent. Medicare benefits were available less than 1 year after the program was signed into law (161), despite the necessity of compromises with hospitals, physicians, and other stakeholders (162). Stop-gap coverage options, such as broadening eligibility to the Medicare, Medicaid, and ACA marketplace plans, should be established during the transition to the new system. The ACP supports establishing a public option in the ACA marketplace (163), and more generous financial subsidies for ACA marketplace plans (7). A Medicare buy-in option for persons aged 55 to 64 years should also be created. In addition, a major public education campaign will need to raise awareness about the new plan.

The ACP envisions that transition might occur as follows:

First, close gaps and stabilize the markets created by the ACA, including creating a public option in all individual insurance exchanges, expanding Medicaid to lower-income persons in all states, and ending the income eligibility cap for premium subsidies and creating a Medicare buy-in for persons aged 55 to 64 years, as ACP has previously recommended as a way to improve the ACA (7, 91).

Next, transition to a publicly financed option for all who want it while allowing individuals to keep private coverage that meets federal requirements, with mechanisms to ensure that everyone is enrolled in a qualified plan.

Over time, if most Americans choose the public choice plan, the United States could transition entirely to a single-payer system.

Part 3: Strategies for the United States to Lower Health Care Costs

ACP Policy Positions and Recommendations: Investing in Primary and Comprehensive Care

8. The American College of Physicians supports greater investment in primary care and preventive health services, including support for the unique role played by internal medicine specialists in providing high-value primary, preventive, and comprehensive care of adult patients.

Primary care is essential in the prevention and early detection and treatment of disease, which can help to avoid costlier future care. Only between 6% and 8% of health care dollars are spent on primary care (164), but greater use of primary care is associated with decreased health expenditures, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality (165). Recent state-level analyses show an association between investment in primary care and reductions in emergency department visits, total hospitalizations, and hospitalizations for ambulatory care–sensitive conditions (166). United States markets with larger numbers of primary care physicians have lower costs and higher quality of care (164). Data suggest that investments in primary care physicians in Medicare would result in an overall drop in total Medicare costs (167). Small increases in the number of primary care physicians (1 primary care physician per 10 000 individuals) have been associated with lower all-cause, stroke-associated, and infant mortality (168). Furthermore, primary care is integral in caring for people with chronic disease, a demand that will become increasingly critical as the U.S. population ages (169).

Increased emphasis on primary care is also critical in addressing downstream
States that have invested in primary care have seen cost-savings, particularly t
states that have adopted the patient-centered medical home. A study of Oregon's Patient-Centered Primary Care Home Program found that $1 invested yielded $13 in savings downstream (170). Rhode Island, assisted by the Center for Medicare and

Medicaid Innovation, made large investments in primary care resulting in 95% of practice sites certified as medical home sites, a shift that might reduce costs (171). A study that compared patient-centered medical home and traditional primary care sites suggested that the former saved 5% (172). Initiatives to increase investment in primary care should align with the Patient-Centered Primary Care Collaborative's recommendations, including standardized metrics, broad stakeholder participation, targeted strategies, aligning payment incentives, and evidence-based outcome evaluation (173).

The ACP believes that an effective approach to reducing or slowing the growth of health care costs should recognize, support, and sustain the role that internal medicine specialists play in delivering high-value, patient- and family-centered care, by virtue of their unique training and skills in primary, preventive, and comprehensive care, particularly in diagnosing and treating adult patients with complex medical conditions. This will require researching, distinguishing, and defining what aspects of the training and skills internal medicine specialists contribute to high-value care, and how those skills and training compare with those of other primary care clinicians. This approach will also require developing and implementing public policies, delivery and payment reforms, and workforce policies shown to be effective in supporting and sustaining ambulatory-based internal medicine as an essential component of a health care system oriented toward facilitating high-value care, and addressing existential threats to ambulatory-based internal medicine. Reaffirming the value of patients having an ongoing relationship with an internist or other primary care physician leading an integrated and multidisciplinary team of clinicians dedicated to achieving the best possible outcomes for patients, as part of developing and implementing a broader strategy of supporting the role of primary care physicians in achieving outcomes at lower costs, is also necessary.

Reducing Excessive Pricing and Improving Efficiency

9. The American College of Physicians supports efforts to reduce excessive list prices for goods and services, reduce price variation not associated with differences in the

cost of providing services, reduce administrative costs at the system level and at the point of care, and improve the efficiency of the health care system.

The ACP believes that there is an immediate need for policy changes to slow spending growth, primarily in health care administrative costs, prescription drug pricing, and low-value care. Highly variable pricing for public and private payers as well as patients also need to be addressed.

Administrative Costs. Health system reforms, such as the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, have spurred exceptional growth in health care administrative costs. From 1975 to 2010, the number of health care administrators increased 3200% while physician numbers increased only 150% (174). The need for administrators increased in part to meet needs, such as those in health information technology, but also to complete increasingly complicated billing and insurance-related tasks. For example, in 2013, the Duke University hospital system employed 1600 billing clerks despite having only 957 hospital beds (175).

Many proposals to reduce administrative costs center on reducing complexity and relying on health information technology. In the current U.S. system, each payer sets their own rules with regard to claims submissions, claims reconciliation, and payment requirements, and the payers are subject to different regulations on the basis of the type of plan. For example, plans covered under the federal Employee Retirement Income Security Act are subject to less stringent federal regulations than plans that must adhere to state and federal regulation. Administrative costs account for 25% of overall U.S. hospital spending, twice that of Canada and Scotland (29). Reducing per capita hospital administrative spending to that of Canada would have saved th United States $158 billion in 2011.

In 2017, ACP called for research on administrative tasks, such as billing and insurance regulation (176). In particular, research is needed to address the variance in regulations across clinical settings. In a study, researchers examined bills throughout an academic

medical center and found that 3% of surgical procedure revenue and 25% of emergency department visit revenue goes to administration (177). The ACP reaffirms the need for rigorous research on the effect of administrative tasks on the health care system.

Prescription Drug Costs. United States policy related to prescription drug pricing has garnered considerable attention from government officials, policymakers, and the general public. Patient responsibility for drug costs increased from $59.5 billion in 2012 to $65.8 billion in 2016, despite increased use of generic drugs and ACA-related out-of-pocket maximums (178). Discounts related to coupons and Medicare Part D may shield patients, but individual out-of-pocket costs vary (178). Spending on specialty drugs in the Medicare Part D program rose from $8.7 billion in 2010 to $32.8 billion in 2015, comprising 30% of prescription drug spending although only 1% of prescriptions dispensed (179).

Numerous proposals at the federal level aim to improve transparency and regulation to the prescription drug market and to introduce tools used by private insurance to the Medicare Part D program to reduce costs and reform the pharmacy benefit management industry. Although these proposals may transform the prescription drug market over the long term, ACP recognizes that short-term strategies are also needed to rein in out-of-pocket drug costs. The ACP has long-standing policy supporting government negotiation of prices in Medicare Part D, as well as other policies that support prescription drug price transparency and increasing competition in the prescription drug market and opposing anticompetitive behaviors that keep lower-cost drugs off the market (180).

Investments in Health Care Infrastructure. In 2014, Sheppard (181) argued that practice of medicine has always had a business component. Currently, hospita health systems must compete to attract new consumers and drive revenue through the delivery of health care services. Health systems must grapple with new regulations, legal issues around absorbing or forming practice groups, and maintaining and updating technology and facility infrastructure, among other issues.

Hospital administrative costs appear to be driven by the complexity of the reimbursement system and the mode of capital funding. In the United States, the main source of capital funds stems from surpluses of day-to-day operations, creating incentives to create profit opportunities facilitated by increasingly complex billing systems (29). Hospitals in France and Germany, which have diagnostic-related grouping billing similar to those in the United States, receive a substantial share of capital from the government and have relatively low per-patient administrative costs (29).

The American Hospital Association has identified 6 major federal capital financing programs that support hospitals (182) and additional, smaller opportunities may be available. The major programs are spread across federal agencies, including the U.S. departments of Agriculture, Commerce, Housing and Urban Development, and Treasury and the U.S. Small Business Administration, with primary goals of economic development and job creation or retention in rural or underserved communities. Because most capital financing programs that assist hospitals limit those eligible to primarily rural or underserved communities, there is little research on how federal investment in larger health systems in more populous areas might impact administrative costs by relieving the pressure to produce revenue for capital expansion projects or modernization. Additional research could be conducted to determine whether additional capital financing grants for U.S. hospitals could result in cost savings in the current health care financing environment.

Overtreatment, Low-Value Care, and Preventable Diseases

10. The American College of Physicians supports greater efforts to reduce low-value care and reduce costs associated with preventable disease.

Overutilization of low-value care contributes to the high cost of U.S. health car estimated that $760 to $935 billion is wasted annually in the health care system, with overutilization or low-value care accounting for $75.7 to $101.2 billion annually (183). Although the United States is not alone in overutilization, particularly overuse of

antibiotics, it leads in overutilization of many services, including imaging services, repeated colonoscopy or chest computed tomography, and diagnostic allergy testing (184). In 2012, the ACP was one of the first 9 specialty partners in the American Board of Internal Medicine's Choosing Wisely campaign to promote high-value care, an effort that has generally been considered a success. However, additional efforts are needed to reduce the overuse of low-value services that are frequently performed and may represent a large share of revenue (185).

Medical liability, fee-for-service reimbursement, and other financial incentives are often cited as reasons for overutilization. However, local practice patterns can also affect the care patients receive (186, 187). Medical liability reform is often cited as necessary to address high health care costs in the United States. A National Bureau of Economic Research working paper examining the military health care system, in which physicians have medical liability immunity, showed that active-duty patients receiving care on a military base were treated less intensively than elsewhere, without adverse health consequences (188). The researchers concluded that providing medical liability immunity could reduce inpatient spending by 5%. The ACP has proposed medical liability reform with a focus on patient safety and reducing errors and including caps on noneconomic damages, piloting communication and resolution programs, and safe harbor protections for physicians who provide care consistent with evidence-based guidelines (189).

One quarter of Medicare dollars are spent during the last year of a beneficiary's life (190). Although there is a need to address these costs, the focus should be on providing high-value, patient-centered care at the end of life and recognizing the potential value palliative care when appropriate (191). Specialist palliative care "[focuses] on symptom management, quality of life, and delineating goals of c patients with serious illness, whether the goal is cure, prolonging life, or maxir function and quality of life" (190). Palliative care has been shown to reduce costs, particularly in the hospital setting, and increase patient and physician satisfaction (192). A study of early palliative care interventions in patients with metastatic non–

small cell lung cancer found both improved quality of life and survival with early palliative care compared with standard care (193).

According to the Centers for Disease Control and Prevention, 90% of U.S. health care costs are associated with people with chronic medical or mental health conditions (194). Chronic conditions, such as cardiovascular disease, diabetes, and obesity, among others, are the leading cause of death and disability in the United States and accounted for $1.1 trillion in direct health care costs and $2.6 trillion in indirect costs (that is, lost economic productivity) in 2016 (195). Addressing risk factors (196) that contribute to these chronic conditions is important to reducing health care costs and improving population health. It is estimated that by 2030, a total of 83 million individuals in the United States will have 3 or more chronic conditions, up from 30.8 million in 2015 (197). Increased investment in public health interventions that target chronic health conditions leads to lower costs and high returns on investment. For example, for every $1 spent on tobacco cessation programs the average return is $1.26 and the economic impact of reducing youth smoking by the Truth campaign is estimated to have saved the United States $6.80 for every $1 invested (198). However, public funding for public health represents a relatively small share of health spending and continues to be underfunded (199). Additional investment is needed at the federal, state, and local levels to keep pace with Americans' health care needs.

Global Budgets and All-Payer Rate Setting

11. The American College of Physicians supports greater adoption of innovative all-payer models, a global budgeting model, or health care growth benchmarks, informed by the experiences of states that have implemented such approaches.

The use of rate setting or oversight of payments from public and private payer[s] new concept in the United States. Prospective hospital rate setting was once a[n] policy option, with as many as 30 states implementing programs by 1980. However, deregulation—attributable to the rise of managed care and political, economic, or institutional factors—reduced the number of states participating in these types of

programs to 2 by 1997 (200). However, policymakers are again considering whether all-payer models and global budgets can limit unsustainable spending growth.

Currently, although virtually all patients are charged the same list price, actual payments vary widely on the basis of negotiated discounts. For example, a hospital may receive reimbursements from more than a dozen different health insurers and health plans, each with its own payment schedule. In addition, Medicare and Medicaid have their own rules for paying hospitals. All-payer systems use the same payment rates for all patients who receive the service or treatment from the same clinician or hospital. Rate setting is used to determine per-service or per-case rates, and the reimbursement a clinician or hospital receives for a given service is the same regardless of who pays. Different payers do not pay different rates for the same service.

Maryland and Vermont All-Payer Models. Maryland currently operates the only all-payer hospital rate regulation system in the United States. Maryland hospitals operate on a waiver from the Centers for Medicare & Medicaid Services that allows the state to set rates that all third parties pay for inpatient and outpatient services. The system stemmed from a legislative edict around 4 principles: efficiency, access for all, equity among payers, and solvency for all efficient and effective hospitals (201). The model is on track to meet targets for both patient safety and savings and has successfully saved Medicare $586 million in hospital payments and $461 million in total health care costs between 2014 and 2016 (202). The model reduces these expenditures without shifting costs to other parts of the health care system outside of the global budgets; however, there was no statistically significant impact on total expenditures or total hospital expenditures among the commercially insured (202).

Maryland's all-payer system also includes a global budget. Global budgeting is "the process by which society chooses, directs, and enforces how much to spend on health care, what to spend it on, and where that spending will take place" and is mostly utilized in the hospital setting (203). Global budgets give hospitals clear incentives to manage provision of care within a defined budget. One of the clearest incentives is to reduce the number of admissions that the global budget must cover, an important

approach to reducing hospitals' variable costs. Global budgets imply that all payers participate and thus is simpler to operationalize in a single-payer or all-payer environment. Global budgets may have either a “hard” or “soft” cap. In systems with a hard global budget, the hospital's payment is limited to the prospectively set global budget amount and clinicians are not reimbursed for all expenditures over the benchmark, creating an incentive to reduce unit costs (204). With a soft global budget, expenditures above the target benchmark may be partially reimbursed. Consensus among policy analysts is that hard global budgets are more effective than soft global budgets in reducing costs, because they rigorously enforce limits on spending and provide spending predictability for payers and health care policymakers. However, once a soft cap is reached, high physician penalties, such as a reduction in fees, may have a similar effect as a hard cap (205).

Evidence from the Maryland all-payer model suggests that acute care hospitals in the state transitioned to global budgets more quickly than projected. However, areas that may also produce cost saving outside of the hospital's control, such as aligning hospital and physician incentives, reducing patient demand, and improving population health, have been slower to take hold (206). Since the model's implementation, the state has identified promoting innovation, technology, and education as part of the program's progress plan and underscored the important role that academic health systems play in fostering the quality of patient care and patient outcomes (207). However, stakeholders need to develop additional policies to ensure that incentives are suitably aligned to balance costs and innovation, and that accountability is not inappropriately shifted to health systems.

In addition to the Maryland all-payer model, the Vermont All-Payer Accountable Care Organization (ACO) Model established state and ACO-level accountability for h outcomes for the state's population, aiming to incentivize the collaboration be the care delivery and public health systems. The Vermont All-Payer ACO Model is distinct from the state's prior consideration and eventual rejection of a single-payer financing system. There has been some early success with the Vermont All-Payer ACO

Model. High-risk Medicaid beneficiaries in the program are using primary care, behavioral health, and pharmacy benefits at higher rates than other beneficiaries, and the percentage of beneficiaries with early to late-stage disease who did not have a primary care visit fell from 4% to 2%. Emergency department visits and hospitalizations also dropped during the first 9 months (208).

Massachusetts Health Care Growth Benchmark. In 2012, Massachusetts enacted a new law establishing a health care cost growth benchmark, a statewide target for the rate of growth of total health care expenditures (THCEs). The THCE includes all medical expenses paid to "providers" by public and private payers, all patient cost-sharing amounts, and the net cost of private insurance. The THCE is calculated on a per capita basis to account for population growth and includes both public and private payers to reduce the likelihood of cost shifting. The law also established the Health Policy Commission (HPC) responsible for regulating costs and setting annual limits on health care cost growth for providers and payers. The HPC does not set rates, instead relying on transparency to steer the market. The HPC monitors the health care market and develops policy to support a sustainable health care system. Since 2016, the HPC has had the authority to require health care entities, including physicians, hospitals, physician groups, and insurance carriers, with excessive cost growth that threatens the cost growth benchmark to implement performance improvement plans and submit to ongoing monitoring (209).

In 2014, statewide health care spending increased by 2.3%, which was 1.3% below the 2013 benchmark. In the second year, statewide health care expenditures increased 1.2% over the benchmark. The HPC found that over one half of this growth was due to prescription drug spending and higher Medicaid enrollment from the ACA's eligibility expansion. As a result, no health care entities have been required to implemer performance improvement plans (210).

The ACP believes that all-payer models, global budgets, or health care cost benchmarks play a role in reducing health care cost expenditures. However, implementing these types of policies alone cannot address unsustainable cost trends.

For these models to be successful, stakeholders, including physicians, policymakers, patients, and the public, must be supportive of the effort and work to assess, identify, and align the needs of all parties, and include appropriate funding levels and merits for success.

12. The American College of Physicians recommends ongoing study of implemented health system budget reforms that measure the potential effects of the policy changes and identify and mitigate unintended consequences.

The ACP believes that when developing or implementing strategies to reduce health care costs and promote high-value care, efforts should aim to mitigate potential negative downstream effects. Policymakers should be committed to continuously refining strategies implemented to reflect consumers' needs and the health system landscape.

Hospitals and physicians look to consolidate in order to increase market share or expand capabilities. One study showed that hospital consolidation improved integration and reduced duplicative practices and costs, leading to operating cost reductions of 15% to 30% (211). Other literature has shown that the merging of 2 hospitals results in substantial price increases, especially in concentrated markets (212). Since 2010, health care markets have become more concentrated, physicians have joined larger physician groups and organizations, and more physicians are employed by hospitals (213). Although consolidation in the health care market is not inherently negative, too much market concentration as the result of consolidation may result in increased costs. The same study that found cost reductions resulting from hospital consolidation also found that these lower operating costs did not translate to lower prices paid by patients. In fact, it found that hospital consolidation led to price increases of 6% to 18%. If implementation of a global budget or all-payer syste being attempted, special attention should be paid to whether the program is structured in such a way that it could result in consolidation of hospitals or health systems and that creates market concentration negatively affecting patient costs and

access, particularly in rural communities. Such effects were seen in Taiwan after the introduction of global budgets (214).

There are many policies that do not prohibit consolidation but would add additional layers of transparency and regulation to mergers needed to evaluate and modify policies as needed. These include requiring data transparency, cost containment, and leveling of prices that align with other ACP recommendations on reducing the cost of care. For example, private and public insurers should make detailed claims data readily available to public agencies and private researchers, enabling researchers and government officials to assess how the latest types of consolidations affect both costs and quality (215). In addition, regulatory agencies that are tasked with enforcing antitrust law could focus explicitly on this trade-off when they examine health care and health insurance markets (216).

Special attention should be paid to underserved or disadvantaged communities and populations, such as those in rural areas, health professional shortage areas, or communities with a high prevalence of negative health outcomes associated with social determinants of health. Access to care is a social determinant, because areas negatively affected by social determinants can lack health care facilities or physicians. Hospitals and physicians are moving away from urban areas and areas with low-income populations into more affluent areas, affecting the ability of patients in these areas to access care. The number of hospitals in 52 major U.S. cities dropped by nearly one half, and more than one half of federally designated primary care shortage areas in those major metropolitan areas have high poverty rates (217). Underlying social and economic conditions are primary drivers of social determinants of health, and ensuring that all-payer models, global budgeting models, or other approaches consider the needs of the community at large will be critical to the success of programs and population health.

Reference Pricing

13. The American College of Physicians supports the adoption of well-designed reference pricing programs for certain elective health care goods and services based on timely, accurate, and accessible local market pricing data supported by all-payer claims databases (APCDs).

The price of health care goods and services in the United States is highly variable. Reference pricing, a cost-containment tool where a payer or employer sets a maximum amount that it will contribute to a good or service and the enrollee pays the remainder, has been used by a number of European Union countries and tested in the United States. Reference pricing is most conducive to goods and services that consumers can shop for ahead of time, such as nonurgent prescription drugs, tests, and procedures. A reference pricing program for knee and hip replacement surgeries initiated by the California Public Employees' Retirement System led to $2.8 million in savings in 2011, with 84.6% of the savings resulting from hospitals lowering their prices (218). In 2013, a national association of 55 Catholic organizations that purchase health insurance for their employees implemented reference pricing for retail drugs. After implementing reference pricing, the average price paid by the association decreased by 14% and generated $1.3 million in employer savings (219).

Another study measured the association between implementation of reference pricing and patient choice of facility, test prices, out-of-pocket spending, and insurer spending on computed tomography and magnetic resonance imaging procedures and concluded that reference pricing was associated with price reductions and lower out-of-pocket costs (220). In addition, reference pricing appears not to be associated with an increase in complications or reduction in quality compared with non–reference-based benefits (221, 222).

Although reference pricing has the potential to reduce spending, there are co about and limitations to the policy, including political opposition to government price controls, the effect on patients with low socioeconomic status, and complexity (223, 224). In addition, physicians may not be willing to lower prices for services unless they

can count on gaining volume to compensate for lower prices, and low-cost physicians may raise their prices in response to reference pricing (225).

The ACP supports state-level legislation that would require public and private health plans to submit standardized data to APCDs and federal grants to support the development of APCDs (226) to gather price information and determine potential cost savings. An analysis using information from the Colorado All-Payer Claims Database found that better aligning prices paid by commercial insurers with those paid by Medicare could result in a $49 to $178 million reduction in annual spending by commercial health payers (227). The ACP strongly supports increased health care price transparency, the establishment of APCDs, and prohibitions on “gag clauses” or other contractual agreements that impede transparency (228).

14. The American College of Physicians supports the rational stewardship of health care resources through the incorporation of cost-effectiveness analyses (CEAs) into coverage or pricing determinations made by public and private purchasers, as well as the incorporation of value statements into clinical guidelines.

Cost-effectiveness analyses can promote efficiency by assessing the value of health care interventions. In 1996, the U.S. Public Health Service made a series of recommendations to standardize methods of cost analysis. This led to an increase in the number of published health care CEAs from 34 annually per year between 1990 and 1999 to more than 500 annually per year between 2010 and 2014 (229). However, application of CEAs across health care interventions is highly inconsistent. Forty-six percent of recent CEAs evaluated drugs, whereas only 22% evaluated surgical or medical procedures, possibly contributing to less efficient use of high-cost health care interventions, such as surgeries that are not cost-effective (229).

Recommendations advocate that CEAs report findings as quality-adjusted life (QALYs) to provide a common measure that incorporates both morbidity and mortality across disease areas (230, 231). There is a lack of consistency and understanding about the role of CEAs and QALYs and their overall impact on patients and the health system

that hinders their potential use in value-based decision making (232). As recently as 2016, the U.S. Second Panel on Cost Effectiveness in Health and Medicine recommended measuring health effects in QALYs as part of CEA and called for development of an "impact inventory," to better understand the health and nonhealth consequences of interventions (233). The United Kingdom has incorporated QALYs into their guidance in Britain since the 1990s. A series of economic crises, social crises, and softening of the political climate led to the operationalization of QALYs for health care decision making (234). Many who are opposed to QALYs worry that the United States would take a rigid approach like the United Kingdom's (235). In an effort to gain bipartisan support and counter claims that use of QALYs would negatively affect access to care, Congress explicitly prohibited the use of CEA in Medicare as part of the ACA, and policymakers remain reluctant to adopt CEA because of concern that it would be considered rationing of care (236).

However, considering the cost-effectiveness or value of health care interventions in clinical practice guidelines can promote cost-conscious, high-value, patient-centered care. Recent clinical guidelines by the American College of Cardiology (ACC) and the American Heart Association (AHA) on cardiovascular disease management include value statements about some high-cost treatment options, such as proprotein convertase subtilisin/kexin type 9 inhibitors, and found that the treatment price would need to be reduced to between $4250 and $6319 to make the drug cost effective to the health care system (237, 238). The ACC/AHA guidelines note whether there is known economic value to using the drug for certain patient populations or whether there is no known economic value compared with other therapies (239).

The ACP recommends that to distribute health care resources effectively, sufficient resources should be devoted to CEA in a transparent way; considers stakehold and reflects societal value, patient needs, and other criteria (108). The ACP rec concerns that including CEA in coverage decision making might lead to claims of rationing of care and socioeconomic biases. However, ACP believes that choosing among clinically effective alternatives based on evidence of value is not the same as

rationing (108). Current prohibitions on using CEA in determinations about price thresholds or coverage determinations should be eliminated to allow for additional flexibility in coverage determinations in a way that protects patients and abides by nondiscrimination language. Cost-effectiveness analysis should be used along with other metrics, including budgetary and economic impact, comparative effectiveness, impact on non–health care–related factors, and patient access to needed therapies.

Conclusion

The United States is the the only wealthy industrialized country without universal health coverage. It spends more on health care than its peers, and spending is growing at an unsustainable rate, care is unaffordable for many Americans (including insured persons), and health outcomes lag behind those of countries with universal coverage. The ACP believes that achieving universal coverage and access is an ethical obligation. The positions recommended in this paper will help achieve ACP's vision of a better health care system, as described in "Envisioning a Better U.S. Health Care System for All: A Call to Action from the American College of Physicians" (1), including a system where everyone will have coverage for and access to the care they need, at a cost they and the country can afford.

Appendix: Prominent "Transformational" Proposals to Achieve Universal Coverage in the United States

Among questions to consider in evaluating these and other proposals:

Does this proposal achieve universal health coverage?

Will this proposal allow Americans to keep the coverage they already have or e
new insurance program? Is this coverage portable, or is it tied to an employer,
residence, or other factor?

Is coverage more affordable than what is offered through Medicare or the typical large employer-sponsored insurance plan? Will low-income individuals be able to afford coverage?

Does this proposal make enrollment compulsory or voluntary?

Is coverage more or less generous than what is widely available now? Is an essential benefit package provided?

How are physicians and other health care providers affected? Would they be required to participate in the new proposal? How are they reimbursed?

How are private insurers treated under this proposal? How are Medicare, Medicaid, and the Veterans Administration system affected? Will enrollees have access to any participating physician, or will provider networks be used?

How are costs controlled? Through global budgets, price controls, cost sharing, comparative effectiveness programs, etc.? Is eligibility limited to United States citizens and/or legal residents? Are undocumented immigrants allowed to enroll?

The Appendix Table summarizes the proposals discussed below.

Appendix Table. Prominent "Transformational" Proposals to Achieve Universal Coverage in the United States

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Model	Achieves Universal Coverage for Legal Residents?	Includes Insurance Regulations to Ensure Access and Affordability? Is Coverage Portable?	Essential Health Benefit Package Required?	Encourage Enrollment Through Individual Mandate, Autoenrollment, or Other Means?	Is Coverage Affordable? Are Tax Credits, Deductions, or Government Price Controls Available?	Is Provider Reimbursement Fair to Reduce Barriers of Care and Enhance Physician Participation?
Medicare for All Act (Sanders): single-payer	Yes; undocumented immigrant coverage optional	Supplemental insurance regulations are unclear	Yes; benefit package based on ACA with additional benefits (e.g., vision) and no deductibles and copayments	Yes; eligible individual would be enrolled over time Automatic enrollment of individual at birth or getting citizen status	Sanders claims a middle-class family would pay $466 a year Plan would eliminate cost sharing The Urban Institute estimates premiums would drop and federal spending would rise considerably compared with now	Probably not; provider reimbursement would probably be based on Medicare fee schedule, so depending on the current payer mix, a physician could see higher or lower pay
Center for American Progress Medicare Extra for All: public choice option	Yes, by 10 years after enactment; legal residents may enroll in Medicare Extra	Yes; employer plans must meet actuarial value requirements Small group plans subject to ACA rules. Complementary insurance subject to guaranteed issue, premium rating restrictions (cannot vary on the basis of age and health status), preexisting coverage requirements, or other factors	Yes; Medicare Extra package, an expanded version of ACA essential health benefits; Medicare Extra would include long-term care services and supports	Yes; uninsured people would be automatically enrolled into Medicare Extra	Yes; Medicare Extra premiums would be income adjusted Premiums would be capped at 10% of annual income for highest earners	Probably not; Medicare Extra references Medicare reimbursement rates; Medicare Extra rates reflect average of rates under Medicare, Medicaid, and commercial insurance minus a percentage Center for American Progress literature says physician rates would be 100% of Medicare; primary care would get a boost to help close primary care–specialist pay gap Medicare-based rates would be extended to employer-sponsored plans as well.
Health Care Choices proposal: other	No	No; ACA age rating, medical loss ratio, single risk pool, premium variation rules repealed	No; essential health benefits are repealed	No; individual mandate repealed	Probably not; block grants focused on low-income population and sick could be transferred to high-risk pool	Possibly; rates could increase if Medicaid enrollees switched to commercial coverage Uncompensated care could rise with uninsured rate
Universal catastrophic coverage for all: single payer	Yes, but only for services that exceed the catastrophic limit on out-of-pocket expenses	No; the Hagopian and Goldman model claims the proposal would "obviate the need" for nearly all state and federal insurance regulations	No, but preventive and some high-value services would be exempt from deductible	Unclear; individual mandate repealed, but Hagopian-Goldman plan says that all legal residents who are ineligible for Medicare/Medicaid would receive catastrophic insurance plan, which would be automatically renewed	Yes; catastrophic subsidy would protect against medical bankruptcy, but high deductibles could discourage receipt of necessary care and could present financial barrier to care for many people	Unclear; however, uncompensated care could increase if patients forgo services because of deductible
Foundation for Research on Equal Opportunity universal tax credit plan: other	No; the plan would achieve "near universal coverage"	Some; guaranteed issue, prohibitions of health status rating, dollar benefit caps would remain in place Age rating 6:1 Plan would leave regulation to states	Some; essential health benefits would be curtailed (not clear how), but states could offer more benefits at their expense	No; individual mandate repealed, but states could autoenroll people into a default plan as long as they can opt out	Yes, but less generous than ACA	Possibly; if Medicaid population moves to commercial plan, reimbursement would increase; on the other hand, hospitals in concentrated markets would see compensation decrease
Healthy America Program: other	No; the plan would "move country close to universal coverage"	Yes, for group and nongroup private insurers	Yes; the ACA essential health benefit package is required for the Healthy America Program	Yes, in the form of a loss of tax benefit Autoenrollment for Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families recipients	Yes, based on ACA premium tax credits and cost sharing reductions but more generous and expanded to additional groups	Probably not; provider rates for the Health America Program would be capped at Medicare rates, although lower commercial rates may be offset by higher rates for the Healthy America Program Medicaid population
Medicare Part E: public choice option	Yes, for legal residents	Unclear, but probably would follow Medicare rules	Yes; a Medicare benefit package would be provided, presumably with additional benefits to cover new groups	All eligible persons are enrolled unless in employer-sponsored insurance or Medicaid	Income-related premiums and cost-sharing reductions; would probably be more affordable than marketplace-based insurance and most employer-sponsored insurance	Probably not; would use Medicare fee-schedule rates and provide higher rates for Medicaid

ACA = Patient Protection and Affordable Care Act.

Prominent Single-Payer Proposals

Note: The following proposals are examples of how a single-payer model could be structured. Inclusion in this section does not mean that ACP endorses or does not endorse the proposal.

S. 1804, Medicare for All Act of 2017 (Sen. Bernie Sanders, I-VT): This paper considers the Medicare for All legislation sponsored by Sen. Bernie Sanders. A 2019 version (and a similar House version sponsored by Rep. Pramila Jayapal) is similar but includes important changes, such as a long-term service and supports benefit.

Hagopian and Goldman; Ed Dolan, Niskanen Center; others—universal catastrophic health coverage (UCC): This proposal would provide private-insu catastrophic coverage. This paper primarily considers a UCC program by Hago and Goldman (240). Another version was developed by Milton Friedman (241).

New York Health Act (NYHA): The NYHA is a proposal being considered in the New York state legislature, which would create a single-payer health plan called "New York Health" (NYH). The following information is from a RAND Corporation research report

on the proposal authored by Liu and colleagues (128). This plan illustrates how a state-based, single-payer proposal could function.

Physicians for a National Health Plan: Physicians' Proposal for Single-Payer Health Care Reform (Gaffney, Woolhandler, and colleagues): The Physicians for a National Health Plan (PNHP) proposal would replace the current multipayer system with a single-payer, government-administered national health program (NHP) (242). The NHP would be similar to traditional Medicare, but without such components as private insurers, cost sharing, and restrictions on long-term care coverage. Physicians and other health care professionals would largely remain privately employed, although hospitals and other facilities would be nonprofit and subject to global budgets.

Eligibility

Sen. Sanders' bill: This would establish a universal Medicare program (UMP) to provide health care benefits to residents of the United States. Eligibility could be extended to nonresidents, including undocumented immigrants, although efforts would have to be taken to inhibit travel and immigration to the United States for the sole purpose of getting health insurance.

UCC proposal: Hagopian and Goldman's proposal (240) would be extended to all legal residents not enrolled in Medicare or Medicaid.

NYHA proposal: All residents of New York would be enrolled in NYH, including undocumented immigrants and persons older than 65 years, pending federal waivers.

Physicians for a National Health Plan NHP proposal: The NHP would cover “every American,” so it is unclear whether undocumented immigrants would be eligible.

Role of Public and Private Insurers

Sen. Sanders' bill: After a transitional period, the UMP would largely replace the current system of private and publicly financed insurance programs (243, 244). The Department of Veterans Affairs and Indian Health Service programs would remain. Medicaid coverage for certain long-term care benefits would continue. Private health insurance, employer-sponsored insurance, and retiree insurance would be prohibited except for supplemental insurance to cover benefits not provided under UMP.

UCC proposal: Private insurers would provide UCC coverage. One version wou “render Medicaid unnecessary” by setting the UCC deductible to zero. Hagopian and Goldman's proposal (240) would be offered to any American not covered by public insurance; each eligible person would receive a high-deductible plan provided by a private insurer contracted by the federal government.

NYHA: Commercial health insurance would largely be replaced by NYH, although nonprofit entities may be contracted to provide coordination services. The proposal would not bar employers from offering health coverage, but since all employers would be subject to a payroll tax to help fund the NYH, Liu and colleagues (128) assume that employers will not sponsor coverage for their employees. The Veterans Health Administration may continue to serve New York veterans.

Physicians for a National Health Plan NHP proposal: Private insurance that overlaps with NHP coverage would be prohibited.

Benefits and Cost Sharing

Sen. Sanders' bill: Services will be covered "if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition." The benefit package is similar to the Affordable Care Act's essential health benefit package required of nongroup and small group plans, but also includes oral health, audiology, and vision services for adults. Benefits will be provided without cost sharing, including deductibles, coinsurance, and copayments. At the Department of Health and Human Services' (HHS) discretion, a cost-sharing schedule may be applied to certain prescription drugs and biologics. A new Medicaid long-term care program may also have cost sharing. The HHS would be authorized to negotiate prices for prescription drugs, medical devices, and medically necessary assistive equipment, and a prescription drug formulary that emphasizes generics would be established.

UCC proposal: This would protect enrollees from major medical expenses with a high-deductible insurance plan that covers most of medical costs after the deductible is met. Medical expenses for low-income people would be fully paid for. Under Hagopian and Goldman's policy (240), the deductible is income-based and pegged at 10% of a family's surplus income. A 5% coinsurance charge is applied until the out-of-pocket cap set at 10 times the deductible is reached. Employers or supplemental insurance could pay for the care subject to the deductible. Certain preventive care and "exceptionally high-value treatments" would be exempt from the deductible.

NYHA: The benefit package would include services covered by Medicare, Medicaid, and the ACA Essential Health Benefit Package. It is also assumed that dental and vision services would be covered and cosmetic surgery, infertility treatments, a adult orthodontics would not. Long-term care services are not offered initially, commission would be formed to create a plan to provide such benefits. Health plans could not offer benefits that overlap with NYH's coverage, but physicians would be permitted to directly contract with patients. Prescription drug coverage would be based on the Medicaid Preferred Drug Program, although "other existing programs could be applied." Other elements include exclusion of brand-name drugs when an

equivalent generic is available and use of preferred brand-name drugs when they are more affordable than generic equivalent.

Physicians for a National Health Plan NHP proposal: Cost sharing would be prohibited. All medically necessary services would be covered, "including mental health, rehabilitation and dental care." The benefit package and formulary would be determined by panels of experts and patient advocates. Services deemed ineffective would not be covered. Long-term care services for the disabled would be covered. Local public agencies with consultation from physicians, social workers, and other health care professionals would evaluate eligibility and coordinate care for long-term care services.

Provider Role and Payment

Sen. Sanders' bill: Physicians and other health care professionals can only be prohibited from participating if they are unable to provide covered services. Providers may enter into private contracts with beneficiaries as long as no claims for the services provided will be submitted to the UMP. Balance billing is prohibited for services provided under the UMP benefit package. The HHS would establish a fee schedule for UMP benefit reimbursement in a way that is consistent with processes for determining payments for items and services under Medicare. Medicare payment reform activities or demonstrations planned or implemented as of the date of enactment (including the Medicare Access and CHIP Reauthorization Act and Affordable Care Act) shall apply to benefits under the Act. The bill would also mandate more regular reviews of the relative value of physicians' services, direct HHS to consult with MedPAC, and other processes to ensure accurate valuation of services.

UCC: In Hagopian and Goldman's proposal (240), an online database with price and quality ratings for all health care providers and goods and services would be developed.

NYHA: At first, payment rates would be based on fee-for-service model and be set by the NYH Board of Trustees on the basis of collective negotiations with provider representatives. Per-enrollee care coordination payments would also be available. Rates must be "reasonable and reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the care service." The NYHA may move to a non–fee-for-service system in the futu the proposal is vague on details.

Physicians for a National Health Plan NHP proposal: Physicians and other outpatient health care professionals would be paid by using a fee schedule based on rates negotiated by the NHP and representatives of health professionals. The fee schedule

would make adjustments “to attenuate discrepancies between cognitive and procedural care.” Those working in hospitals, clinics and other facilities, health maintenance organizations, and integrated health systems would be salaried. Hospitals would be funded by a global budget and for-profit hospitals would be converted to nonprofit structures with a refund to compensate for investments. Capital investments would be funded by appropriations and regional health planning boards would allocate funds.

Financing

Sen. Sanders' bill: Funding designated for Medicare, Medicaid, Federal Employee Health Benefits Program, and some other federal health programs would be shifted to the new UMP Trust Fund. Sen. Sanders has offered options for raising revenue to pay for the program, including an income-based premium paid by employers, 4% income based premium paid by households, raising the personal income tax (40% on income between $250 000 and $500 000 up to 52% on income above $10 million), taxes on financial institutions and offshore accounts, and other options.

UCC: Hagopian and Goldman (240) would establish a UCC benefit funded by a dedicated per capita tax. Low-income subsidies would be offset by changes in the health insurance tax exclusions.

NYHA: Existing state and federal spending for Medicaid, Medicare, and other health programs would be pooled to fund the NYH plan (assuming waivers are approved by federal government). Additional funding would be raised through state payroll and nonpayroll income taxes (on interest dividends, capital gains). Eighty percent of the payroll tax would be paid by employers and employees would furnish the remainder. These new taxes would be progressively graduated, so higher-income individuals would pay a larger proportion.

Physicians for a National Health Plan NHP proposal: Total expenditures would be capped at the “same proportion of [Gross Domestic Product] as the year prior to [NHP's] establishment.” The proposal lacks detail on how revenue for NHP would be raised but progressive taxes are mentioned as one option that would also reduce income inequality, which the PNHP says is a social determinant of poor health. All public funds currently spent on health care, including Medicare and Medicaid subsidies for employer-based insurance, would be directed to the NHP budge term care services would be funded through a global budget for a designated area and provided by contracted caregivers and other professionals or through a capitated payment or global budget directed to integrated provider organizations.

Transition From Current to New System

Sen. Sanders' bill: The program would not be implemented immediately for adults, so the bill establishes transitional coverage options. These include a Medicare buy-in option with phased-in eligibility for those aged 35 to 55 years; a transitional public option on the ACA health insurance marketplace, with enhanced cost-sharing subsidies; and more generous benefits for traditional Medicare, such as zero deductibles for parts A and B.

Prominent Proposals for Public Choice or Medicare Choice

Note: The following proposals are examples of how a public choice model could be structured. ACP has not formally endorsed any of the following proposals.

Medicare Part E (for Everyone): This proposal was developed by Jacob Hacker, Yale University professor and director of the Institution for Social and Policy Studies (245).

Medicare Extra for All: This proposal was developed by the Center for American Progress, which describes itself as an independent nonpartisan policy institute (142).

Eligibility

Medicare Part E: All legal nonelderly U.S. residents are automatically enrolled in Medicare Part E unless they have comprehensive employer-sponsored coverage or Medicaid. Undocumented immigrants would not be eligible for Part E coverage. According to an analysis from the Century Foundation, 212 million Americans would be eligible for Medicare Part E (246).

Medicare Extra for All: Medicare Extra is structured to provide universal coverage for all lawfully residing Americans over a period of 8 years from enactment.

Role of Public and Private Insurers

Medicare Part E: Employers would have the option of either offering private insurance (with benefits that are at least as generous as those under Medicare Part E) or pay for a portion of their employees' (and their families') Part E coverage. In the latter scenario, employees would be automatically enrolled in Part E. Independent contractors and the self-employed would also be enrolled in the new program. Medicare Advantage plans would be required to offer coverage to the Part E population.

Medicare Extra for All: Those covered by existing public or private insurance w become eligible to enroll in Medicare Extra. Newborns and those turning 65 years of age would be automatically enrolled in Medicare Extra. Those without any sort of coverage would be automatically enrolled at the point of care. Medicaid and CHIP are integrated into Medicare Extra. Employers would be able to continue offering coverage to their employees, but would have to meet a minimum benefit standards

comparable to the Medicare Extra benefit package. Employers could also contribute to the cost of Medicare Extra for their employees. Small employers are exempt. Medicare Advantage would be renamed “Medicare Choice” and be required to meet new standards.

Benefits and Cost Sharing

Medicare Part E: This would combine Parts A (hospital benefits), B (physician, outpatient, etc.), and D (prescription drugs) into a single package. The component and its risk pool would be separate from the existing Medicare program that mainly covers elderly persons. Premiums would be income adjusted, with lower-income individuals paying “a limited amount.” Hacker (245) estimates that the most a higher-income enrollee would pay is around $300 a month for family coverage. Hacker's article mentions that Medicare Part E would cover Medicare's hospital, physician, and prescription drug package, but a report from the Urban Institute (247) mentions that the proposal would cover the ACA essential health benefit package. Whether the Medicare Part E benefit package would be altered to include services from the ACA essential benefit package but omitted from Medicare is unclear. Out-of-pocket costs for current Medicare beneficiaries would be capped.

Medicare Extra for All: Medicare Extra guarantees a benefit package that covers the 10 essential health benefit categories, plus additional services including dental, vision, and hearing services and early and periodic screening and treatment services for children. Long-term services and supports are covered for elderly and people with disabilities. Provides universal coverage of home and community-based services. Families with incomes below 150% of the federal poverty level (FPL) would have premiums of zero; those between 150% and 500% of the FPL would have premiums ranging between 0% and 10% of income; those with incomes over 500% of the FPL would have premiums capped at 10% of income. Deductibles, copayments, and out-of-pocket limits would be determined on the basis of income. Further, copayments would be lower for care received by providers of high-quality care.

Provider Role and Payment

Medicare Part E: Medicare Part E would use Medicare provider payment rates (Hacker [245] does not indicate whether Medicare-participating physicians and hospitals would be required to also participate in Part E). Medicaid payment would be increased to parity with Medicare (Hacker references the ACA here, which required temporary Medicare–Medicaid pay parity for certain evaluation and management codes. It is unclear whether this proposal would be limited to those services or include all Medicaid services).

Medicare Extra for All: Provider payment rates under Medicare Extra would reference current Medicare rates and would reflect an average of Medicare, Medicaid, and commercial rates, minus a percentage. These payments would be site-neutral. Primary care average rates would be increased by 20% compared with certain specialty care rates on a budget-neutral basis. Employer-sponsored plans would be prohibited from reimbursing out-of-network providers more than the Medicare Extra rates. Hospitals would be reimbursed for a bundle of services received within 90 days of discharge. Providers who participate in Medicare would also participate in Medicare Extra. Providers would need to report only one set of quality measures and credentials to the Center for Medicare Extra. Claims and payment would be transmitted electronically, utilizing electronic health records.

Financing

Medicare Part E: Savings would be garnered by allowing Part E to use Medicare reimbursement rates, which are substantially lower than those of private insurance plans. Hacker (245) predicts this would drive down private insurer rates as commercial plans face competitive pressure from the new program. Medicare would be allowed to negotiate on prescription drug prices. Revenue would be needed to subsidize Part E premiums and cost sharing and fund Medicaid pay parity. The Medicare tax would be increased to help offset the cost of better benefits for current Medicare beneficiaries. Hacker also mentions the possibility of an income tax surcharge on "extremely high-income households" to help pay for the program.

Medicare Extra for All: Drug, medical devices, and durable medical equipment prices would be negotiated; savings would be garnered from lower payment rates to physicians and other health care professionals. High-income earners would pay surtax on adjusted gross income, Medicare payroll and net investment income taxes would be increased, and capital gains tax would be assessed upon assets at death. The employer-sponsored insurance tax deduction would be capped and alcohol and tobacco excise taxes would be raised. In addition, states that did not expand Medicaid would pay maintenance-of-effort payments to the federal government.

Transition From Current to New System

Medicare Extra for All: First year of enactment: A public option for bare count be offered by the Center for Medicare Extra.

Year 2: The public option will be expanded to other counties.

Year 4: Medicare Extra will be launched, with newborns and those turning 65 years of age being autoenrolled; employer-based insurance and Medicare enrollees can transition to Medicare Extra;

Year 6: Medicaid and CHIP will transition to Medicare Extra.

Year 8: Large employers can sponsor Medicare Extra for employees.

Other Approaches

Health Policy Consensus Group/Heritage Foundation Health Care Choices Proposal (HCCP): This proposal is focused on helping individuals purchase private health insurance, rather than achieving universal coverage. It was offered after ACA repeal attempts in 2017 failed (248).

Foundation for Research on Equal Opportunity universal tax credit plan (UTCP): This proposal, developed by Avik Roy (249), would affect the ACA marketplaces, Medicaid expansion, the Veterans Health Administration, Medicare, and other areas of the U.S. health care system. The section below focuses on the ACA marketplace and Medicaid expansion aspects of the plan.

Urban Institute Healthy American Program (HAP): This proposal, developed by the Urban Institute (246), builds on the ACA. It shares elements with the public choice option model but would not achieve universal coverage, mainly because it does not include an individual mandate.

Eligibility

Health Policy Consensus Group/Heritage Foundation HCCP: ACA coverage programs would be repealed, and a state-based block grant would be established in their place. The state block grants would be used to “help the low-income and sick access the care they need.” The Medicaid population would have the option of using Medicaid dollars to purchase private insurance. States may provide incentives to insurers to give discounts to individuals who maintain continuous coverage; there would be no individual mandate.

Foundation for Research on Equal Opportunity UTCP: The UTCP seeks to “expand coverage well above ACA levels” while reducing the federal deficit and health care costs. It would repeal the ACA's individual mandate and employer mandate and give regulatory authority to states. States could automatically enroll residents in a d[illegible] insurance plan, providing the enrollee can opt-out. In addition, the proposal w[illegible] increase the eligibility age for Medicare. The acute care Medicaid population (t[illegible] not the long-term care population) would be transferred to the premium assistance program. Those receiving care through the Veterans Health Administration could opt to receive premium assistance to purchase private care instead.

Urban Institute HAP: This would affect all lawfully present people younger than 65 years. The authors concede that "most of the remaining uninsured would be undocumented immigrants" and the proposal "approaches" universal coverage. The Veterans Affairs health program, TRICARE, Indian Health Service, and Federal Employees Health Benefits Program would be maintained. The authors estimate that the number of people with coverage would grow by nearly 16 million.

Role of Public and Private Insurers

Health Policy Consensus Group/Heritage Foundation HCCP: The ACA's premium tax credits, cost-sharing reduction payments, and Medicaid expansion funding would be redirected to fund a block grant for each state. Initially, the block grant amount would be based on ACA spending, but after a certain period, the amount would be based on the number of low-income residents in the state. Block grant, Medicaid expansion, and CHIP populations would have the option to use premium assistance to buy private insurance. Subsidies could be used to buy direct primary care plans and health sharing ministry plans. The ACA medical loss ratio would be repealed.

Foundation for Research on Equal Opportunity UCTP: The role of private insurers would grow under the proposal because the Medicaid acute care population would be transitioned to private insurance plans that are federally financed with state-based oversight. Regulatory responsibility would be shifted to the states. States could set up an alternative means of distributing tax credits, such as an Internet-based insurance marketplace operated by a private company, instead of the ACA's marketplaces. Medical loss ratio rules are repealed.

Urban Institute HAP: This would replace the ACA marketplaces with a new program where the Medicaid acute care population, individual health insurance market enrollees, and CHIP enrollees would be combined in a "Medicare-style marketplace" with a single risk pool and a new government-administered public option. The employer-sponsored health insurance market and ACA individual insurance market regulations like guarantee issue would be maintained (250). Enrollees in this new market would choose from public plan coverage or private insurance. Nondiscrimination laws would be established to prevent employers from dropping coverage for sicker workers. The employer mandate would be eliminated. Low-income individuals would be autoenrolled into the Healthy America market, and those who remain uninsured would lose a portion of their standard tax deduction. Permanent reinsurance and risk adjustment mechanisms would prevent adverse selection in the HAP.

Benefits and Cost Sharing

Health Policy Consensus Group/Heritage Foundation HCCP: The proposal would repeal the ACA's essential health benefit requirement. Individual and small group benefits would be based on state benefit mandates. The 3-to-1 age rating band would be repealed. It is unclear whether preexisting condition protections (or premium rating rules, out-of-pocket limits, and more) would be repealed, although the proposal would "leverage sensible approaches to protect people with pre-existing conditions without making coverage so costly for the young and healthy" and describes a high-risk pool–like mechanism for covering patients with preexisting conditions. The block grant funding could not be used to fund abortions. Health savings account (HSA) contribution limits would be doubled and the types of HSA-compatible plans would be expanded to include any plan with an actuarial value of less than a certain number (for example, 70%).

Foundation for Research on Equal Opportunity UCTP: The proposal would create a means-tested refundable tax credit. People with incomes up to 317% of the FPL would be eligible for a means-tested tax credit. The income-based eligibility threshold would be adjusted annually in line with an inflation-based index. It would maintain the ACA's metal-tier system for rating insurance plan generosity (with amended actuarial values where bronze is 40%, silver is 55%, and so on), guaranteed issue requirements, and lifetime and annual dollar limit prohibitions. Premiums could not be adjusted on the basis of gender or health status, but age-based adjustments of 6-to-1 rather than the current 3-to-1 would be allowed. The plan would reduce the "overall prescriptiveness" of the essential health benefit package to ensure that they would not "limit the value" of high-deductible insurance with HSAs.

The benchmark plan on which tax credits would be based will have an average deductible of $7000 per individual per year and $14 000 per family. Those eligible for premium support would receive an HSA contribution of $1800 per year for an individual and $3600 for a family; people with incomes under 250% of the FPL would receive a larger HSA credit. Subsidies could be used to purchase care through a direct primary care arrangement.

Urban Institute HAP: This plan would bolster the premium tax credits and cost-sharing reduction payments to make coverage more affordable. Premium tax credits would be based on gold-level plans and comparable to average employer-bas
instead of the second-lowest cost silver plan as under the ACA. Premiums are
income, like under the ACA, and range from 0% (for Medicaid acute care popu
to 8.5% of annual income. The ACA's 400% FPL premium tax credit eligibility cap is eliminated. Cost-sharing subsidies are enhanced. A system for withholding and transferring HAP premium tax credits among employers and federal government would be created.

The HAP plans would cover the ACA's essential health benefit package, with additional benefits for low-income children, the current Medicaid-covered populations, and people with disabilities.

Provider Role and Reimbursement

Health Policy Consensus Group/Heritage Foundation HCCP: Not specified, although presumably reimbursement could change for some claims, such as if an individual currently enrolled in Medicaid uses the subsidy to purchase private insurance which typically pays physicians at a higher rate.

Foundation for Research on Equal Opportunity UTCP: The proposal estimates that average provider access for the nonelderly adult population will improve by 4% and increase by 98% for Medicaid acute-care enrollees who transfer to the universal tax credit/private insurance program. Hospitals in very concentrated markets would be paid Medicare rates for treating the privately insured and the uninsured. The proposal would increase graduate medical assistance funding by $6 billion a year starting in 2016, move graduate medical education funding from public insurance to congressional appropriation, broaden the number of foreign visa for U.S. licensed immigrant physicians. The proposal would eliminate restrictions on physician-owned hospital construction. It would also allow reference pricing so insurers could give a cash-out benefit to enrollees to travel to other (cheaper) areas for care. It would also encourage the Federal Trade Commission to investigate hospital mergers to prevent consolidation.

Urban Institute HAP: "Provider" reimbursement rates for nongroup plans would be tied to Medicare levels. According to the authors, rate caps would increase insurer participation and address health system monopoly power in certain areas.

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Comments

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Dr.William Pevsner • SMG • 23 January 2020

Seriously?

If anyone thinks a single payor is the fix all for healthcare, they are seriously delusional. Me pointing out how poorly and expensively Healthcare is run, that more government regula proper lack there of) which is mainly the reason it runs like an over bloated inefficient and disastrously expensive, does not solve any problems. It just guarantees everyone will get thrown into the same line at the DMV. Bragging about saving will be glorified while politicians can feel enthralled claiming "EVERYONE NOW HAS GUARANTEED HEALTHCARE while hiding actually real

outcomes in the bureaucracy. Only those who are going to at the top of these institutions and not in the trenches will get a voice and the rest of us in the trenches will suffer trying to make bricks without straw!

Melvyn Sterling • Solo • 13 October 2020

I have seen single payer and recommend that supporters experience it for themselves.

I was treated in a US Navy facility where, after a vaso vagal response associated with a dental procedure, I was informed that I was allergic to all local anesthetics. Four years later after multiple very painful dental procedures I was evaluated at Billings Hospital at the University of Chicago where it was demonstrated that I was not allergic to these drugs.

I have cared for patients visiting the US from Canada and the UK. After appropriate care here they returned to their home countries and died shortly thereafter due in one case to grossly inappropriate access to care for CAD and in the UK patient, who was over 70 years old and on dialysys, died after learning that dialysis was not available if past 70.

Be careful what you wish for!

Disclosures:

No conflicts, just want to keep living.
