The New England Journal of Medicine

Volume 328:1489-1493 Number 20
May 20, 1993

The American Health Security Act -- A Single-Payer Proposal

Almost 30 years after the nation's last brush with comprehensive health care reform, the prospect of fundamental change once again seems almost palpable. As in1965, policy analysts, interest groups, and the public are debating the nature and extent of reform. This time, however, it is imperative that we adopt a solution that will successfully control costs, while improving access and quality.

The American Health Security Act of 1993 (S. 491), which one of us (Senator Wellstone) introduced into the Senate, proposes such a solution, through a publicly accountable single-payer system -- in our opinion, the best way to control costs. The system would provide coverage for a comprehensive range of health care services for all Americans; these services would be available from the providers of their choice, regardless of where they work or whether they work, and regardless of whether they have a "preexisting condition." It would eliminate micromanagement of clinical decisions by insurance companies and put decision making back in the hands of providers and consumers, where it belongs. Moreover, the system would be equitably financed.

The bill has five cosponsors in the Senate, where it has been referred to the Finance Committee. No action is expected on the bill before President Bill Clinton's health care proposal is submitted, probably this month. The bill is similar in most respects to a bill in the House (H.R. 1200), which has 70 cosponsors, led by Representatives Jim McDermott (D-Wash.) and John Conyers (D-Mich.).

The bill offers a timely blueprint to the White House health care task force. The plan it proposes combines the cost efficiencies of a single-payer system with the latitude to experiment with changes in the delivery of health care that will be needed by states, practitioners, and patients to make the system work.

The elements of the proposal are fairly simple: fixed annual budgets; free choice of providers, including consumer-oriented managed-care plans; streamlined and publicly accountable administration; universal coverage based on residency instead of employment; comprehensive benefits with an emphasis on primary and preventive care; quality controls based on outcomes data and designed with the involvement of providers and patients; equitable financing; and affordability.

Basic Operation of the System

A single public entity, the federal government, would be responsible for collecting and distributing to the states all funds needed to pay for covered health care services in the United States. The annual health care budget could increase only as much as the gross domestic product. Each state would receive allocations based on the size and geographic distribution of its population, and on any special health needs. To allow for flexibility, states would administer the program. The state budgets would be divided into operating and capital expenses, with the share consumed by administration capped at

3 percent. Measures to improve the quality of care, described below, would reduce unneeded services and encourage the provision of more cost-efficient primary and preventive services. The General Accounting Office has estimated that by eliminating administrative waste and shifting the system's priorities, such a program would be well able to extend care to uninsured and underserved groups without additional expense.

Administrative Simplicity

Woolhandler and Himmelstein1 have estimated that 25 cents of every health care dollar now goes toward administrative expenses, including those of the nation's 1500 insurance companies. Differences in criteria for eligibility, covered benefits, underwriting procedures, and marketing costs within the insurance industry are in turn responsible for many of the administrative costs of hospitals, doctors, and other providers seeking reimbursement.

Under the American Health Security Act, the federal government would collect the necessary funds -- a function it unquestionably performs effectively. A full-time seven-member national board, whose members would be appointed by the President for six-year terms, would oversee the program; the national board would be mirrored by a board in each state. There would also be federal and state advisory boards, as well as panels concerned with particular issues that need ongoing attention, such as standards of quality and benefits for mental health care and the treatment of substance abuse. All boards and panels would include both providers and consumers.

Each state would administer its own program, unless it requested that the federal government do so. The state would receive an annual budget and could in turn negotiate with providers and consult with its advisory boards to allocate those funds within the state. This method would permit decentralized decision making with local access. The state could either pay bills directly or contract with one fiscal intermediary, which could be an insurance company or a third-party administrator, to do so, as Medicare now does within regions. Health insurance companies could not sell duplicative insurance for covered services, but they could cover benefits that were not included, such as elective cosmetic surgery.

Cost Control

Like many going concerns in America, in both the private and the public sectors, the health care system would come under the discipline of a budget. The American Health Security Act would tie increases in health care expenditures to the increase in the gross domestic product, which rose 2.1 percent in 1992, when health care costs rose about 9 percent. Health care institutions would have global annual budgets. States could negotiate with providers to pay outpatient facilities and individual practitioners on a capitated, salaried, or other prospective basis or on a fee-for-service basis according to a rate schedule. Balance billing would be prohibited.

Billing by practitioners would be reviewed quarterly, in conjunction with volume-performance standards for those receiving fee-for-service payment. An American Health Security Quality Council would collect data and establish practice guidelines in order to identify patterns of practice that suggested deficiencies in the quality of care. Peer review of these patterns of practice, rather than individual utilization review of every service ordered, would help to enforce the budget. This

method would lead to an important reduction in the administrative "hassle factor." In addition, rates could be reduced if increased volume threatened to cause a budget shortfall.

Rates would be designed to increase fees for primary care, while probably slightly reducing fees for specialty care. As in all other industrialized countries, which similarly regulate reimbursement of physicians, however, U.S. physicians would continue to earn several times the national average income. In every country, admission to medical school is highly competitive, with many times more applicants than training slots available. Should some practitioners receive somewhat lower fees, the trade-off would be the autonomy to practice medicine without micromanagement by an insurance company.

Consumer-oriented managed-care plans, which we term "comprehensive health service organizations," could enroll members for 12 months at a time and would be paid on a capitated basis according to a global budget. Start-up costs could be allocated as part of the state's capital-expense budget. As an incentive for efficiency, providers could be allowed to keep some portion of budget savings, to be determined by the board, if they could demonstrate that standards for service and quality had been maintained.

These plans would attract members on the basis of the quality of care they offered. There would be no difference in price to the consumer among managed-care plans or between such plans and fee-for-service providers. In our current inequitable system, which has more than two tiers, any substantial difference in the price of plans drives low-income people into lower-priced plans. Without constraints, as far too many managed-care plans have demonstrated, health plans driven to control costs will reduce services, either by taking the telephone off the hook to discourage initial visits or by limiting the services available to those who do manage to consult a provider. As long as good care is available elsewhere to those who will pay, there is insufficient pressure to provide high-quality care to all, and there is in effect no real choice for many consumers.

If all plans charged the same amount for comparable benefits, however, patients' satisfaction with the quality of care and the level of services would become the main determinant of enrollment. Managed-care plans would have to compete for members by realizing their potential advantages -- for example, by encouraging consultation among multidisciplinary teams to improve quality -- and they would achieve solvency by systematically evaluating their operations to improve efficiency. States could allocate funds and capital resources in ways designed to redress current imbalances in services and would be encouraged to plan regionally to create centers of excellence.

Universal Coverage

Everyone would be covered under the same health insurance system with the same benefits, and there would be no duplicative insurance outside the system for covered benefits. Additional insurance would be permitted only for services that were not covered, such as elective cosmetic surgery. Reciprocity among states would be ensured. The link between employment and coverage would be broken. This is a critical feature of any reform -- to ensure security of coverage as our mobile population moves from job to job, to ensure that everyone receives the same quality of care, and to hold down administrative costs. It would take the increasingly contentious issue of health care benefits off the bargaining table and further assist businesses by relieving them of the administrative

burdens of providing health care. States could choose whether or not to cover undocumented workers.

Comprehensive Benefits

In any health care system, what we pay for will determine what we get. Unlike many insurance plans, the American Health Security Program would cover a full range of primary and preventive care, as well as inpatient services and long-term care. Within the discipline of a global budget that limited unnecessary inpatient care, coverage for a broad range of services for mental illness and substance abuse would be affordable, along with services to coordinate care.

The American Health Security Act would increase funds for training the personnel necessary to make these benefits accessible. The national board, guided by an Advisory Committee on Health Professional Education, would develop, coordinate, and promote policies and set goals for training more primary care physicians as well as midlevel practitioners and nonprofessional community health outreach workers. An initial goal would be to have 50 percent of medical residents in training programs in primary care within five years of the program's enactment. The act also addresses deficiencies in the health care infrastructure, which now prevent many low-income Americans from receiving timely and adequate care, through increased funding for community and rural health centers, for the National Health Service Corps, and for many other important but currently underfunded public health services.

Quality Assurance

Many useful criticisms have been made of aspects of the current quality of health care, ranging from the adequacy of information available to providers to providers' responsiveness to consumers' concerns. In response, changes have been made in the training curriculum for health professionals and sophisticated data-collection systems have evolved to begin to meet those challenges. In the long run, the most important improvement this proposal would make in the quality of care would be to remove the perverse financial incentives that distort medical practice today. However, even the experience in Canada, which has drastically altered those incentives, indicates that in the interim there is a need for careful attention to evaluating and improving the quality of medical practice. The critical issues are the extent to which practitioners are integrally involved in creating and enforcing their own standards, and the extent to which better clinical management is assumed to be a function of economic forces, as opposed to a conscious effort by practitioners and consumers.

The American Health Security Act proposes a publicly accountable system that would be highly sensitive to the views of providers and patients about quality. A national Quality Council would develop and disseminate practice guidelines based on outcomes research and would profile health care professionals' patterns of practice to identify outliers. A national data base would facilitate both the portability of patient records and research on outcomes.

In determining the need for and the nature of ongoing benefits for chronic conditions, a combination of services to coordinate care and utilization review may be desirable. In such cases, regulations would require peer review by equivalent professionals, financial independence for reviewers, timely decisions, and an appeals process.

The board would develop incentives to encourage the appropriate use of centers of excellence, defined as tertiary care centers that could meet standards for the frequency of performing procedures and the intensity of support mechanisms that are consistent with the high probability of desirable patient outcomes. The Quality Council would develop guidelines for certain medical procedures designated by the board to be performed at these centers.

The emphasis on primary and preventive care would encourage the maintenance of health and the early diagnosis of illness. The act would require states to develop incentives for multidisciplinary care, a key to high quality in the most successful group practices. State plans would have to include a procedure for regional management and planning functions that would address the maldistribution of health personnel and facilities. Each state's procedures would also have to encourage needs assessments and community-oriented primary care, with integration of public health epidemiologic data into the delivery of care. The plan would discourage the overuse of procedures that may be both unnecessary and harmful.

Equitable Financing

The single-payer system would replace private premiums with public premiums. Instead of insurance plans that charge individual people and businesses the same amount regardless of income or profits, the public plan would be progressively financed by increases in the top marginal income-tax rates for individuals and corporations, payroll taxes on employers, and a premium equivalent to the Medicare Part B premium to be paid by those over 65 years of age, as well as by closing a variety of tax loopholes. The vast majority of people and businesses would pay far less for health care than they do now. These savings would in part offset the increase in taxes, and some of the savings to business would be available to employees as wage increases. In return, every American would receive the security of comprehensive health care services for life, services that would be available whenever they were needed.

Alternative Proposals

Proposals for managed competition have been the leading contenders in the recent debates about health care reform. Articles by Relman,2 Iglehart,3 and Mariner4 have described a variety of approaches to managed competition and employer mandates and have pointed out likely limitations on their capacity to control costs and maintain the quality of care. From 30 to 40 percent of the country is made up of areas that do not now and could not support even as many as three competing provider groups,5 and there is no theoretical basis in any case for inferring the minimal number of groups that would be necessary to sustain competition. In our present profit-oriented insurance market, competition based on price could permit the same kind of adverse selection and cost shifting that characterize the current health care system. In addition, assuming that small insurers would be shaken out of the market, the remaining large firms could collude to maintain prices as easily as they could compete to lower prices. Current managed-care plans, although they offer some excellent examples of multidisciplinary practice and of the use of data to improve care, have not on the whole saved money.

In contrast, the Congressional Budget Office (CBO) reported on February 2 that central features of

the American Health Security Act would increase the likelihood of success in controlling cost increases, as compared with alternative proposals. These features are a single payment mechanism or clearinghouse, restrictions on the ability to purchase health care outside the regulated system, global budgeting for hospitals and other health care institutions, regular monitoring and adjustment of payments to physicians, rate setting for all services, and a good data-collection system with uniform reporting by all providers to allow quick feedback. According to the CBO, if such a system had been in full effect in 1986, it would have resulted in national health expenditures of only $651 billion in 1991, rather than the $752 billion we actually spent. In contrast, the CBO estimated no savings within five years of the establishment of a system based on managed competition.

A Yardstick for Reform

These features of the proposed American Health Security Act present a yardstick for reform. It is the elements of reform, not the labels, that are important. In any reform, it will be important for states to have the option to set up single-payer systems if they so choose. An acceptable plan for reform could also incorporate purchasing cooperatives that are nonprofit, publicly accountable administrative bodies, if the health plans they offer are truly comprehensive and available to all. But allowing large employers to opt out of the system would simply recreate the segmentation of the risk pool that has led to the current spiral of adverse selection and cost shifting, to say nothing of disruptions in the continuity of care and possible discrimination against workers who are older or otherwise seen as being at risk for major illness. Similarly, care for low-income people, the unemployed, and the self-employed must be paid for from the same sources that finance care for the majority of the population. Experience shows that poor people's programs are poor programs. We cannot set up funding mechanisms that are subject to easy cuts; the bill for delayed but necessary care is ultimately paid by all of us.

The achievement of high-quality, readily accessible care must involve removing providers as far as possible from the influence of financial incentives and letting them compete on the basis of quality. Well-reimbursed professionals, with a wealth of well-grounded information and peer support available, who are willing to listen to and respect their patients, will provide good care if they are not diverted by misguided financial incentives. Our health insurance plans must include as much of the population as possible under one roof, and coverage must be based on residency, not employer-based.

Every other industrialized nation has been able to use the power of a public authority to provide a secure and dependable environment for the healing arts. In every other industrialized nation people are far more satisfied with their health care system than we are in the United States, and by every measure of public health they are in better condition. Although costs may rise, these countries can and do use the lever of public control to recognize problems quickly and then move to address them. Surely with all our technology, creativity, and good will, Americans can borrow from their experience and do equally well.

Senator Paul D. Wellstone (D-Minn.)
Ellen R. Shaffer
Washington, DC 20510

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Goldin H. M., Konstam M. A., Kimmelstiel C. D.,
Wellstone P. D., Shaffer E. R.

N Engl J Med 1993; 329:1357-1358, Oct 28, 1993.
Correspondence

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