MILLIMAN REPORT

Congress asked nine questions about single payer. Here are 27 answers.

March 2019

Milliman

Introduction

In recent weeks, single-payer healthcare proposals have begun to emerge in Congress. While much of the attention during the single-payer discussion has been on specific proposals, Milliman has tried to take a broader view—via questions from a Congressman. On January 8, 2019, Rep. John Yarmuth (D-Ky.), the Chairman of the House Budget Committee, sent a letter to the Congressional Budget Office (CBO) posing questions about a potential single-payer system in the United States.[1] The Congressman's questions offer a useful lens for considering the broad spectrum of single-payer proposals, both those already on the table and those that may emerge. So we set out to field the nine questions posed in Rep. Yarmuth's letter. But we quickly realized that we could not answer the nine questions with only nine answers, because there are so many different potential flavors of single-payer systems. So we developed three distinct scenarios as ways of showing the varied answers to the Congressman's nine questions.

At its core, a single-payer system is one in which the system's primary financing (and oftentimes the primary enrollment) comes from a single payer, which is typically the government. Reflecting the many unique ways that the federal and state governments fund and regulate American healthcare, we have identified three different single-payer scenarios, ranging from least disruptive to most disruptive compared to the status quo.[2] These three options provide lenses through which to view Congressman Yarmuth's questions.

1. **Least disruptive—Fill the gap scenario (Gap).** In this scenario, many of the insurance mechanisms that exist today would continue, with the single-payer system filling in coverage gaps and providing consumers with additional options. There would still be commercial insurance options and many people would still receive coverage through their employers. Medicaid would continue as a program for covering those with low incomes and the disabled. An example of such a fill the gap scenario is the proposal in Washington state to provide a public option that reimburses healthcare providers at Medicare rates (lower than typical commercial reimbursement) and gives consumers a silver or gold plan.[3] A Gap scenario would likely work better in a state that has already expanded Medicaid and developed an exchange, as is the case in Washington.
2. **Medium disruptive—Current government programs with enhancements (Gov+).** This scenario includes a lot of Medicare Advantage types of coverage. All people would have access to a basic basket of government-funded benefits that would include catastrophic coverage. Not all services would necessarily be covered. Many people would opt to purchase supplemental policies to access richer benefits, potentially through any of the existing channels. The Gov+ scenario would include a consolidation of existing government programs. Employers would have an option to buy in, but wouldn't be required to do so and might choose to continue providing the existing plan to their employees.
3. **Most disruptive—"Medicare for All" (M4A).** All health coverage would run through a single federal entity. There would be no Medicare Advantage. A full scope of benefits would be covered. Such a system might incorporate consumerist concepts, such as cost sharing, but the only option would be the single federal system. There would be no private insurers, including no employer-sponsored insurance. This is the closest to the "Medicare for All" program being broadly discussed, but as others have written this might be something of a misnomer.[4] The Gov+ scenario more closely resembles Medicare as it currently exists than the proposed M4A approach to universal healthcare.

None of these scenarios contemplate expanding the system to include nonmajor medical services, including nursing home care, long-term care (LTC), dental, or other healthcare needs. Nor do we contemplate the possibility of a new paradigm of government-run hospitals and government-employed medical professionals.

[1] The full text of Rep. Yarmuth's letter may be found at https://budget.house.gov/Budget-Democrats-Single-Payer.

[2] The word "disruptive" was once largely pejorative, but has recently become synonymous with game-changing innovation. For the sake of our discussion, both meanings may apply.

[3] Walters, D. (January 17, 2019). Gov. Jay Inslee's "public option" plan to reduce health care costs is ambitious – and untested. Inlander. Retrieved February 14, 2019, from https://www.inlander.com/spokane/gov-jay-inslees-public-option-plan-to-reduce-health-care-costs-is-ambitious-and-untested/Content?oid=16086068.

[4] Scott, D. (February 11, 2019). John Delaney has a plan for universal health care – but don't call it "Medicare-for-all." Vox. Retrieved February 14, 2019, from https://www.vox.com/2019/2/11/18220118/2020-presidential-campaign-medicare-for-all-john-delaney.

1. How would the system be administered?

Scenario	Key considerations
Gap scenario	Administration would likely be handled at a state or regional level. Most administrative activities would persist. Public sector entities could be developed or private sector entities contracted to provide administrative services.
Gov+ scenario	Administration would likely be handled at a regional level. Most administrative activities would persist, although some activities could be redesigned or eliminated. Public sector entities could be developed or private sector entities contracted to provide administrative services.
M4A scenario	Administration would likely be handled at a regional level. Scope of administrative activities would depend on program design. Some activities could be redesigned or eliminated. Private sector entities would likely be contracted to provide administrative services.

DISCUSSION

All three scenarios would require significant administrative infrastructure. The scope of administration, however, would depend on the programmatic design. For example, Medicare's existing fee-for-service program, which could provide a blueprint for the M4A scenario, primarily focuses on claims payment (performing few if any care management activities). Baseline administrative activities would likely include enrollment, customer service, and provider reimbursement/claims.

The approach to administration could be at the state, regional, or national level. The more disruptive scenarios are likely to involve regional or national administration. Public sector entities would be formed to provide oversight, but private sector organizations would likely have a role in all scenarios, serving as contractors to the new public sector agency.

Many assume that a single-payer operation will significantly reduce administrative costs. This is partially true because some functions may be reduced or eliminated (e.g., sales) but likely to a lesser extent than many think. Basic functions like claims processing, member services, billing and accounts receivable, and care management programs must continue to be delivered. With tens of millions of members already, the largest insurers already have access to massive economies of scale, and the marginal economies of scale for a larger plan (e.g., the entire U.S. population) is limited. Milliman research indicates that administrative economies of scale are negligible once a plan surpasses 2 million members.[5] Any of our three scenarios would likely exceed 2 million members, and thus the potential for cost efficiency between our least disruptive and most disruptive scenarios are not as great as they might seem.

[5] Naugle, A.L. (January 31, 2008). Optimizing Administrative Expenses. Milliman Insight. Retrieved February 14, 2019, from http://www.milliman.com/insight/healthreform/Optimizing-administrative-expenses/.

2. Who will be eligible for coverage and how would they be enrolled?

Scenario	Key considerations
Gap scenario	One of the primary purposes of a single-payer system from an actuarial perspective is to concentrate as much enrollment into the system as possible. However, certain carve-outs may be appropriate if the needs of the population cannot be meaningfully met within a single, unified framework. The Gap scenario seeks to preserve a robust employer-sponsored market. Eligibility requirements would be important as the federal government must weigh the cost of covering the Gap population against the cost of tax-deductible employer-sponsored coverage. Allowing for employer-sponsored insurance to exist alongside a broad single-payer system could foster innovation among employer plans while retaining a viable fallback for individuals who do not have access to meaningful, affordable coverage.
Gov+ scenario	Everyone would be eligible for basic coverage and would have the option to buy up to richer benefits. The baseline tier would probably have tighter prescription drug formularies and might have narrower provider networks.
M4A scenario	Everyone would be in the same system. Would there be a mandate requiring participation? With the government providing coverage at low cost to the member, and premiums potentially varying based on income, there would seemingly be incentive for most people to participate. Possible penalties for delaying enrollment could also encourage participation.

3. What services should be covered and what cost-sharing requirements should be imposed?

Scenario	Key considerations
Gap scenario	This new program would exist alongside existing programs and might build on essential health benefit requirements established by the Patient Protection and Affordable Care Act (ACA). Both the Gap and Gov+ scenarios allow for a premium support approach similar to Medicare Advantage. Premium support models could include an income- and/or wealth-dependent premium scale that ensures those who can afford to pay for coverage pay a reasonable premium while those who cannot still have meaningful access to affordable coverage. At the same time, member premiums in this context are essentially another form of taxation, though one more explicitly targeted at the benefit received. However, the psychological nature of a specific "premium" versus a more nebulous "tax rate" may cause individuals to be more invested in care and in particular in evaluation of the value of coverage.
Gov+ scenario	The Gov+ scenario could also build on the ACA's essential health benefits (EHBs). This scenario features a basic tier of benefits with the option to buy up to richer plans. With more people in Medicare Advantage-type plans, it might create pressure on the employer-sponsored market to skew closer to the EHBs. This scenario also allows for a premium support approach similar to Medicare Advantage. The same considerations from the Gap scenario also apply here.
M4A scenario	Everyone gets all the care they need, with minimal formulary construction. This scenario could work with or without cost sharing, depending on whether or not cost control was a priority. Means testing would also be a possibility.

DISCUSSION

Beyond standard medical services typically included in major medical healthcare, a single-payer system could also consider coverage of more robust dental and vision benefits, similar to what is sometimes available in many employee benefit packages. While these services have not been deemed to be as essential as other employee medical benefits, they can be a valuable part of employee compensation and more widespread adoption may be appropriate. Another important consideration in this vein is long-term supports for disabled individuals and those suffering from mental health and substance use disorders. These long-term supports are not often part of typical medical coverage, nor are they frequently included in employee benefits packages; however, the growing need for and concern about the cost of this care makes it a key component of a discussion of services that should be covered. At the same time, adding these services would serve to increase the overall financing needs for the system.

4. What role should private insurers play?

Scenario	Key considerations
Gap scenario	Insurers would play a significant role in continuing existing systems and in facilitating the new Gap system.
Gov+ scenario	Insurers would provide supplemental and/or enhanced primary policies that could be purchased. Depending on how this is implemented, insurers could provide expanded services.
M4A scenario	There would no longer be a commercial insurance market, but there might still be a need for entities to administer the system.

DISCUSSION

Insurers serve a vital role of helping to control costs, spread risk, and efficiently manage many aspects of the healthcare system. Private insurers would have an essential role in our least disruptive scenario, and potentially a prominent role as part of the medium disruptive scenario. Private insurers have supercharged the current Medicare system. By virtue of the flexibility in Medicare Advantage plan design, MA organizations (MAOs) are able to expand the appeal of Medicare and avoid some of the pitfalls of a one-size-fits-all approach. Furthermore, the financing structure of Medicare Advantage helps ensure that MAOs save money for Medicare for those who find MA coverage appealing. Our first two scenarios could give private payers an option for customizing the system to better meet the needs of all enrollees and control costs.

A transition to a single-payer system could involve extending a standardized fee schedule to all payers. That could support something like Medicare Advantage, where payers can implement care management strategies to create savings they redeploy as benefit enhancements or cost reductions for enrollees.

In addition to care management strategies and price, private insurers are often competing on provider networks. From the narrow networks predominantly featured in many ACA-compliant products, which limit coverage to a relatively slim list of providers, to preferred provider organization (PPO) products that feature a network of preferred providers but allow members to seek service anywhere (at potentially higher costs), members can determine the extent to which they value price against desired providers, helping the system better meet the preferences of enrollees. This flexibility plays a significant role in the relatively high customer satisfaction with Medicare and Medicare Advantage.

5. What other programs (Medicaid, Veterans Health Administration, Indian Health Service, Military Health System) would continue to exist?

Scenario	Key considerations
Gap scenario	These programs would all continue under the Gap scenario.
Gov+ scenario	Given that these programs all cover unique populations, they might persist in the Gov+ scenario. Or, because these programs retain specialized services and professional staff, they could be incorporated into the single-payer system.
M4A scenario	Some of these programs would be folded into the larger single-payer system. The Indian Health Service (IHS) has unique treaty requirements. The Military Health System has its own structure to ensure troop readiness.

DISCUSSION

The Veterans Health Administration (VHA), Indian Health Service (IHS), and Military Health System (MHS) have separate missions that extend beyond the scope of just providing healthcare services. For example, the MHS tries to ensure that active duty service members (ADSMs) are mission-ready; then that active duty dependents (ADDs) are taken care of (to reduce distraction for ADSMs); and then to provide services for non-active duty and dependents (NAD/Ds), e.g., retirees and their dependents.[6] The MHS may need to retain that mission orientation for ADSMs, but could outsource the ADD and NAD/D responsibilities to the single-payer system. The MHS does this in part today through the TRICARE program, which primarily serves ADD and NAD/D members through the equivalent of a large administrative services organization (ASO) operation.

Medicaid also represents a significant component of our national healthcare landscape. Medicaid varies on a state-by-state basis, including populations covered, provider reimbursement levels, services included, and care management programs. Additionally, enrollment churn in Medicaid programs is a significant source of uncertainty for affected members. As such, Medicaid's role may be de-emphasized in a single-payer system, but maintained to provide additional coverages for populations with specific healthcare needs.

Similarly, health needs of American Indians and Alaska Natives are different, and may be informed by treaty requirements with each specific nation. As a result, Indian Health Services likely would continue under a single-payer system, though care should be given to ensure that IHS coverage aligns with the new single-payer system. This may require additional funding for IHS, which frequently faces capacity and staffing limitations that can interfere with its ability to provide care.

The VHA has frequently been in the news and the exact methods and funding of care provided by the VHA remain a prominent political football. Currently, the VHA is a system of government-run health centers supplemented with payments to private providers due to capacity limitations at the VHA. Like active duty military, veterans have unique medical needs arising from their prior military service, and so a dedicated staff of medical professionals who are familiar with these needs offers a distinct benefit to this population. However, any reform should consider the ability for the VHA to meet the needs of its entire eligible population and how services may best be integrated with the broader healthcare system.

[6] Health.mil. About the Military Health System. Retrieved February 14, 2019, from https://www.health.mil/About-MHS.

6. How would provider payment rates be established?

Scenario	Key considerations
Gap scenario	Because our least disruptive scenario keeps much of the current health system intact, it may be anticipated that any newly covered individuals or new public option programs would utilize existing reimbursement levels from other government programs, which may be Medicare.
Gov+ scenario	The basic tier of benefits would be paid for by the single-payer system; however, it may be anticipated that a large share of individuals will remain in the commercial employer market. But any supplemental policies would likely pay at the single-payer fee schedule, similar to the Medicare supplement programs today that pay the coinsurance amounts. Depending on the number of members utilizing this structure of benefits, the expanded coverage at Medicare reimbursement would place pressure on providers to either limit their patient populations under this option or increase reimbursements from those remaining in the commercial environment.
M4A scenario	This scenario may be the most disruptive for not only the American citizens accessing the healthcare system but also for the providers. The single-payer government program would need to establish a new composite fee schedule reflecting the current reimbursement levels of a combination of the Medicaid, Medicare, and commercial healthcare programs. The composite fee schedule would need to be considered to maintain overall provider reimbursement to retain healthcare providers in the system. Assuming no funding is initially removed from the reimbursement rates through a composite fee schedule, ongoing annual provider increases may become politically difficult given the overall fiscal impact.

DISCUSSION

For all three scenarios, provider payment rates are a significant factor in the overall viability and affordability of any healthcare arrangement. Provider payment rates need to balance the concerns of patients, providers, and payers. Providers may be primarily concerned that payment rates are sufficient to pay for costs. Current Medicare fee-for-service reimbursements are often lower than those for the commercial population, and many providers use these higher commercial rates to offset reduced payments for Medicaid and Medicare patients. If Medicare reimbursements were simply extended to other populations, providers could face significant financial repercussions. At the same time, payers are largely interested in getting good value. The cost-control challenges posed by fee-for-service Medicare are well documented. In response, alternative payment methods have emerged, and could be deployed in a single-payer scenario. And patients have their fingers in both pools—they want quality care and enough providers that they can access care when needed.

A well-established approach exists for developing fee schedules, as Medicare and many state Medicaid programs already do this. The difficulty is not so much in establishing the fee schedule itself so much as understanding all the contributing factors that go into it, balancing the needs of cost control, equitable compensation, and disruption from current payment rates.

Each of the three scenarios will need to address some or potentially all of the following questions.

- Will a fee schedule be mandated across all covered populations or only some populations, such as those that do not currently have an established fee schedule?
- Will the reimbursement vary by provider and how closely will it tie to current reimbursement levels?
- If reimbursement is aligned across all of the current payer segments (Medicare, Medicaid, commercial under 65, uninsured), there will be winners and losers among healthcare providers, depending on existing payer mixes. How will this disruption be managed?
- How will reimbursement levels reflect geographic cost and practice pattern differences?
- How will alternative payment models fit into this and will they vary significantly by the population managed?
- Will existing provider contracts with health insurers in the under-65 market be superseded by the single-payer terms? What about Medicare and Medicaid?

7. What participation rules should be established for providers?

Scenario	Key considerations
Gap scenario	A system that leverages private payers is likely to have more variation in network types than a system in which the government handles all reimbursements directly.
Gov+ scenario	Participation rules become less important if the single-payer system covers a greater portion of the population. In our Gov+ and M4A scenarios, most providers will need to accept single-payer coverage in order to have enough patient volume to remain in business. In this case more attention would need to be paid to reimbursement levels to avoid regional or national provider shortages, both in the present and in the future. While other countries with single-payer systems take a variety of approaches to provider participation, most have a parallel private healthcare system that serves those who are willing to pay for care beyond that provided by the single-payer system—similar to our medium disruptive scenario. Providers might look to these supplemental plans to counteract lower reimbursement in the single-payer system.
M4A scenario	A single payer does not necessarily mean a single network. Some countries with single-payer systems have vibrant, parallel private insurance markets with variation in network composition. In the M4A scenario, with literally only one payer, everyone would essentially be in the same provider network and all providers would be expected to participate.

DISCUSSION

To succeed, a single-payer system would need to establish participation rules that ensure enough providers accept reimbursement from the program to cover all enrollees in the program—while continuing to allow providers to opt out, as they can with Medicare today. Some sort of Goldilocks scenario would be necessary to make participation economically attractive.

8. What methods should be used to contain costs?

Scenario	Key considerations
Gap scenario	With the single-payer system filling in the gaps and other programs continuing, the Gap scenario would have a smaller risk pool that might be selected against. This creates cost control challenges. That said, private insurers have the incentive to control cost because they are taking risk.
Gov+ scenario	The cost control mechanisms that exist in Medicare and Medicare Advantage today would still be available in the Gov+ scenario. Private insurers providing the MA-type policies would have the incentive to control cost because they are taking risk. Members could be incentivized by using coinsurance, copays, and other cost sharing.
M4A scenario	As the only payer the government would wield significant influence over dictating unit costs and utilization requirements. Some form of cost sharing would help control costs.

DISCUSSION

Medicare is currently conducting various cost control experiments. Many of these have developed slowly or taken time to pick up steam. This points to the difficulty of implementing cost control on a nationwide basis. A move to a single-payer system won't change the fact that all care is local.

Many single-payer systems have limited physician and facility supply, creating a de facto quota for nonemergency services. Any cost containment strategies should be developed with an explicit consideration of both how effective the strategy may be and the impact the strategy will have on the ability of patients to receive needed care in a timely fashion.

The system should also consider best practices in utilization management, and could consider explicit development of evidence-based care management programs instead of focusing on a simple fee-for-service model. It's unclear who ultimately would be responsible for managing healthcare utilization—payer, provider, or administrator—and the answer to that question would influence design. Is it the provider's job to employ proper risk-based incentives? Do value-based incentives fall to the payer? Is it some mix of the two?

Many of the cost control questions tie to questions about reimbursement, eligibility, market competition, and provider network composition. For example, would a subset of providers that met adequacy standards be able to work together to provide insurance products that were lower-cost and potentially higher-quality than the average care delivered in the single-payer market?

9. How would the system be financed?

Scenario	Key considerations
Gap scenario	Much of the current healthcare financial status quo would remain the same. The Gap scenario would be funded by a mix of tax revenue and premium support.
Gov+ scenario	Much of this would be paid for through tax revenues. The richer tier of coverage would include premium support.
M4A scenario	Fully funded through tax revenues.

DISCUSSION

In all these cases, funding will come from tax revenues, from premium support, or from some combination of the two.

There are consequences to both insufficient and excessive funding. Consider a few possibilities:

- **Inadequate:** Limitations on available funding could result in reduced payment rates that in turn limit the ability for providers to build sufficient infrastructure to meet patient need, effectively resulting in care rationing.
- **Inadequate but member-subsidized:** Cost-sharing requirements may be strongly informed by the total expected cost of providing coverage and the pool of available funding. If available funding is only 70% of the underlying medical costs, other sources of funding such as cost sharing and member premiums would need to be set to recoup the remaining 30%.
- **Excessive:** Full financing by the federal government without any member contribution may make implementing effective cost containment methods challenging, not to mention have possible implications for the federal deficit and other government programs. Additionally, this may reduce incentives to work for individuals with significant healthcare needs.

The sources of government funding is another key question. Medicare follows the middle scenario, with the federal government picking up a significant chunk of costs but requiring individual enrollees to contribute as well. On the other hand, Medicaid represents a shared funding of expenditures by state and federal governments, with dramatically different health programs that can fit into any of these buckets based on each state's ability and willingness to spend money on providing coverage to the needy populations that Medicaid serves.

Other lingering questions

A few other questions come to mind that did not make the Congressman's letter.

What are the primary goals of a single-payer system? Before any approach can be selected, policymakers first need to understand what problems the single-payer system is trying to address. Is the primary focus access to care? Or is it affordability of care? Is the focus on the scope of coverage? Is the single-payer system aiming to reduce cost trends? Does it aim to redistribute income? Is it attempting to address cost and benefit disparities between current coverages, including commercial coverage, Medicare, and Medicaid? Is it primarily aiming to reduce the number of uninsured? Is it trying to address coverage continuity and portability of coverage? Each of these goals has a significant impact on what approaches and considerations are viable and any solution that prioritizes one of these goals will almost certainly have to make trade-offs that negatively impact others.

Can a single-payer system improve health outcomes? Healthcare research and reporting continually show increasing rates of health conditions ranging from obesity to autism incidence, and recent trends even show a drop in life expectancy. To what extent, if at all, would a single-payer system be able to address these needs and improve the overall level of health in our country? Because many of these health cost drivers are unrelated to treatment (diet, housing, lifestyle) would the existence of a single payer system directly lead to other laws and freedom restrictions in the name of single-payer budget goals?

What about pharmacy costs? Pharmaceutical trends have been significant cost drivers in recent years. That trend has ebbed, but the potential for drugs to drive up healthcare costs is established. How will drug trends be managed in the future? Possible scenarios include price lists that are dictated or the implementation of a bidding system similar to Medicare Part D. Pharmacy benefit managers (PBMs) could be leveraged or the federal government could negotiate directly with pharmacies as it essentially does with medical fees in the Medicare market today. Would this limit pharmaceutical innovation, leading to more deaths over time? Who would pick up the tab on pharmaceutical innovation?

How will this impact total national spending on healthcare? Much publicity is given to the annual Medicare report that tells us when the Medicare Trust Fund will run out of money. Healthcare expenses continue to be a major driver of federal and state spending. This is compounded by healthcare cost trends that exceed other indicators of economic growth. Can a single-payer system meaningfully bend the cost curve and put our healthcare system on a path to long-term financial sustainability? Can we bring healthcare costs in the United States more in line with those in the rest of the developed world?[7]

Will single-payer proposals crowd out other payers? Critics of government payer programs contend that many beneficiaries of these programs would otherwise have care funded by the private sector—that is to say, private payer care is crowded out. So would a single-payer system result in this crowding out? This question is more relevant to the Gap and Gov+ scenarios; after all, in the M4A scenario there would be no employer-sponsored market. The Gap program could be configured in a way to only fill the uninsured need, a true last resort program. This would require mechanisms to keep the Gap program from attracting all the worst risks.

[7] The Society of Actuaries and the Kaiser Family Foundation recently released a white paper entitled "Initiative 18|11" that addresses this disparity and drivers of costs, and introduces future research seeking to better understand these drivers in order to meaningfully decrease health costs. It is available at https://www.soa.org/Files/static-pages/research/topics/initiative-1811.pdf (PDF download).

What about state versus federal rights? The ACA proved the degree to which state rights can affect the original designs of a federal health reform law. Medicaid expansion was intended in 50 states but ultimately became a state decision. With different regulators in every state, any reform needs to navigate questions about state versus federal authority.

Will this upset or optimize the applecart? Today people migrate from one part of the system to another and it's not uncommon to change insurance coverage regularly. Such coverage changes can result from changing jobs, where two employers might have significantly different plan designs, provider networks, or prescription drug formularies. The same can be true for a person becoming unemployed and eligible for Medicaid or simply aging into Medicare. It may also result from a change in personal needs, or finding a better option in price or coverage. It may result in a new entrant to the market, bringing an innovative approach, and better service or quality. A single-payer system could minimize (or limit) some of that churn if it means that people now know who is paying for their healthcare moving forward, which could in turn lead to longer-term relationships with providers, potentially incentivizing more preventive and wellness initiatives over the continuum of care. Alternatively, changes could disrupt 20% of the economy. Aetna, Cigna, United, and Humana employ a total of 400,000 people alone. The healthcare industry as a whole employs 2.6 million people. While 28.5 million Americans (8.8%) are currently uninsured, 295 million Americans (91.2%) are currently insured primarily through employer-sponsored and government-funded programs.[8] Also, to the extent providers choose not to participate in the single payer system, patient/doctor relationships may be severed. Fundamentally changing healthcare financing may have wide-ranging implications on job creation, the economy, and the health care coverages currently accessed by most Americans.

[8] Keith, K. (September 13, 2018). Two new federal surveys show stable uninsured rate. Health Affairs. Retrieved February 14, 2019, from https://www.healthaffairs.org/do/10.1377/hblog20180913.896261/full/.

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