# SINGLE PAYER

## A look at other Countries and those within the United States

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# SINGLE PAYER SYSTEMS ARE NOT ALL THE SAME!

- Some systems are federally mandated and care is paid for/provided by government
- Some are through insurance type arrangements
- Others use types of funds based on population or employment demographics
- Others use some combination of mechanisms but are primarily orchestrated locally or regionally

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# FRANCE

- Government requires that all insurers in program are in a single national exchange.
- Financed by payroll taxes paid by employer and employee and a national earmarked income tax as well as taxes on tobacco, alcohol, pharmaceuticals and voluntary health insurance companies.
- Coverage is mandatory

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# FRANCE

- Requires registration with a GP
- Government sets covered services and a pricing committee sets rates of coverage and prices.
- Cost-sharing is in the form of coinsurance, copayments, and balance billing.
- Many people have voluntary coverage to offset these costs.
- Senior citizens are covered by the same plan as those under 65
- Wait time for elective procedures: low.

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# CANADA

- Regionally administered public insurance program paid with tax revenue both provincial and federal.
- 67% buy voluntary coverage for NONCOVERED services. PHI often through employers for things that aren't covered like outpatient drugs.
- Coverage levels are determined by province.
- No cost-sharing for covered services, drugs covered primarily inpatient only.

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# CANADA

- Primary care physicians act as gatekeepers in most provinces.
- Non-referred visits to specialists are paid less – most outpatient specialist care is provided in hospitals.
- Provincial governments negotiate with and pay medical providers.
- Wait time for elective procedures: high.

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# ENGLAND

- Government has created the National Health Service.
- Some practices are owned by NHS and there are many private physicians as well.
- Many U.K. residents have supplemental coverage to allow them to access coverage more quickly or to receive treatment in private hospitals.

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# ENGLAND

- Most services are covered but some procedures considered elective may have a waiting period before they become available.
- There are some small copayments for prescription drugs and some patients are exempt from any copayment at all.
- Almost all specialists are salaried employees of NHS hospitals.

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# SWITZERLAND

- Mandatory health insurance system with private insurance exchanges that are regionally supervised by cantons
- Insurance companies negotiate with providers but cantons involved with some provider negotiations particularly hospitals
- Cost is paid through community rated insurance premiums supplemented by tax revenue

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# SWITZERLAND

- Mandated core benefit package including deductibles and coinsurance.
- Voluntary coverage is underwritten and individuals may be turned down for coverage.
- Wait times for elective procedures: low.

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# GERMANY

- Coverage is mandatory and is provided through competing nonprofit nongovernmental health insurance funds and also through private insurance
- States own most university hospitals and municipalities own about half of all hospital beds
- Fundamental - Regulation and price negotiation is delegated to self-governing associations within sickness funds and provider associations which together make up the Federal Joint Committee.

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# GERMANY

- All employed citizens below a certain income level are mandatorily covered by SHI and non-income earning dependents are covered free of charge.
- Individuals above income threshold can remain in SHI or purchase PHI. Most stay in SHI. Contribution rate is 14.6% of wages shared by employer and employee.
- Wait time for elective procedures: low.

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# NETHERLANDS

- Universally mandated private insurance through a national exchange
- Government regulates and subsidizes insurance
- Although insurers negotiate pricing with providers, there is some government involvement particularly in terms of hospitals.
- Financed with an earmarked payroll tax and community-rated insurance premiums as well as general tax revenue
- Cost equity is ensured with risk adjustment
- Private plans provide mandated benefits
- Referrals from a GP are required for hospital or specialist care.

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# NETHERLANDS

- Population is very risk averse – 84% of population also buys voluntary coverage for benefits not covered such as dental care, alternative medicine, physical therapy, vision care, contraceptives and copayments
- Premiums for voluntary coverage are not regulated and can be based on risk factors.
- People with voluntary coverage do not receive faster access to any type of care or have increased choice of specialists or hospitals.
- Balance billing is prohibited.
- Wait time for elective procedures: low.

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# UNITED STATES

- The United States already has some government run programs:
  - Medicare - federal
  - Medicaid – federal/state
  - Children's Health Insurance Program – federal/state
  - VA - federal
  - Tri-care - federal

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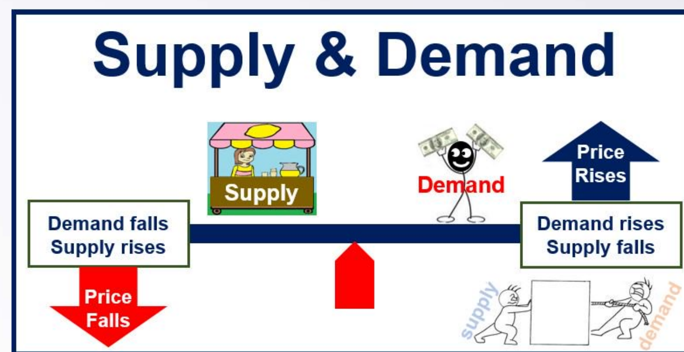
# UNITED STATES

- The balance of the market is heavily regulated by states and the federal government
- The idea of our private system is one based on free market principles which primarily work based on the economic principles of supply and demand as influenced by the pricing mechanism

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# UNITED STATES
*Politics*

- National Level:
  - Currently Republicans control the House, Senate, and White House.
  - This effectively precludes any single payer system from gaining enough traction to pass.
  - Yet, interest in single payer is growing. For the first time in history, the Single Payer bill by Bernie Sanders has 16 Senate Co-sponsors. It would enroll all U.S. residents in a single plan.
  - There are now multiple proposals that would create a new Public Plan option.
  - And the makeup of Congress may change with the mid-term elections in November.

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# UNITED STATES
## *Politics*

- Frustration with the current system opens the door for a broadening of our current public programs little by little.
- This could lead to incremental additions to our current government-run programs:
  - Buy-in to Medicare
  - Buy-in to Medicaid (Could be introduced at the state or federal level
  - A Public Option
- All of these programs would likely be permitted to use government-negotiated prices in competition with commercial products which were required to operate without this advantage

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# UNITED STATES

## *State Level Efforts*

- The biggest threat in terms of Single Payer efforts is at the state level, where politics can be more predictable.
- Already we have seen efforts in:
  - Colorado
  - California
  - New York
  - New Mexico

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# California Efforts

- AB2472 – Requires a feasibility study for a public option in California
- AB2517 – Establishes Advisory Panel on Health Care Delivery Systems and Universal Coverage with the goal of establishing a plan to achieve universal coverage and publicly financed health care.
- AB 3087 – Establishes a commission o set prices paid to providers using Medicare as the reference point.
- SB 562 – Would create a universal Canadian-style Single Payer system.

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# UNITED STATES

- The United States is different from other countries – ideas that may work in Europe may not work well in the United States.
- Reasons:
  - **Our history of no government involvement in provider pricing for private plans**
  - Our culture of employer-provided health plans
  - Our size – The Netherlands is 17.17 million people – the population of Illinois alone is 13.8 million people.

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