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Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors

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The key issue in the emerging national health care debate is the role of the federal government. While some Members of Congress favor a "single-payer" national health insurance system—"Medicare for all"—others, including President Obama, propose a new public plan, modeled after Medicare, to compete with private health plans in a national health insurance exchange.[1]

Many independent experts expect a "crowd out" of existing private options and a rapid evolution toward a single-payer system of national health insurance.[2] In either case, the federal government would amass greater power over the financing and delivery of medical services; it would also determine the benefits and medical procedures that Americans would get and the prices providers are paid for them. This concentration of government power over health care would have a profound impact on all Americans, especially members of the medical profession.

Such government control would:

- Result in substantially lower payments to physicians and other health care providers compared to a multiple-payer system;
- Reduce the quality of care by limiting the ability of physicians to invest in advanced medical equipment that takes advantage of new technology;
- Limit access to care in the near term, as current physicians and other professionals retire earlier or otherwise leave the profession;
- Limit access to care even more substantially in the long term, as the prospect of lower lifetime earnings reduces the incentive for talented people to choose careers in health care; and
- Reduce the rate of medical progress, because fewer talented people receiving medical training decreases the supply of talented medical researchers.

Doctors' Frustration. Many physicians, quite reasonably frustrated by the cost and hassle of dealing with billing multiple insurance companies—not to mention the time lost appealing seemingly arbitrary denials of payment—often conclude that the solution lies in a "single-payer" system along the lines of a "Medicare for all" concept. A single payer—a government agency—would at a minimum eliminate the duplication of effort associated with signing on and maintaining relationships with multiple private insurance companies. It would standardize billing processes and coverage rules and perhaps even establish clearly defined rules to reduce the frequency of apparently arbitrary "down-coding" and denials of payment.

What many fail to appreciate, however, is the extent to which the existence of multiple, competing payers prevents government payers such as Medicare from reducing their payment levels to much lower levels than prevail now. As it stands, a

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reduction in Medicare payment rates can induce physicians to drop Medicare patients and try to make their living from a higher percentage of (or even only) privately insured patients. This would inevitably result in reduced access to care for Medicare patients—and thus political pressure from those patients for increased Medicare payments to improve access.

The Medicare Model. If Medicare or something like it were the "single payer"—the sole purchaser of health care—no such pressure would exist. If the single payer established lower payment rates, by definition physicians could not drop out and make their living from other patients, because there wouldn't be any other patients.[3] The only alternative for a physician would be to cease the practice of medicine and either retire or find another profession. While this would certainly happen to some degree, a large percentage of physicians—who have invested many dollars and years of training in their practices—would be unable to find an alternative profession that is nearly as satisfying or as remunerative. The inevitable result would be much lower payment rates and lower income for physicians.[4]

Patients would suffer as well, especially in the long run. Because fewer highly talented people would be willing to undergo the years of training (under difficult working conditions and low pay) to become physicians, patients would suffer decreased access to health care and longer wait times. Lower payments would mean that physicians would invest less in advanced medical equipment and would likely spend less time with each patient. In addition, with fewer people undergoing the training necessary to conduct medical research, new treatments and cures would be developed at a slower rate, costing many lives.

Medicare Payment Levels. Medicare determines the level of its payments to physicians based on a complex formula involving crude estimates of the relative costs of providing different services,[5] annual adjustments based on estimates of demand for services, and growth in the Medicare population and the overall economy. The annual adjustment process is expressed in the "Sustainable Growth Rate" (SGR) rule[6] which attempts to constrain the growth in Medicare spending and "make up" for the differences between previous years' estimated and actual utilization.

Each year since 1999, the SGR calculation has called for a reduction in the Medicare payment levels (a "negative update") for physician services, because actual use outstripped previous forecasts, and forecasted future utilization outstripped the growth rate of the Medicare population and gross domestic product (GDP). And each year, physicians' representatives have gone to Congress to argue that reducing payments will cause some physicians to drop out of the Medicare program, reducing elderly Americans' access to health care. Negative updates were allowed to go into effect in only three of the last 11 years—in the other eight years, after intensive lobbying from physician groups, Congress has intervened and passed legislation either freezing payments or providing a positive update.[7]

1. Robert E. Moffit and Nina Owcharenko, "The Obama Health Plan: More Power to Washington," Heritage Foundation *Backgrounder* No. 2197, October 15, 2008, at *http://www.heritage.org/Research/HealthCare/bg2197.cfm*.
2. See Robert E. Moffit, "How a Public Health Plan Would Erode Private Health Care," Heritage Foundation *Backgrounder* No. 2224, December 22, 2008, at *http://www.heritage.org/Research/HealthCare/bg2224.cfm*.
3. If patients were allowed to pay on their own, a small percentage of physicians could service this market. This occurs in the UK, for example. But in a stricter "single-payer" system like Canada's, this would not be possible.
4. To some advocates of single-payer systems, this is viewed as one of the benefits, since it could reduce health care spending.
5. These relative "costs" are collectively known as the Resource-Based Relative Value Scale (RBRVS). The cost of each service is measured in "Relative Value Units" (RVU). The process through which specific RVU numbers are assigned to each service is described in American Medical Association, "RVS Update Process," 2007, at *http://www.ama-assn.org/ama1/pub/upload/mm/380/rvs_booklet_07.pdf* (April 3, 2009).
6. See Section 1848(f) of the Social Security Act, as amended by section 4503 of the Balanced Budget Act of 1997, Pub. L. 105-33.
7. M. Kent Clemens, "Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians," Centers for Medicare and Medicaid Services, various years.

Competition Among Buyers. The basis for the physicians' now-annual argument to Congress is that reducing Medicare payments will cause more physicians to drop Medicare patients and make their living from privately insured and self-paying patients only. Indeed, anecdotal evidence indicates that some physicians have already done so,[8] as Medicare payments are already significantly below those of private insurance by almost 20 percent for physician services overall and by 12 percent for primary care.[9]

As if to demonstrate the effects of lower payments, in most states Medicaid payments are even lower than Medicare's, and far fewer physicians participate in Medicaid. Not surprisingly, states with relatively lower Medicaid payments compared to other states have lower rates of physician participation in Medicaid.[10]

Access Issues. Physician advocacy groups make the reasonable—and believable—argument that every reduction in the Medicare payment rates will result in a further reduction in the number of physicians who find it worthwhile to take Medicare patients and instead try to make their living from patients with private payers. A survey found that in response to a proposed 10 percent cut in Medicare rates, 28 percent of physicians would stop accepting new Medicare patients, 8 percent would stop treating Medicare patients already under their care, and much higher percentages would discontinue nursing home visits, reduce available hours, or defer investment in medical and health IT equipment.[11]

Obviously, this would not affect physicians in all specialties equally. Most pediatricians have very few if any Medicare patients[12] and would hardly be affected at all, but cardiologists and oncologists, for example, would be hit hard, since a large percentage of their potential patients are over age 65. The impact on nephrologists would be especially severe, because anyone with end-state renal disease is covered by Medicare regardless of age. Yet for every reduction in the payment level, a few more physicians would find it better to drop Medicare than to stay in.

The absence of other payers would give the "single payer" the freedom to reduce payments far more than Medicare can in the presence of a large percentage of privately insured patients. The result would be substantially lower payments—the "single payer" would be a "stingy payer." Physicians' income would be substantially reduced. Indeed, in countries with single-payer health systems, the average income of physicians is substantially lower than in the United States. For example, physicians in the Britain and Canada have incomes more than 30 percent lower than their U.S. counterparts.[13]

The existence of multiple private payers limits not only the ability of Medicare but also that of private payers themselves to reduce payment levels. Although physicians usually face "take it or leave it" contracts from insurance companies, and most physicians have little ability to actually negotiate, a health plan that sets payment rates too low will find that many physicians choose to "leave it." When enough physicians leave, patients have difficulty obtaining access to care and eventually leave the health plan.

In order to continue to sell the health plan (either to individuals or to employers), the insurance company will have to increase payments to induce phy-

8. Audrey Grayson, "Docs Bailing Out of Medicare, Medicaid," ABC News, July 8, 2008, at *http://abcnews.go.com/Health/story?id=5326078&page=1* (April 2, 2009).
9. Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009, p. 96, at *http://www.medpac.gov/documents/Mar09_EntireReport.pdf* (April 3, 2009).
10. Stephen Zuckerman, Joshua McFeeters, Peter Cunningham, and Len Nichols, "Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation," *Health Affairs* (January–June 2004), at *http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.374* (April 3, 2009).
11. American Medical Association, "Member Connect Survey: Physicians' Reactions to the Medicare Physician Payment Cuts," February 2008, at *http://www.ama-assn.org/ama1/pub/upload/mm/399/mc_survey.pdf* (April 3, 2009).
12. A very small number of children are covered by Medicare due to disability or end-state renal disease.
13. OCED Health Data 2008 (December 2008 update).

sicians to join. While this process is slow and imperfect compared to market mechanisms in other industries, it does limit the ability of plans to set arbitrarily low payment rates.[14]

"Stingy Payer" Damages Future Generations as Well. The establishment of a "single-payer" health care system would inevitably result in lower payments for physician and other health care providers. The immediate effect of having a single ("stingy") payer would be lower incomes for physicians and a reduction in the supply of active physicians, thereby impairing access to health care for all patients. However, the result of "single/stingy payer" health care will not only be lower incomes for physicians now but reduced access and lower quality health care for future generations as well.

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14. We normally think of competition as a process that reduces prices, because we normally think of competition as occurring between providers of a good or service. But for a given level of suppliers, competition between payer serves to increases prices. Just as a monopoly (sole provider) can extract high prices from buyers, a monopsony (sole buyer) can extract low prices from providers.