Congressional Budget Office

Testimony

Key Design Components and Considerations for Establishing a Single-Payer Health Care System

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Chairman Yarmuth, Ranking Member Womack, and Members of the Committee, thank you for inviting me and my colleagues to testify about the Congressional Budget Office's recent work on single-payer health care systems.

Some Members of Congress have proposed establishing a single-payer health care system in the United States. Many more people would probably have health insurance as a result—but the government would take much more control over the health care system. The effects of such a system on its participants and total health care spending could vary greatly depending on the details of the system's structure and operation.

Earlier this month, CBO released a report on single-payer health care systems.[1] That report describes the primary features of single-payer health care systems and discusses some of the considerations for establishing such a system in the United States. It represents our first step in a broader effort to support you as you consider the issue and to build our capacity to estimate the costs of specific proposals.

I want to convey two main points this morning.

First, moving to a single-payer system would be a major undertaking. It would involve significant changes for all participants—individuals, providers, insurers, employers, and manufacturers of drugs and medical devices. Because health care spending currently accounts for about one-sixth of the nation's economic activity, those changes could significantly affect the overall U.S. economy. And the transition toward a single-payer system could be complicated, challenging, and potentially disruptive.

Second, to establish a single-payer system, lawmakers would need to make many decisions and would face complex trade-offs.

The first figure in our report, which you also have in front of you as a handout, identifies some of the major questions that would need to be answered (see Figure 1).

With the balance of my time, I will focus on three sets of issues that illustrate the complexities involved in designing a single-payer system.

Coverage

In a single-payer system that achieved universal coverage, everyone eligible would receive health insurance coverage with a specified set of benefits regardless of their health status. People who currently have private insurance would enroll in a public plan.

Under the current system, an average of 30 million people per month are projected to be uninsured in 2019. Most of those people are U.S. citizens and would be covered by a public plan under a single-payer system. Policymakers would have a lot of choices to make about how to extend coverage, particularly if each state administered a separate plan. One of those choices would be whether noncitizens who are not lawfully present would be eligible. An average of 11 million people per month are expected to be in that category in 2019, and about half of them have health insurance under the current system.

Costs

Under a single-payer system, the government (federal or state) would pay a larger share of all national health care costs. In 2017, private sources such as businesses and households contributed just under half of the $3.5 trillion of total national health care spending. Shifting such a large amount of expenditures from private to public sources would significantly increase government spending and require substantial additional government resources.

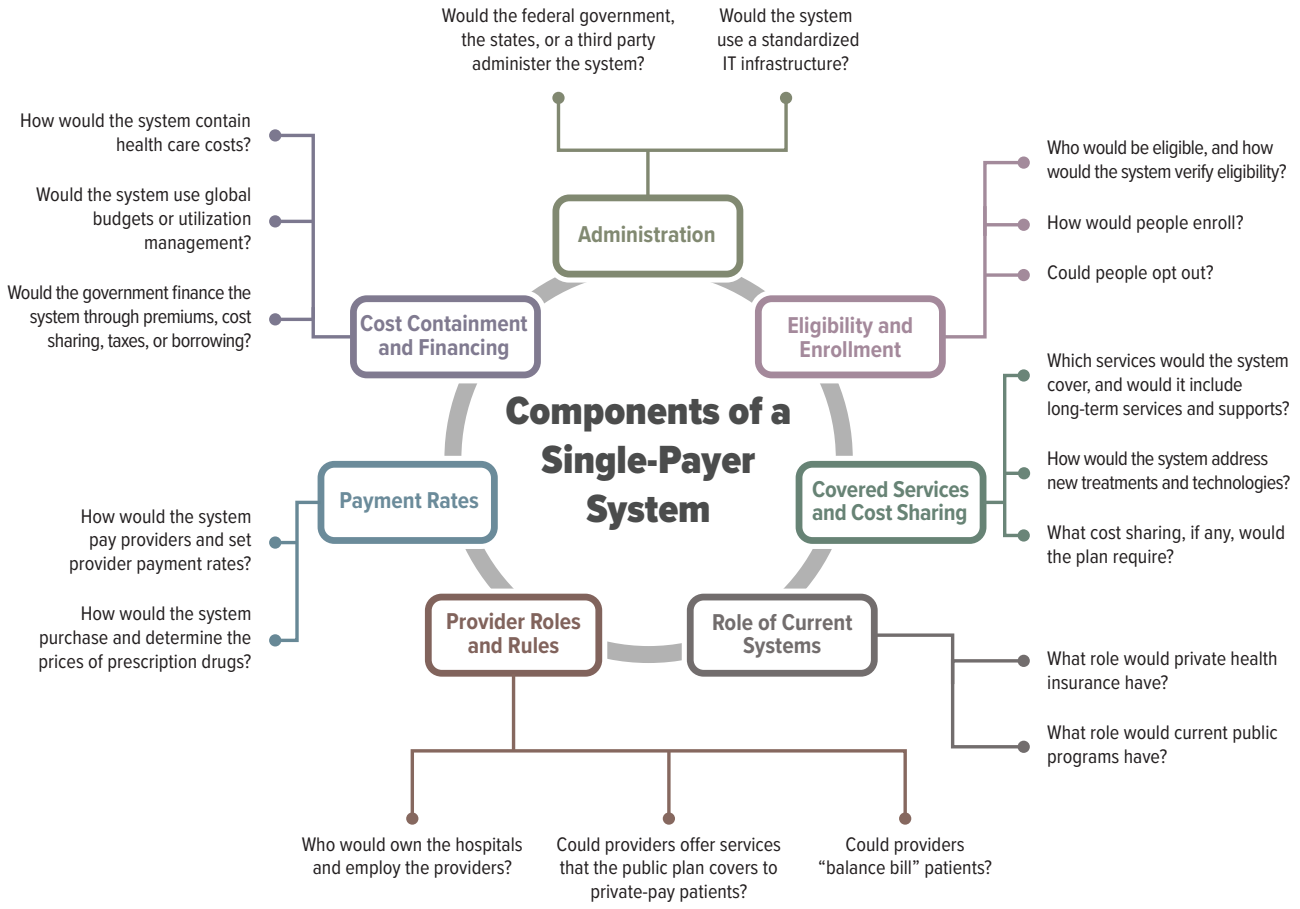
Total national health care spending under a single-payer system might be more or less than it is under the current system depending on the key features of the new system, including the services covered, patients' cost-sharing requirements, provider payment rates, and administrative costs:

- **Services Covered.** The benefit package could be designed to cover services that are typically covered by private insurance or by Medicare. Alternatively, it could be expanded to cover additional services, such as long-term services and supports. Expanding the benefit package to cover additional services would tend to increase health care spending. A single-payer

1. Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

Figure 1.

Designing a Single-Payer Health Care System



Source: Congressional Budget Office.

IT = information technology.

system would also need a way to decide which new treatments and technologies it would cover.

- **Cost-Sharing Requirements.** Cost sharing affects beneficiaries' financial well-being and total health care spending. People use more care when their cost is lower, so no cost sharing would tend to increase the use of services and lead to additional health care spending.

- **Payment Rates.** Under a single-payer system, provider payment rates could be based on the rates paid by Medicare, Medicaid, or commercial insurers—or they could be set at some other level. Medicare payment rates are substantially lower than commercial payment rates, on average. If provider payment rates were set at Medicare's rates rather than average commercial rates, then total national health care spending would be lower. But the amount of care supplied and the quality of that care might diminish.

- **Administrative Costs.** When fully implemented, a single-payer system would probably have lower administrative costs than the current system, because it would consolidate administrative tasks and eliminate insurers' profits. To give a sense of scale,

the federal government's cost of administering the Medicare program accounted for 1.4 percent of total Medicare expenditures in 2017. When the administrative costs of Medicare Advantage and Part D plans are included, total administrative costs for the Medicare program accounted for about 6 percent of its expenditures. By comparison, private insurers' administrative costs averaged about 12 percent in 2017. But other possible features of a single-payer system, including efforts to coordinate patient care and eliminate fraudulent spending, could add to administrative costs.

A single-payer system could affect costs to providers and individuals in other ways. It could reduce the amount of uncompensated care, for example. Moreover, unlike private insurers, which can experience substantial enrollee turnover, a single-payer system would have no turnover. For that reason, a single-payer system would have a greater incentive to invest in preventive measures that have been shown to reduce costs. Whether the system would act on that incentive is unknown.

Access to Health Care Services

An expansion of insurance coverage under a single-payer system would help more people receive more health care. People who are currently uninsured would receive coverage, and some people who already have coverage would use additional services if benefits were more generous than under their current coverage. Whether the supply of providers would be adequate to meet the greater demand would depend on various components of the system. If the supply of services was not sufficient to meet the demand for care, patients might face increased wait times and reduced access to care. The government, however, could implement policies to encourage the provision of services, and in the longer run, providers might deliver care more efficiently.

Under a single-payer system, people who are currently covered by private insurance might have more providers available to choose from. Participants would not have a choice of insurer or health benefits, however. The public plan would provide the same set of health care services to everyone eligible, so it might not address the needs of some people. For example, the public plan might not be as quick to cover new treatments and technologies as would a system with competing private insurers. Policymakers could try to design the single-payer system to mitigate such risks.

As I said at the start of my testimony, CBO has worked to build our capacity to support this committee and the Congress as you consider these issues, and we look forward to being helpful to you and your staff. My colleagues and I are happy to answer your questions. Thank you.

This testimony was prepared by Mark Hadley, Jared Maeda, and Xiaotong Niu. Helpful contributions were made by Jessica Banthin, Sarah Masi, and Lyle Nelson. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the testimony contains no recommendations.

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