



The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

No. 127

Updated January 2005

The Grand Illusion: The Perennial Quest for a Single-Payer Health Care System that Works

First in a Series on Single-Payer Systems

There is a specter haunting the U.S. health care system: it is the perennial hope that somewhere, somehow, someone has figured out how to make a single-payer health care system that actually works.

Recently, three states — Maine on the East Coast, Illinois in the Heartland and Oregon on the West Coast — have explored creating their own state-based single-payer health care systems. The Oregon plan was resoundingly rejected by voters because the program would have exceeded the entire state budget, the Illinois legislation was reduced to a study, and Maine adopted a scaled-down “voluntary” system in 2004 known as Dirigo Health, which is already way behind schedule. Ironically, states already have a single-payer health care system: Medicaid. Anyone who thinks single-payer systems would be a panacea for increasing access to high-quality health care at lower costs need only look at the chronic problems plaguing Medicaid.

A Legacy of Failed Single-Payer Attempts. Over the past decade, numerous states — energized by the debate over the Clinton health care plan — considered implementing single-payer systems. A few states succeeded in passing a first step, and have been struggling ever since to limit or undo what they did.

Tennessee: The closest thing to a state-based single-payer system was Tennessee's TennCare, which as originally envisioned in 1993 would cover every uninsured and poor person in the state for *less* money than the state was currently spending on Medicaid.

The magic bullet that would make this feat possible? Savings from putting everyone in managed care.

However, within a few years after implementation, the rich benefits package and coverage expansion — a hallmark of all single-payer proposals — was straining the state budget. The state's health care expenditures grew by 69 percent between 1992 and 1999, while

personal income increased by only 38 percent, and covered 24 percent of the population. A 1999 audit of the program found that TennCare:

- Included 16,500 enrollees who lived out of state;
- Paid \$6 million to cover 14,000 dead enrollees; and
- Enrolled 450 state employees who had access to the state employees' health plan.

A 2003 audit of TennCare also found massive problems, including “Inadequately monitoring the \$850 million pharmacy program . . .” and “Not ensuring providers are licensed to work in Tennessee . . .” according to an article in the newspaper *The Tennessean*. As a result of the program's financing problems, Governor Bresden announced in January 2005 that TennCare will revert to a Medicaid managed care program and drop 323,000 people who will not qualify for Medicaid.

**The Difference in Medicaid Spending versus Education Spending
(Millions of Dollars)**

State	2004 Medicaid (est)	2004 Education (est)	Difference
Pennsylvania	\$14,375	\$9,065	\$5,310
New York	\$27,562	\$18,828	\$8,734
Tennessee	\$7,246	\$3,628	\$3,618
Connecticut	\$5,444	\$2,881	\$2,563
Missouri	\$5,725	\$4,552	\$1,173
Louisiana	\$4,772	\$3,635	\$1,137
Florida	\$12,159	\$11,050	\$1,109
Rhode Island	\$1,568	\$972	\$596
Illinois	\$11,590	\$8,419	\$3,171
Massachusetts	\$5,856	\$4,758	\$1,098
Maine	\$1,772	\$1,098	\$674
Arizona	\$5,007	\$4,080	\$927
Ohio	\$12,073	\$9,754	\$2,319
South Carolina	\$3,808	\$2,813	\$995
South Dakota	\$557	\$511	\$46
North Dakota	\$508	\$444	\$64
Nebraska	\$1,317	\$1,111	\$206
New Hampshire	\$1,080	\$1,057	\$23
Arkansas	\$2,760	\$2,243	\$517
North Carolina	\$7,011	\$6,996	\$15
Mississippi	\$3,175	\$2,589	\$586
Kentucky	\$4,009	\$3,662	\$347
Maryland	\$4,713	\$4,324	\$389

Source: National Association of State Budget Officers, 2003 State Expenditure Report, published in 2004.

A New Magic Bullet? Undaunted by repeated failures, single payer proponents have a magic bullet: bulk purchasing

According to Citizen Action Illinois, which advocated for a single-payer system, “Using the purchasing power of a massive risk pool consisting of the vast majority of uninsured ‘Healthy Illinois’ will make quality, affordable healthcare available to residents and will initiate new processes for cost and quality improvement.”

Sure, just like they did in Tennessee!

States Already Have a Single-Payer System. If states want to see how well a single-payer system works, they should look no further than their own Medicaid programs. If “a massive risk pool” is the answer, some state Medicaid programs already include more than a million people. Do state Medicaid programs increase access to quality care while saving the state money? In fact, virtually every state is cutting benefits, rationing care and trying to control costs — and pulling funds from other sources, such as education.

For years, education was the states’ biggest spending item. But by 2004, 23 states spent more on Medicaid (including federal matching grants) than education up from 19 in 2002. [See the chart.] In an effort to slow that spending trend, most states have cut services, removed or restricted certain populations and limited access to prescription drugs.

Does a Single-Payer System Save Money? Proponents argue that a single-payer system is less expensive than a private health care system. While it is true that data show that every country with a single-payer system spends less per capita on health care than the U.S., that doesn’t mean they are more efficient. They simply impose a global budget and refuse to spend more, letting Americans with private insurance subsidize medical and pharmaceutical innovations. But those in single-payer systems also get less.

Price controls: The states on average reimburse doctors and hospitals for Medicaid recipients only about 60 percent of what large employer groups reimburse those same providers for the same services. But utilization of services in Medicaid is vastly greater than that experienced by the general population, more than two-and-a-half times greater! That’s partly because the services are “free” to people with Medicaid coverage. It may also be that providers do more — much more — to compensate for the lower reimbursements.

Administrative costs: Proponents also claim that single-payer systems are much more cost efficient than the private sector because of vastly lower administrative costs.

Based on an earlier CAHI analysis, the actual administrative costs for Medicaid and Medicare — both single-payer systems — are estimated at roughly 31 percent of benefit costs and 23 percent, respectively. That is because a large amount of the cost is hidden in the general budgets of governments, whether in the

budgets of the legislative or other branches, or in interest payments created by the deficits such programs help produce.

Government services do not come free. For example, conservatives in England claimed on July 6 that cutting red tape would save the National Health Service £1.7 billion. So much for efficient government services!

Why Single-Payer Systems Always Lead to Rationing. In a single-payer system, health care dollars must compete with other valid claims on government funds such as education, welfare and defense. As a result, there is never enough money. There is not one single-payer country in the world — and that is almost every other country — with adequate funds. Not one. And so, some patients — usually the very old, very young, sickest, poorest and the least powerful — don’t get the care they need in a timely fashion.

All anyone interested has to do is look at the newspapers from single-payer countries. Just consider some recent stories (all citations are found at www.factcheckers.org):

- *The Gazette* (Canada, December 3, 2004): “More than 5,500 children are on waiting lists as long as one year for corrective surgery in Montreal’s two pediatric hospitals.”
- *The Evening News* (Scotland, December 28, 2004): “The number of Scots opting to pay for private operations rather than join record NHS waiting lists has soared, according to independent hospitals.”
- *National Post* (UK, January 8, 2005): “Thousands of patients are languishing on ‘hidden’ hospital waiting lists which are not counted in official figures, it emerged last night.”

Conclusion. Every state is struggling with Medicaid access and funding problems — just like every single-payer country. Every state legislator is aware of the challenges, and yet some foolishly believe that a state-based single-payer system will work. It is a grand illusion built on an unwillingness to learn from the evidence in front of them.

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