There is no shortage of proposals for U.S. health insurance reform. In our recent book, *We’ve Got You Covered: Rebooting American Health Care* (Einav & Finkelstein, 2023), we offered one more. It grew out of our internal debates over healthcare reform, between two academic economists who work (often together) on U.S. health policy but have not yet been involved in making that policy.

We started by trying to define the goal: what is the problem that healthcare policy should address? There are many good reasons for government to be involved, but the reasons are usually assumed rather than articulated when proposing or evaluating a specific policy proposal. That’s unfortunate. It’s hard to have a constructive debate about solutions unless we’ve articulated—and hopefully agreed upon—goals.

We therefore spent a fair amount of time trying to identify the driving impetus behind our history of health policy reforms and attempted reforms. From this, we ended up concluding that our health policy has been motivated by an enduring, if unwritten, social contract: access to essential medical care, regardless of resources.

We expected a fair amount of push back on this definition of the goal of U.S. health policy. After all, we are a society known for advocating independence and liberty, and for lifting oneself up by the bootstraps. We are also, (in)famously, the only high-income country without universal health insurance coverage. We therefore devoted about a third of our book to trying to convince our readers that in fact this social contract exists, and that the myriad problems with the current U.S. health insurance “system” reflect our failure to fulfill our obligations, not their absence.

Somewhat to our surprise, in the many reactions we’ve received from readers across the political spectrum, there has been near-universal agreement with our premise: that the U.S. is committed as a society to trying to ensure access to essential medical care for everyone, whether or not they can pay for it. Reactions have instead focused on particular elements of our proposal for how to fulfill this commitment.

We described what we thought an ideal system would look like, freed from political, but not economic, constraints. It contains two main elements. The first is universal coverage that is automatic,
free to the patient, and basic. The second is the option—for those who want and can afford it—to pur-
chase supplemental coverage in a well-functioning marketplace. We argued that we could thus fulfill
our social contract without tackling the other multi-trillion-dollar elephant in the room: the problem
of high and often inefficient healthcare spending.

In what follows, we briefly describe how we arrived at these key elements.

**UNIVERSAL COVERAGE THAT IS FREE AND BASIC**

**Universal**

Once we recognize that we always have and always will attempt to provide access to medical care
to those who are ill and cannot provide it for themselves, the sensible solution is to formalize that
commitment up front with universal coverage and finance it through the tax system. This is not a new
argument. It has been recognized and embraced for centuries across the political spectrum.

In the 21st century, Republican Governor Mitt Romney (Bebinger, 2012) and Supreme Court
Justice Ruth Bader Ginsburg (2012) advanced this argument in support of universal coverage in Mas-
sachusetts, and nationwide, respectively. Perhaps most tellingly, even libertarians like Charles Murray
of the American Enterprise Institute, who wants to dismantle government intervention in the lives of
individuals, support compulsory health insurance. As he argues (Murray, 2016), it is because of the
inevitably of the government stepping in to provide essential medical care if individuals fall ill without
the resources to cover their medical care.

**Free**

Any medical care that is included in basic coverage would be completely free to the patient. No
co-pays, co-insurance, or deductibles.

We are well aware that coming out against patient cost-sharing is about as close to professional
heresy as one can come to as an economist. For a half century, the unambiguous recommendation of
our profession has been that patients must pay something for their medical care. Giving patients some
financial “skin in the game” means that they will be more judicious in their choice of medical care,
and healthcare spending will be lower.

The empirical evidence is incontrovertible: when patients must contribute to the cost of their medi-
cal care, they use less of that care. Fewer visits to the doctor, prescription drugs, hospital admissions,
and even fewer visits to the emergency room. We’ve contributed to this body of research ourselves.
We stand by our evidence, and that of legions of other economists.

Often, the additional care—the care that patients wouldn’t have gotten had they had to pay for it—
is not consequential for health. It is for this reason that economists have consistently advocated for
patient cost-sharing, to make patients think twice before rushing to the doctor every time they sneeze,
or requesting an MRI when they have a crushing headache.

But the experience of the many high-income countries that have followed economists’ advice and
introduced some cost sharing into their universal basic coverage has laid bare the problem with this
received professional wisdom, at least when it comes—as it often does—in the context of universal
coverage.

Time and time again, as countries have introduced or increased requirements that patients pay for
some portion of their universally-covered medical care, they have simultaneously added programs
that reduce or eliminate that cost sharing for large sections of the population. The net result has been
to add complexity and uncertainty, as well as hassles for patients and administrative costs for the
government, with little ultimate impact on how much patients pay for their health care, or on total
national healthcare spending.
In the UK, for example, patients nominally face small co-pays for vision care, dental care, and prescription drugs. But there are copious exemptions. For people with particular diseases, below certain incomes, or below and above certain ages. For people with disabilities, or work-related injuries. For full-time students, women who are pregnant or have recently given birth. For veterans of certain wars. Different exemptions for different treatments. So many exemptions, in fact, that they have proven to be the rule rather than the exception. In 2019, only about 10% of all prescriptions in England involved patient co-payments. The rest were dispensed for free (Kulakiewicz et al., 2022).

American states that tried incorporating small patient fees into Medicaid have had similar experiences. It turned out to be a substantial administrative burden to identify who was required to pay those fees and who qualified for the many exemptions. Sometimes the administrative cost of collecting the fees exceeded the amount to be collected. Many of the fees went unpaid. Some states gave up altogether and discontinued their attempts to impose these fees. In several European countries—including Germany, the Netherlands, and Hungary—the government has likewise thrown in the towel and abolished recently-introduced attempts to impose cost sharing in their universal basic coverage. In France—where the national health insurance has always included substantial patient cost-sharing—a series of public programs and public subsidies has produced a similar outcome: 95% of the population has supplemental insurance which covers these cost-sharing obligations (Tikkanen et al., 2020).

There is a simple reason for this pervasive policy tendency to eliminate most of the cost-sharing requirements in universal coverage programs. It stems from the very purpose of universal coverage: to provide access to essential health care, regardless of resources. There will always be people who can’t manage a $5 copay for a prescription drug, or a $20 copay for a doctor visit. Which necessitates creating policy exceptions and exemptions to come to the aid of patients who cannot afford the required patient payments for that basic coverage.

To re-purpose a memorable phrase, cost-sharing in universal coverage is on a collision course with itself.

Basic

Basic coverage must cover all essential medical care, including primary and preventive care, specialist care, and hospital care—both emergency and non-emergency. Much of what this means is obvious. Flu shots and appendectomies are in. Purely cosmetic plastic surgery is out.

But there is also a large gray area of specific types of care where there are cases that can be made both for exclusion and for inclusion in basic care. Infertility treatment, dental care, vision care, physiotherapy, treatment of erectile dysfunction, various forms of long-term care—the list goes on and on. We deliberately do not weigh in here, other than to say that the starting point must be to define a budget for basic care—how much taxpayer money we are willing to devote to health care. Only then can we have a meaningful discussion about these gray area decisions.

Nor will this be a one and done discussion. Decisions about what is included in basic coverage will have to be made on an ongoing basis as incomes grow, medical technology improves, and notions of what constitutes disease evolve. This is why most countries have a formal process for considering whether to cover new treatments under universal health care. We will need one too.

In addition to the question of what will be covered, there is also a question of how it will be covered. The social contract is about providing essential medical care, not providing a high-end experience. There are many non-medical aspects of care that may be desirable without being essential. The ability to see the doctor of your choice at your preferred timing and location, for example, or semi-private hospital rooms. This would be substantially limited under basic coverage.

Basic coverage would likewise involve longer wait times for non-urgent care than what people with private health insurance or Medicare are currently accustomed to. Wait times would be closer to those experienced by Medicaid patients, or by veterans who receive their medical care through the Veterans’ Administration (VA).
Non-medical amenities would also be limited in the basic coverage, as they are in many other countries where hospitals offer a range of hotel-like amenities. In Singapore, for example, the basic coverage provides hospital care with eight beds in a room, a shared bathroom, and no air-conditioning. Patients can pay out of pocket to upgrade partway or all the way to the VIP treatment, which gets the patient a single room, with a private attached bath, television and, of course, air-conditioning, which is no small matter in Singapore’s notoriously hot and humid climate. Australia’s system is similar.

An analogy with airline travel may be useful. An airplane’s main function is to move its passengers from point A to point B. Almost everyone would prefer more legroom, unlimited checked bags, free food, and high-speed internet. But if our social contract were to make sure everyone could fly from A to B, a budget airline would suffice. Anyone who’s traveled on one of the low-cost airlines that have transformed airline markets in Europe knows it is not a wonderful experience. But they do get you to your destination without crashing.

Those who have the money and want to do so can upgrade to business class. That is where supplemental coverage will come in. It can allow a patient to “jump the queue” for hip surgery, for example, or to have the surgery performed by their first-choice surgeon, or to recover in a private hospital room.

**THE OPTION TO SUPPLEMENT**

We estimate that about two thirds of Americans—those who are covered by Medicare or by private health insurance through an employer—would want to supplement beyond the basic. There are two key design issues with supplemental coverage: how it is priced, and how to prevent it from eroding the adequacy of the care provided through basic coverage.

**A top-up system**

When the government guarantees basic provision of some service—be it health care or education—there are two existing models for how people can upgrade. In one approach, individuals who want more than the taxpayer-financed basic package must purchase an entirely new package, (re)paying for the services the government would have provided through the basic package, as well as for any upgrades. That’s the approach taken by the British National Health Service (NHS) and the U.S. Medicaid program, among others.

The other approach is to a top-up system, so that the patient only pays for the incremental cost of the additional benefits they receive. That’s the approach taken by many other countries in their universal coverage programs, including Singapore, Israel, Germany, Switzerland, and the Netherlands. It’s the approach the U.S. has taken in its Medicare program. And it’s the approach we advocate for on the basic economic principle of efficiency.

**Preventing erosion of basic coverage**

The biggest danger with supplemental insurance that can pay for “better” versions of what basic coverage would provide is the possibility that its existence will erode the basic coverage to the point where it is no longer fulfilling our social contract. The supplemental system may mean fewer doctors—or fewer of the best doctors—providing care in the basic system. It may also erode political support for the requisite public funding of the basic system. These forces can leave the basic system struggling to care for some of the most difficult and complex patients.

The experience of many Latin American countries serves as a cautionary tale in both regards. Many have publicly-funded universal healthcare systems that are chronically underfunded and widely
considered inadequate. The better-off buy into an entirely separate private system in a situation that some have likened to “medical apartheid.”

But the experience of other countries also makes clear that such problems are not inevitable, even when the supplementary system is sizable. In Australia, about half of people purchase supplementary insurance (Colombo & Tapay, 2003). In Singapore, two thirds of the population does so. Yet, in both cases, coverage under the basic system remains excellent. In Singapore, for example, although the majority of the population has private insurance, about 70% to 80% of hospital stays are still delivered through the public system (Singapore Ministry of Health, 2020). Indeed, far from being concerned about potential negative impacts of private insurance on the basic system, the Australian government has used tax incentives to explicitly encourage private health insurance purchases as a way to reduce strain on the public system (Colombo & Tapay, 2003). Likewise, government policy in the U.S. has actively encouraged the growth of the private Medicare system. One reason to encourage supplementary insurance is that it may pay higher prices to doctors and hospitals, relieving some of the funding pressures on the basic system. Indeed, a common argument—sometimes voiced as a complaint—is that private insurance in the U.S. helps “pay for” the care of publicly insured and uninsured patients. We are still waiting for the research that may support that hypothesis, but it—and the actions of the U.S. and Australian governments—certainly raises the possibility that a supplementary system can strengthen and support the basic one.

We don’t pretend to know the exact ingredients of the “secret sauce” that has allowed Australia and Singapore to stave off the problems that supplemental coverage has created in Latin America. But fortunately, we don’t have to. The experience of numerous countries underscores that when these problems materialize, there are some rather straightforward government solutions. Confronted with excessively long wait times in the basic system and an increasing use of the supplementary system, the Israeli government responded by increasing funding for the basic system and introducing incentives for physicians to work full-time in the public system (State of Israel, 2014). The UK, Norway, Denmark and Portugal, among others, have likewise enacted reforms to ensure an adequate supply of physicians to the basic system (Barros et al., 2013; Bath, 2021; Denmark Ministry of Health and Prevention, 2008; Gomes, 2016; Helse Norge, 2019; Siciliani et al., 2013).

Basic coverage must be adequately funded and physicians sufficiently incentivized to provide care. But this is true regardless of whether supplementary coverage is allowed. As long as we continue monitoring the fulfillment of our social contract with respect to basic coverage, and respond when cracks appear, having an active market for supplemental coverage can nicely complement—and perhaps even benefit—the basic system.

SEPARATING HEALTH INSURANCE COVERAGE REFORM FROM HEALTHCARE DELIVERY REFORM

From Nixon to Clinton to Obama, presidents have bundled proposals for universal coverage with proposals to reduce the level of healthcare spending. The instinct is understandable. After all, coverage and costs are arguably the two great problems in the U.S. healthcare system.

We, however, have deliberately shied away from tackling the problems of healthcare delivery. That’s because we can tackle the problem of coverage—and fulfill our social contract—without tackling the problem of healthcare delivery. We do not have to hold our healthcare commitments hostage to improving the efficiency of healthcare delivery.

Which is a relief, since we don’t (yet) have the silver bullet for dramatically lowering healthcare spending while fulfilling the dictate to “do no harm” to the patient. Nor, we hasten to add, does anyone else. Despite what you may have heard on TV. It’s indisputable that there is a lot of waste in U.S. health care. But the old adage about advertising is also true: half of spending is wasted, we just don’t know which half.
However, even without “bending the cost curve,” we could provide our proposed universal, free basic coverage that fulfills our social contract without raising taxes. To see this, consider the level of government healthcare spending in other high-income countries whose universal basic coverage with (almost) no consumer payments looks similar to what we propose. The UK is one example. Canada and Germany are others. In 2019, total healthcare spending in these countries was about 8% to 9% of their economy, with most of this spending financed by taxpayers. Guess how much U.S. taxpayers spent in that same year on health care? Also about 9% of the economy (World Health Organization [WHO], 2019).

Of course, total spending on health care in the U.S. as a share of national income is much larger than it is in any other country—17% in the U.S. in 2019—compared to an average of 9% across high-income countries. That higher U.S. spending, however, primarily reflects higher private spending, not higher public spending (WHO, 2019). Our taxes are already paying for the cost of universal basic coverage. We’re just not getting it.

Because total healthcare spending need not change under our proposal, the healthcare system and the provision of medical care need not change either. That will be reassuring to those worried about health insurance reform disrupting a sector that amounts to almost one fifth of the economy, but disappointing to those who would like to radically improve the efficiency of U.S. healthcare delivery. Whatever your perspective, these issues are distinct from the reform that is required to fulfill our social contract.

Likewise, we deliberately left unspecified many of the health policy debates that loom large in the public zeitgeist. Will basic coverage be provided through a single, public payer who directly employs the healthcare providers (as in the UK or the U.S. VA), or through multiple private payers paying private healthcare providers (as in Switzerland or the Netherlands or Medicare coverage for prescription drugs in the U.S.), or through some combination of the two (as in Australia or Medicare coverage for hospital and physician care in the U.S.)? These and many other design questions can involve important trade-offs. But their resolution is not a requirement for fulfilling our social contract. The experience of other countries makes that clear.

The experience of other countries provides another reassuring observation. We developed our proposal from first principles by focusing on the problem that needs to be solved and what is essential to that solution. But once we did this, we were struck—and humbled—to realize that, at a high level, our proposal contains several key components that every high-income country (and all but a few Canadian provinces) has embraced: guaranteed basic coverage which must be delivered within a fixed budget (two things the U.S. currently doesn’t have), and the option for people to purchase upgrades. The lack of universal U.S. health insurance may be exceptional. The fix, it turns out, is not.

REFERENCES


**AUTHOR BIOGRAPHIES**

**Liran Einav** is Charles R. Schwab Professor of Economics at Stanford University, 579 Jane Stanford Way, Stanford, CA 94305–6072 (email: leinav@stanford.edu).

**Amy Finkelstein** is John and Jennie S. MacDonald Professor of Economics at MIT, 50 Memorial Drive, Building E52, Cambridge, MA 02139 (email: afink@mit.edu).