Bringing universal health care to the United States

Delilah Zak

A solution can be found only by addressing the underlying causes of the problem, not just the symptoms.

Fred Gluck

Were it a patient, the US health care system would be on life support. Fully 30 percent of the country's population lacks health insurance or is underinsured, much of the care delivered in the United States is inferior, and the rocketing growth in the cost of care places an untenable burden on individuals, employers, and the country's finances. In short, the current system is unsustainable and must be overhauled.

But how? Beneath these troubling symptoms lurk systemic problems, exemplified by the degree to which the country's existing tax structure and insurance programs perpetuate hidden subsidies and encourage excessive demand for health care, while still leaving millions of people uninsured. Moreover, there are serious shortcomings in the delivery system for patient care—largely attributable to the snail's pace at which providers adopt clinical and managerial innovations.

The United States also suffers from the side effects of its otherwise enviable level of national prosperity. Technology guarantees that the medical profession can treat an ever-widening, and ever more costly, array of maladies, while affluent (and arguably self-indulgent) lifestyles ensure that such treatments are necessary.

Redesigning the system ultimately requires tackling all of these problems and will, inevitably, be difficult and controversial. Determining the coverage that patients will receive under a new health insurance program, for instance, will raise inescapable moral and ethical questions about whether the potential benefits justify the costs. Likewise, reshaping the delivery system for patient care and promoting healthier lifestyles among consumers—both vital steps in cutting costs and improving quality in the long run—present complex challenges that will ultimately need to be addressed

on an institutional level (see sidebar, "The role of a national health agency").

Although the problems seem intractable, the US health care system can be revived. By reexamining our current approaches and removing the systemic obstacles, I believe health insurance could be extended to the entire US population—for no more than the current cost and quite possibly significantly less—while simultaneously removing the perverse incentives that contribute to rising costs. Moreover, this goal could be accomplished largely through existing institutions and without either soaking the rich unjustly or overburdening the poorest families. In short, such a system would be an equitable, effective, and efficient way of delivering a high level of health care to all Americans without guaranteeing all possible care to everyone.

Danger signs

How would such a health care system work? To answer that question, let's examine the current situation: 45 million US citizens—around 15 percent of the population—are uninsured, and perhaps an equal number are underinsured. This situation stems largely from the schizophrenic fashion in which health care is provided to those who can't afford it. For instance, the government legally requires providers in the private and nonprofit sectors to deliver emergency care to all patients yet refuses to pay for the uninsured or underinsured. Similarly, government reimbursements for Medicaid and Medicare patients typically cover only a fraction of the cost of treatment. Such shortfalls contribute to higher medical costs across the board.

And, as everyone knows, costs are out of control. In 1950, for instance, the annual per capita cost for medical care was about $150. By 2005, it was nearly $7,000 in nominal dollars. In fact, while the median per capita income in the United States has grown substantially since 1970, the nation's per capita health care expenses have grown even faster, from around 4 percent of median income in 1970 to almost 15 percent in 2005. The United States now spends 16 percent of GDP on health care (half of which is public spending) and is on pace to increase to a whopping 40 percent by 2040. The country's rapidly aging population only exacerbates the upward pressure on costs while making our present course less sustainable.

Worse still are the alarming signs that health care in the United States is not only overpriced but also wildly inconsistent and often of poor quality. The US Institute of Medicine, among others, has noted abundant evidence of overuse, underuse, and outright misuse of health care services.[1] The results are often tragic. According to the US Department of Health and Human Services, for example, more than 770,000 people are injured or die each year in hospitals from "adverse drug events."

Providing health insurance for everyone

We must do better, and I believe we can. This effort requires an unflinching look at the causes of our country's health care crisis. We must improve the ways in which hospitals and other providers deliver care. We must improve our unhealthy lifestyles. Moreover, we must rethink our insurance and reimbursement systems—both private and public—by reexamining whom they cover, where the subsidies flow, and how the cost and benefit trade-offs are handled. At the same time, we must be equitable at both the societal and personal levels and recognize that some individuals are more able to pay for care than others. If we do, I believe that we could provide everyone in the United States with a high level of health care without breaking the budgets of either our families or our government.

What the plan looks like

The plan I'm suggesting would involve a single, identical, and mandatory insurance policy written for everyone in the United States. The policies would be fully portable, and premiums would depend only on the number of people in a given household and their ages, independent of any family member's prior medical history. Broadly speaking, premiums would be less expensive for younger, single people and more

[1] "Crossing the quality chasm: A new health system for the 21st century," Committee on Quality of Health Care in America, US Institute of Medicine, 2001.

expensive for older people and those with larger families.

The policies would replace all government-subsidized insurance programs and all current private insurance—including employer-provided schemes—yet wouldn't prevent individuals from buying their own supplementary private coverage. People would pay into the mandatory program according to their means—the richest would pay the full cost and the poorest would pay nothing. Public money would cover about half of the program's total cost, with low- and middle-income people receiving subsidies on a sliding scale determined by household income.

The plan would fully cover all preventive measures, as well as the treatment of extraordinary and unexpected situations that meet certain cost-benefit requirements. For the purpose of this discussion, the former might include inoculations, annual checkups for selected groups of patients, certain lab tests, and mammography, while the latter might include everything from episodic emergencies such as a heart attack or broken bones to chronic illnesses such as diabetes or cardiovascular disease. The plan would also cover prescription drugs (emphasizing the use of generics and other cost-conscious approaches wherever possible). Determining the specific modalities to be covered would require scientific, economic, and ethical scrutiny—as well as public debate—to ensure that all concerns were addressed.

The plan would include a deductible and thus would not cover most routine care. Why not? The decisions on when to seek routine care are highly situational, subjective, and discretionary (including those made

The role of a national health agency

Putting the ideas outlined in this article into action—and making them sustainable—requires significant institutional capacity. One way to build it would be to create an independent national health agency designed along the lines of, say, the US Federal Reserve Board (where long appointments help insulate officials from short-term political pressures). The NHA would have three duties.

First, it would shape the new health program by specifying the provisions of the mandated insurance policy, the specific populations to be covered, and the amount of funding necessary. The agency would work with Congress to determine the exact formula for providing subsidies and also manage the national risk pools and negotiate with insurance companies. The NHA would work with appropriate professional medical organizations, physicians, economists, and ethicists to evaluate and rank all FDA-approved treatments according to their consistency with medical best practices and to their costs and benefits to individuals and society.

Next, the NHA would be responsible for creating a new approach to monitoring and improving the quality and cost of our health care delivery system—including bringing the costs of malpractice insurance and defensive medicine under control. These problems are significant, long-term challenges. Lowering costs and improving quality, for instance, require that we encourage innovation where care is provided, not just among drug manufacturers and equipment suppliers (as is the case today). The NHA would coordinate efforts by providers, as well as finance and evaluate promising approaches in both the clinical and administrative arenas.

Finally, the agency would be tasked with promoting healthier lifestyles. Unhealthy ones contribute greatly to increases in the cost of caring for the chronically ill (itself a significant driver of costs). An obvious example is the connection between obesity and adult-onset diabetes or between smoking and cancer. Government efforts to raise awareness about the latter problem offer hope that through increased education and a clever mix of positive and negative incentives, we might be successful in stemming the tide of other chronic lifestyle diseases as well.

by a parent for a child) and therefore don't lend themselves to a workable cost-benefit analysis prior to the care being consumed. Thus by requiring individuals to pay for routine care, we can ensure that people would approach treatment with the same cost-benefit mind-set that they bring to other important financial transactions. Such an approach would help lower the aggregate demand for health care, and as a result its absolute cost. Of course, routine care is often necessary and beneficial and therefore requires that we devise a way to extend it to those who cannot afford it. I will discuss this scenario, and the broader issue of subsidies, later in this article.

Extending a high level of health care to everyone—while simultaneously making individuals responsible for a greater portion of its cost—would improve the health of patients and the system alike. For instance, a hospital's emergency room would no longer need to serve as the de facto primary care facility for uninsured and underinsured people—a current practice that is not only demeaning to patients but also notoriously inefficient, prohibitively expensive, and often responsible for inadequate levels of care.[2] Unburdening such facilities would in fact *increase* their financial ability to provide charity care, by reducing hospitals' exposure to the bad debt and charity write-offs they currently face as a result of the government's low levels of reimbursement.

Indeed, by eliminating Medicare and Medicaid, the new policy would entirely remove the pernicious, hidden cross-subsidy that arises when government reimbursements for care—whether emergency or otherwise—don't fully cover the cost of treatment. These cross-subsidies raise the price of everyone's health premiums and add to the extraordinary complexity of a system in which numerous, smaller state and federal entities preoccupy themselves with making millions of individual decisions about who will be subsidized and for what.

What it would cost

A look at the ledger shows that the United States spent $2 trillion on health care in 2005, some $920 billion of which was public money.[3] The cost to the government on a per capita basis is around $3,060 for each and every person in the country. Could we provide the coverage I'm calling for with this amount of money?

Absolutely. In fact, we could do so for less. To see what coverage we could afford, let's use a currently available HDHP policy as our guide.[4] Exhibit 1 shows how the price of such a policy varies by the policyholder's age.

These figures suggest that the total cost of insuring everyone in the United States between the ages of 21 and 65 for one year (61 percent of the population) would be about $385 billion. The cost for those below age 20 (26 percent of the population) would be approximately $25 billion. Using a similar approach, but estimating the rates for Medicare recipients to reflect actual costs, gives us a total of $292 billion a year for people over 65. Adding $100 billion to account for preexisting conditions brings the total costs for providing insurance for the entire population to $802 billion.[5]

Adding the costs of special Medicare and Medicaid programs for the blind and disabled ($247 billion) brings the total cost of the plan to $1,049 billion (not including the costs of routine care, which we will account for in the discussion of subsidies below).

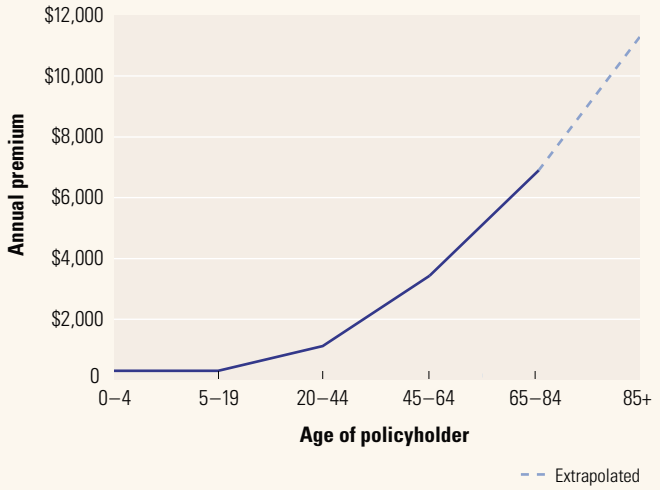
If we eliminated all regressive tax-based preferences for health care—the largest of which is not treating the cost of employer-sponsored health plans as taxable income to the employee—and instead subsidized 90 percent of the cost of insurance for the population over 65 (to exclude recipients with higher incomes) and 40 percent of the cost for the rest of the US population, the picture changes dramatically (Exhibit 2).

[2] David Brown, "Crisis seen in nation's ER care," *Washington Post*, June 15, 2006.
[3] In 2005 Medicare spending was $340 billion, Medicaid and the State Children's Health Insurance Program (SCHIP) was $320 billion, and all other state, local, and federal health care spending amounted to $260 billion.
[4] The policy I've chosen as a benchmark is a typical high-deductible health plan (HDHP), which serves as a good surrogate for estimating costs. Since premium estimates for the cohorts above 65 and 85 were unavailable, they were extrapolated using data on actual costs for those age groups.
[5] The estimated costs for insurance are probably conservative because the zip code chosen for the estimate is in Chicago, which is a high-cost area (~10%); the reduction in premiums for national risk pools has not been included (~20); and the estimate of $100 billion in premiums to account for preexisting conditions is probably too high based on the cost of state high-risk pools.

Exhibit 1

Costs increase with age

Cost of typical premium by age group, for high-deductible health insurance plan[1]



[1]Estimates based on Aetna high-deductible HSA-compatible PPO1 plan for zip code 60611 in Chicago, Illinois; since premium estimates for cohorts 65–84 and 85+ were unavailable, costs were extrapolated using data on actual costs for those age groups.

The total cost to the government for subsidizing the mandated insurance, continuing Medicare and Medicaid programs for the blind and disabled, and adding another $50 billion to cover out-of-pocket costs for routine care for the subsidized population[6] brings us to $739 billion for programmatic costs. Adjusting for the $220 billion in new revenues from the elimination of tax preferences brings the net cost to the government down to $519 billion, or about $1,730 per capita—roughly 80 percent of what we spend today per capita on Medicare and Medicaid alone and *just over half of total government per capita spending on health care.*

Better yet, a universal policy that included coverage for preexisting conditions would allow for the creation of a national insurance pool for each age cohort to spread the insurance risk more efficiently than is currently possible. This move would lower the cost of premiums further still. In order to circumvent the problem of adverse selection, the federal government could use existing insurance companies to administer the program and reinsure the risk itself.

Moreover, the system could be dramatically simplified by moving to a single, universal policy, subsidizing patients based only on their total income and eliminating market segmentation to select out preexisting conditions. Since the additional costs of carrying out this simple, streamlined program would be far less than the current complex and redundant bureaucracies, we can have great confidence that the total cost to the government would be one-half to three-fourths of what it spends today. There would be significant savings in the private sector as well.

All of this is good news. Indeed, under the scenario described here we could not only insure the entire US population for considerably less money than is currently being spent but also substantially slow the increase in the growth of health care costs compared with the growth of GDP.

How to administer the plan

Under this proposal, the premiums for the mandatory policy would be collected through routine deductions

[6]Assumes routine care subsidies of up to $1,000 a person for the subsidized population.

Exhibit 2

A dramatic change

Programmatic costs

Component		Age group	Millions of people	Total cost, $ billion	Government subsidy,[2] $ billion
Insurance		0–20	78	25	10
		21–65	183	385	154
		>65	39	292	263
	Subtotal		**300**	**702**	**427**
Allowances	Preexisting conditions		N/A	100	40
	Medicaid disabled and elderly		11.3	212	191
	Medicare disabled		6.6	35	32
	Routine care[1]		all	?	50
	Total			**1,049**	**739**
	New revenues				**220**
	Net costs to government			**N/A**	**519**

Per capita costs = $1,730

[1] Assumes routine-care subsidies of up to $1,000 per person for subsidized population.
[2] Figures do not sum to total, because of rounding.

Source: ehealthinsurance.com

from existing payroll systems. The employer would continue to receive a tax deduction for the amount it pays for insurance. However, the total *value* of each employee's insurance payments would be added to the employee's taxable income.

The reason for this change is that the existing scheme is highly regressive and massively subsidizes people who don't need help. Today's deductions pass directly through to the employee as the equivalent of tax-free compensation and effectively benefit the most well-off segments of the US population—those people with steady jobs and good salaries—while ignoring lower-paid and hourly workers, the unemployed, and millions of people working part time or for small companies. In effect, the existing scheme recycles money through the tax system and back to the people who paid it in the first place (in the form of employer-sponsored health care) while siphoning off a hefty percentage for administrative costs. Eliminating this problem would create roughly $220 billion a year in new revenues that could support more sensible subsidies.

The financial effect of the plan on workers would likely range from, at worst, a small negative impact to, at best, a moderately positive one. Only about one-quarter of all US taxpayers were above the 15 percent tax bracket in 1997. In other words, three-quarters of all filers paid a marginal rate of 15 percent or less. Therefore, taxing the value of health insurance would minimally affect lower-income groups. An individual earning less than $27,000 a year, for example, would bear an additional cost equivalent to 15 percent of the cost of the premium now paid by the employer—a relatively small burden and one that would be lowered further by subsidies, as explained in the next section. Even the wealthiest individuals would pay an additional amount equivalent to just 40 percent of the cost of the original policy. However, if the policy were cheaper to start with, as discussed earlier, many employees would be affected even less, and in some cases could even come out ahead

if employers fully compensated workers for the costs of the policy. Workers could also benefit from cheaper policies through increased compensation. How? Good old-fashioned competitive pressure might provide an employer with the motivation to increase its employees' salaries to counteract any expected tax hit. Businesses face growing pressure to attract and retain talent, and the benefits a company offers are a crucial part of its value proposition to employees. A recent McKinsey survey of US executives, for instance, found that the vast majority see employee benefits as important to their company's competitiveness.[7]

How would the subsidies work?

Of course, reapportioning the country's health care expenses in this fashion would make insurance even less affordable for low- and middle-income families—not to mention the millions of unemployed, elderly, or disadvantaged people who would also need help. Therefore, we must devise an equitable and efficient scheme to deliver subsidies.

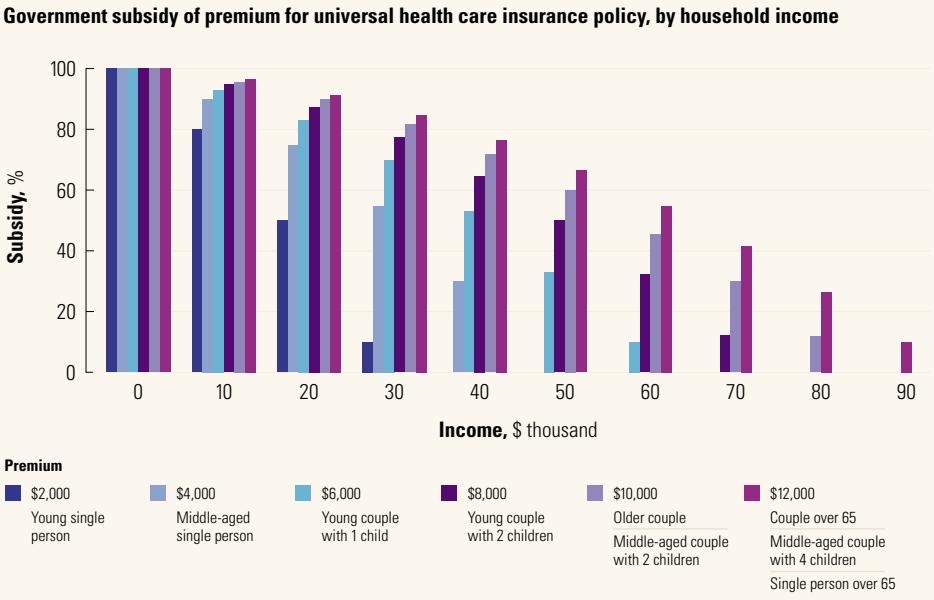
The system I propose would provide full coverage for those with no income, a substantial subsidy to those whose income placed them below the 20th percentile (around $20,000), and gradually diminishing subsidies thereafter as household income increases. All told, this approach would be roughly equivalent to subsidizing half of the cost of the mandated program. Such a system would provide health care to about 90 percent of our nation's elderly, as they tend to have lower incomes than those under age 65.

When the cost of a household's premium exceeded a specified maximum, the insurance company would simply bill the government for the difference (or the full amount in the case of the unemployed). The maximum would be set at 4 percent of income for those at or below the 20th percentile of income and around 10 percent at the 80th percentile—with graduated intervals in between and beyond this range.[8] Since 90 percent of US households include four people or fewer, most household premiums would fall somewhere

[7] "An executive perspective on employee benefits: A McKinsey survey," *The McKinsey Quarterly*, Web exclusive, June 2006.
[8] The choice of these parameters reflects the expected cost of the policy given our HDHP policy benchmark.

Exhibit 3

How the subsidies work



from $2,000 (single young adult) to around $10,000 (a typical family with two children, or two adults approaching retirement age).

Subsidies would be concentrated among families with lower incomes and high premiums. The richest 20 percent of the population would, for the most part, pay the full amount (Exhibit 3).

For instance, a family of four with a total income of $40,000 and a premium of $10,000 would pay a maximum of 6 percent of its income, or $2,400, and the government would pay $7,600. The same family with $60,000 of income would pay 8 percent, or $4,800, and the government would pay $5,200.

To ameliorate the burden that paying for routine care would place on the very poorest families or others who met predetermined income criteria, the government could provide individual, nontransferable credit cards (or charge accounts) that could be used only for routine care. The cards could have a rolling 12-month limit of, say, $1,000, and the US Internal Revenue Service could calculate the extent of the allowed subsidy as it would for other subsidies under the plan. Together with the charity care provided by hospitals—which would help any low-income families that had exceeded their rolling 12-month limits—this plan would ensure a safety net that was not regressive and could be managed with a minimum amount of bureaucracy.

The US health care system is failing fast. The nation now faces the prospect of having to deliver more health care than it can afford while continuing to provide for society's other needs. But there is another choice. By treating the causes of the crisis and not just its symptoms, we can refashion our health care system into one that is more equitable, effective, and efficient for everyone.