I was gratified to see Liran Einav and Amy Finkelstein write, “if Furman and others like him are enthusiastic about trying to build momentum for a proposal for universal, automatic, basic coverage with income-related cost-sharing and the option to supplement it, we would be happy to pull up stakes and declare victory.” But I am worried that there may not be many others like me so we might be up to three people out of 300 million now in strong support of the Einav-Finkelstein-Furman plan.

But before getting back to feasibility, let us talk a bit more about the substance. Is it a good idea to have a health insurance plan floor that ends up with the majority of people getting coverage on top of it? I am genuinely unsure. In the case of Medicare it is clearly the result of the flawed program design, one reason why I was pleased that Einav and Finkelstein neither called their plan “Medicare for All” nor designed it based on Medicare. Medicare is not genuine insurance in that some coverage maxes out and is effectively uncapped. It subjects you to intolerable risk unless you get Medicare Advantage, Medigap, or combine with another plan like employer-sponsored insurance or Medicaid. That is why 90% of people do not rely solely on Medicare.

The Einav and Finkelstein plan would be genuine insurance. It might be consistent with their intention of providing everyone with a hostel that offers a warm bed, a toilet and a shower—which is all you need for an overnight—and letting them pay more for a nicer room with greater amenities. In that case, two thirds of people choosing to buy more would be no more troubling than the fact that currently 100% of people choose to buy more on clothing than what they are provided for free by the government (which is nothing in the case of clothing). But it is hard to tell because Einav and Finkelstein do not tell us enough about the basic plan to enable judgment about how sufficient it would seem to be judged on its own.

And this gets back to cost sharing. Part of how the plan would be basic would presumably be limitations on what is covered and who is covered. Those are not spelled out because they would strike the majority of people as extremely unpleasant, in part because they are like a corner solution where you max out on those tools because you do not want to use any other tool—like limits on cost sharing. Most optimization problems in economics involve an interior solution where you combine two tools rather than put everything into one while doing nothing on the other.
But all of this is quibbles about the details of the North Star. Let’s turn to political feasibility. The issue of what Congress can pass at any given moment is inextricably linked with the question of what is socially sustainable. After all, the goal is to take the social compact around healthcare and instantiate it in legislative form. This point is awkward for my views too. I worked hard to help design the so-called “Cadillac Tax” on high cost plans in the ACA. I was part of a very difficult negotiation with the labor unions to get them to accept it. And helped Congress write the law—which actually did pass. Unfortunately what resulted was perhaps the single most bipartisan component of the ACA—in that Congress on a strong bipartisan basis repealed it before it ever went into effect.

All of that said, it is not just economists (even economists with over a decade of government experience) who are terrible forecasters of what is and is not politically feasible. Political people are terrible at predicting politics too. Most of the smartest political minds in the White House were completely convinced that the Affordable Care Act (ACA) could not pass—the one major exception being President Barack Obama, but even he barely defended his political analysis; instead in one memorable Oval Office meeting he asserted that he was feeling the same lucky feeling he had felt when deciding to run for President.

The White House political team’s dramatic forecasting errors about the ACA were about what would happen weeks or months in advance on a relatively well settled political and policy issue. The R^2 on forecasting something as big as the complete overhaul of the health system that might happen or years of decades in the future is even lower.

That is why it is so good to have a relatively unconstrained vision of what reform could look like. But also why this serious proposal also deserves a serious debate about how to refine the finer points of the North Star, a debate I have been happy to play a small part in.

A North Star, however, is not enough. Even if we agree on where we would eventually like to get to, we still need to know how to start going there. The right approach to a destination is not walking in a straight line but avoiding perilous mountains and uncrossable deserts. Similarly, policymaking is often the art of the second best—not just in the political sense of the first best being politically infeasible but also in the sense that the second best is now always necessarily the option that is closest to the first best. So, now that we are close to converging on the North Star, I am hoping that Einav and Finkelstein will next turn their talents to helping us think about what direction we should start out on to get there.

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