Insight

The Slow Creep Toward Single-payer Health Care

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Executive Summary

- The adoption of a single-payer health care system is often framed as a one-time, revolutionary event, but there is reason to suspect that the real path to single payer is the incremental displacement of the private sector.
- From aggressive investigations of private payers that provide health care coverage to drug price fixing using most favored nation policies and the Inflation Reduction Act's Medicare price negotiations, the traditional market-based health care industry is under siege.
- One by one, these measures erode the strength of private markets and make the piecemeal establishment of a centralized, government-run health system appear more likely.

Introduction

The adoption of a single-payer health care system is often framed as a one-time, revolutionary event that would require something like the passage of a Medicare for All bill. But there is increasing reason to suspect that the actual path to single payer is paved with incremental intrusions by the government that displace the private sector. In recent months, policy developments in general – not those restricted to health care – have moved in this direction. For example, industrial policy is on the rise, as the federal government has taken direct stakes in the ownership of tech and steel firms. It is likely only a matter of time before health care receives the same treatment.

Undermining Private Insurance Markets

For example, policy changes at both the state and federal levels are compounding challenges in maintaining the employer-sponsored insurance (ESI) market. As of 2023, there were nearly 165 million individuals with ESI. ESI offers structural benefits: It rewards work, supports both employee compensation and retention, and allows customization that aligns with employer and employee needs. This productivity and flexibility outperform the one-size-fits-all structure of programs such as Medicare.

New mandates around drug pricing, transparency, and surprise billing, however, add compliance and coverage burdens that erode the comparative advantage of the private market. Employers may question whether it is worth remaining in the ESI system. As private coverage loses its grip as the dominant model, the argument for simply consolidating coverage into a government-run framework becomes stronger – especially if incremental policies have already forced the standardization of pricing and benefits across the system.

Meanwhile, the Medicare Advantage (MA) program, once a model of public-private partnership in health care, is now being assessed against the same standardization rubric. Congressional action and executive agency agendas are severely limiting the ability of MA carriers to design plans that meet the needs of the populations they serve. Individual states are also increasingly stepping in to regulate insurance practices, particularly around artificial intelligence and prior authorization, signaling a shift toward treating plans like public utilities subject to stricter standards. While scrutiny and reform may indeed be warranted as the programs evolve – the MA program of 2025 is not the MA program of 2005 – unilateral administrative crackdowns with limited opportunities for private markets to adapt do not make for good policy.

Drug Pricing Controls

Most recently, last week a discussion during a cabinet meeting demonstrated the administration's use of the most favored nation (MFN) policy and tariffs to force pharmaceutical companies to acquiesce to its preferred drug pricing schemes. The administration revealed it was "deep into negotiations with 14 companies" to implement MFN. The subsequent admission that tariffs are being used as a tool to implement MFN creates a concern that the stick-no-carrot treatment flies in the face of normal policymaking. The practical consequence of these policy proposals will then be the expansion of government's role in determining pharmaceutical prices.

Historically, pricing was mediated through private negotiations between insurers, pharmacy benefit managers, and manufacturers. As federal regulators establish "fair prices," though, the private sector's ability to compete or innovate around price shrinks. The United Kingdom (UK) is currently offering a cautionary tale. The Voluntary Scheme for Branded

Medicines Pricing and Access – which limits the UK's National Health Service (NHS) drug spending growth by requiring pharmaceutical companies to rebate excess revenue – is currently in disarray.

In 2025, the rebate rate surged to nearly 23 percent, far exceeding the government-projected 15 percent, provoking industry backlash. UK Health Secretary Wes Streeting attempted to negotiate lower rates, promising higher prices for new drugs and increased NHS spending on pharmaceuticals. But the Association of the British Pharmaceutical Industry rejected the offer. The collapse of talks means manufacturers must continue with the inflated claw back or risk stepping into a stricter statutory scheme. This impasse risks weakening investment in the UK life sciences sector and limiting patient access.

This scenario underscores risks embedded in heavy-handed pricing controls: market reaction may include withdrawal of investment, innovation slowdowns, or disruption in drug availability. These are real considerations as the United States centralizes pricing authority.

Conclusion

From drug pricing measures such as MFN and the Inflation Reduction Act's Medicare price negotiations to aggressive investigations of private payers that provide government health care coverage, the traditional market-based health care industry is under siege. Layer by layer, these measures erode the strength of private markets and make a centralized, government-run system more likely to arise after piecemeal installments.