

A Blueprint for U.S. Health Insurance Reform

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The current U.S. health insurance “system” was not deliberately planned and constructed but has emerged piecemeal over the past half-century through a series of incremental and haphazard reforms. That policy history also reveals a clear but unfulfilled societal commitment to providing access to essential health care regardless of resources. To fulfill this obligation, the solution proposed in this article has 2 key elements: 1) universal coverage that is automatic,

free, and basic, and 2) the option to buy supplemental coverage in a well-designed market. Such a system could, if desired, be created without raising taxes and without disrupting or changing the delivery of medical care.

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Any effective attempt at designing U.S. health insurance policy requires that we first identify its purpose. In this article, we therefore describe what seems to be the overarching aim of our health insurance policy history and our 2-part proposal to achieve this aim: 1) universal, automatic, basic coverage that is free for the patient, and 2) the option to buy supplemental coverage in a well-designed market. This discussion synthesizes the arguments that are developed in greater depth in our recent book (1). We then broaden the discussion to address several implementation questions that have arisen in response to our proposal, including taxpayer cost and disruption to the health care sector.

We deliberately do not discuss political feasibility. We believe that an important role for academic economists such as ourselves is to develop and articulate the best ideas and to try to keep them alive and ripe in the public imagination until the day when, in the words of one economist, “the politically impossible becomes the politically inevitable” (2). For those who are too impatient—or too skeptical—to wait for that day, we argue that we still must start by defining the ideal. Only then can we weigh in on the desirability of many potential compromises.

THREE KEY PROBLEMS

Health policy attention tends to focus on the 30 million Americans who lack health insurance at a given point in time (3). Two other critical problems confront the remaining 90% of insured Americans but receive much less attention: incomplete coverage and insecure coverage.

Incomplete Coverage

The purpose of health insurance is to protect its enrollees against large out-of-pocket medical expenses, yet both private and public insurance plans have deliberately built in substantial patient cost sharing. For example, by 2019, almost 1 in 3 people with employer-provided health insurance—the primary form of private health insurance—were in high-deductible plans in which the patient must pay the first several thousand

dollars (or more) of any medical spending for the year (4). Likewise, Medicare, the public health insurance program for elderly and disabled people, requires its enrollees to pay one fifth of all doctors' bills, with no cap on these payments. As a result, of the \$140 billion in medical debt that was owed to collection agencies before the pandemic (5), we estimated using the 2018 Survey of Income and Program Participation that about three fifths of that debt was incurred by households with health insurance.

Insecure Coverage

In addition, insured Americans younger than 65 years—whether covered through employer-provided health insurance, a private health insurance exchange, or Medicaid—are constantly at risk of losing their coverage. We estimated using the Medical Expenditure Panel Surveys from 2014 to 2019 that about 12% of Americans younger than 65 years who have insurance will lose their coverage over a 2-year period; this is about the same as the fraction of Americans in this age group who are uninsured in any given month. Moreover, about half of those who lose insurance will spend at least 6 months uninsured, and about a quarter will remain uninsured for more than 2 years. And although the risk of being uninsured at a given point in time decreased by about half after the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, the risk of an insured person losing their coverage barely changed (6).

This insurance uncertainty is an inevitable consequence of the incremental approach to health insurance reform that the United States has pursued for well over half a century, sequentially extending or subsidizing coverage to different groups. Whenever there are varied pathways to eligibility, many people will fail to find their path. It is telling that about 6 out of 10 uninsured Americans are in fact eligible for free or heavily discounted health insurance (7). People cannot sign up for programs they are not aware of, and they often have trouble enrolling or staying enrolled in the ones that they do learn about.

THE PURPOSE OF HEALTH INSURANCE POLICY

To consider solutions, we must start by defining goals.

There are, of course, many potential rationales for health insurance policy, such as improving health, reducing disparities in access to medical care, or fixing market failures in the health care sector. However, our reading of past and current policies in the United States reveals a particular driving rationale that is rarely articulated but always present: a clear social commitment to providing everyone with essential medical care, regardless of resources.

This social norm has been the impetus behind much of our policy history, which has seen laws enacted to create health care coverage for different groups at different moments: people with particular diseases (until they recover), low-income children (until they grow up), patients experiencing an emergency (until they are “stabilized”), pregnant women (until shortly after they give birth), hostages and their family members (during their captivity and for a limited time afterward), people with disabilities (after waiting 2 years), prisoners (until they are released from prison), and so on (8-19).

This same social contract is also behind the piecemeal slew of policies at the federal, state, and local levels that has created a large and complex web of publicly regulated and publicly funded programs that provide free or low-cost care for people who lack formal health insurance. The result of this patchwork of policies is that people who are nominally “uninsured” receive about four fifths of the medical care they would get if they were insured—this includes primary care, preventive care, prescription drugs, emergency care, and nonemergency hospital care (20)—and they pay only about 20 cents on the dollar for that care (21).

THE SOLUTION

Once we recognize that we always have attempted and always will attempt to provide access to medical care to people who are ill and cannot get it for themselves, the only solution is to formalize that commitment up front with universal insurance coverage. This argument has been recognized and embraced across the political spectrum, from the free-market economist F.A. Hayek and the libertarian Charles Murray to the Republican Massachusetts Governor and Utah Senator Mitt Romney and the liberal Supreme Court Justice Ruth Bader Ginsburg (22-25). Our proposal therefore calls for universal coverage that is automatic, free to the patient, and basic, as well as the option—for those who want and can afford it—to purchase supplemental coverage in a well-functioning marketplace.

Coverage must be automatic because requiring people to have coverage does not make it so. The United States' experience with the health insurance mandate under the ACA makes that clear: The share of people younger than 65 years who are uninsured in

any given month decreased from about 20% in the period from 2007 to 2013, before the major health insurance expansions under the ACA, to about 12.5% in the period from 2014 to 2019 (6), but it has not gone to zero. Indeed, the uninsured rate remained roughly constant through 2022, the latest year for which data are available (26).

Coverage must be free at the point of care, with no copayments or deductibles. Making people pay part of the cost of their health care does reduce health care spending. There is an enormous and incontrovertible body of empirical evidence on this point, including evidence from multiple randomized controlled trials as well as quasi-experimental evidence from changes in patients' cost sharing (27).

However, cost sharing in universal, basic coverage conflicts with its purpose. This is clear from the experience of other high-income countries that have introduced or increased requirements that patients pay for a portion of their universally covered medical care. Time and again, as countries have added cost sharing into their universal coverage system, they have almost simultaneously added programs to reduce or eliminate that cost sharing for large segments of the population. The net result has been added complexity and uncertainty as well as hassles for patients and administrative costs for the government, with little ultimate effect on how much patients pay for their health care or on total national health care spending (28-32). Cost sharing can do little to reduce health care spending when most people are exempted from that cost sharing.

These exemptions are inevitable because there will always be people who can't manage a \$20 copayment for a physician visit or a \$5 copayment for a prescription drug (33). Multiple high-income countries have therefore discovered that attempts to include cost sharing in their basic coverage inevitably collide with the goal of that basic coverage, namely to ensure that everyone has access to this care regardless of resources.

Finally, coverage should be basic—more like Medicaid for all than Medicare for all. The social contract is about providing essential medical care, not providing a high-end experience. Those who want and can afford supplemental coverage can purchase it in a well-functioning market.

We suspect that about two thirds of Americans—those with private health insurance or Medicare—would therefore purchase supplemental coverage to augment the basic package. With basic coverage, these people would no longer face the risk of losing coverage or owing a large amount out of their own pocket for their “covered care.” However, relative to their current coverage, basic coverage would involve longer wait times for nonurgent care—along the lines of what people covered by Medicaid or the U.S. Department of Veterans Affairs (VA) experience (34-36)—and fewer nonmedical amenities, such as semi-private hospital rooms.

Keeping basic coverage basic will keep the cost to the taxpayer down. Another key element for controlling government health care spending will be a budget for publicly funded health care. The U.S. government has a budget for most other goods and services it provides, from infrastructure to education, and every other high-income country has a budget for health care (37–39). However, the U.S. government has never had to operate within a health care budget (40).

Only once a clear budget exists can policymakers work on ways to meet it. This will involve, among other matters, making tough choices about what new medical technologies to cover in the basic plan. Most other high-income countries follow a formal 2-step process for such decisions. First, scientific experts formally assess the costs and clinical benefits of the new technology. Second, other stakeholders, such as health care professionals and government officials, use the results of that first-phase technical assessment as well as other factors, such as “societal values,” to make the hard choices about which new technologies to cover (41). Inevitably, those choices will leave some people wanting more, which is the role of supplemental coverage.

WHAT WOULD THIS MEAN FOR TAXPAYERS AND THE PROVISION OF HEALTH CARE?

Whether or not taxes will increase and the nature of medical practice will change is a choice, one that is distinct from what we must do to fulfill our social contract.

Because basic coverage would be financed by taxpayers, there is a possibility that taxes would increase to finance a universal basic coverage system that fulfills our social contract. However, taxes would not need to increase. It is true that as a share of its economy, the United States spends about twice as much on health care as other high-income countries, but in most other wealthy countries, this care is primarily taxpayer-financed, whereas only about half of U.S. health care spending is financed by taxes (42). In other words, taxpayer spending on health care as a share of the economy is about the same in the United States as it is in other high-income countries. The other half of U.S. health care spending is privately financed, and this is the part that would (or could) pay for supplemental coverage.

If taxes do not increase, current taxpayer-financed spending on health care would need to be diverted from the large amount spent on Medicare coverage for elderly and disabled people—which is more generous than the basic plan needs to be—and reallocated toward providing the basic floor of coverage for everyone. Of course, the basic coverage could be more generous, either for everyone or for people previously covered by Medicare, but that would then require higher taxes.

We have deliberately not addressed many of the health policy debates that loom large in the public zeitgeist. Basic coverage can be provided through a single public payer that directly employs the health care providers (as in the National Health Service in the

United Kingdom or the VA in the United States), through multiple private payers paying private health care providers (as in Switzerland, the Netherlands, or U.S. Medicare coverage for prescription drugs), or through some combination of the two (as in Australia or U.S. Medicare coverage for hospital and physician care). These and many other design questions can involve important tradeoffs that are beyond the scope of this article and require further study and consideration. However, the experience of other countries makes it clear that resolving these tradeoffs is not a requirement for fulfilling our social contract.

On a related note, total health care spending and the nature of health care delivery need not change under our proposal. For those worried about the substantial amount of waste and inefficiency in the U.S. health care system, this will come as a disappointment. For those who worry that our plan would disrupt an enormous part of the economy—the provision of medical care, medical innovation, and physician and hospital livelihoods—it may be a relief.

HOW COULD WE GET THERE?

We have been gratified by the widespread support for the basic principles of our proposal that we have encountered from the medical and policy community. However, we have also been struck by their desire for us to spell out a practical path forward to implement our proposal, something we have resisted until now. We therefore close by offering a few initial thoughts on this.

First, our proposal could be implemented at either the state or the federal level. Second, one (of many) potential implementation paths could be to automatically enroll everyone in the existing state Medicaid program and allow those who want to purchase supplemental coverage to do so. This could be done in the same manner in which almost half of Medicare enrollees currently opt out of the original, publicly provided Medicare program to purchase private Medicare Advantage plans (43). Finally, an entirely different way to view our proposal, particularly for those who believe that only incremental reform is feasible, is not as a destination per se but rather as a “North Star” by which to assess whether various incremental reforms are or are not moving us in the right direction.

However implementation is pursued, our main goal is to convince people of the need for reform and of the key elements that are essential for achieving that goal—and, we hope, to inspire them to look for ways to achieve it.

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