

Designing US health insurance from scratch: A proposal for universal basic coverage

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Designing US health insurance from scratch: A proposal for universal basic coverage

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Abstract

U.S. health insurance policy has proceeded incrementally, and haphazardly, for over half a century. In this proposal we consider what an ideal system would look like, freed from political, but not economic, constraints. We start by articulating the goal behind our policy history, arguing that it reflects an attempt to fulfill a societal commitment to try to provide access to essential health care regardless of resources. From this perspective, we identify three fundamental issues with the state of U.S. health insurance coverage: the uninsured, the widespread risk of insurance loss for those who have insurance at any given moment, and the potential for catastrophic medical bills even for those who maintain their coverage. The solution we propose is universal basic coverage, with an option to buy supplemental coverage in a well-designed market. The universal coverage would be provided automatically and for free—without any patient fees—but it would be quite basic, similar to what Medicaid enrollees currently receive. A budget would be set and imposed to force decisions about what is included in that basic coverage.

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I. Introduction

There's no shortage of proposals for U.S. health insurance reform. They invariably focus on the 30 million¹ Americans who lack insurance at any given moment. But the U.S. health insurance problems are much more deep-rooted than that, extending to most of the remaining 90 percent of Americans who currently have insurance. Many live with the constant danger of losing that coverage if they lose their job, give birth, get older, get healthier, get richer, or move. And even if they manage to maintain their insurance, most insured Americans can still face enormous medical bills for their "covered" care.

In other words, the coverage we do have is a universal mess. It is nonsensical by design or, more accurately, by lack of design. It was never deliberately planned as a coherent system. Rather, it has emerged haphazardly, with different parts created at different times to deal with different issues that got thrust into the limelight when a particular policy window opened.

These incremental policy patches, though they have given many Americans health insurance coverage at least temporarily, have still left us with a system with large gaps. Individuals can lose coverage, often without realizing their eligibility had changed from one type of coverage to another. Others fail to reconfirm their continued eligibility for their current program, or they do not manage to even enroll in free coverage for which they are eligible in the first place.

In this proposal we consider what an ideal system would look like if we could start from scratch, freed from political—but of course not economic—constraints. The goal is to provide a "north star" that can be used to assess alternative policy proposals, both radical and incremental. To do so, it is imperative to begin by defining the goal of U.S. health policy. It's shocking to us how much of the debate over U.S. health insurance reform never clearly articulates its goal. We can't argue about the solution until we define—and hopefully agree on—the problem we are trying to solve.

We argue that the purpose of U.S. health insurance policy is to fulfill a long-standing societal commitment to try to provide access to essential health care regardless of resources. Whether or not one agrees that this is what our social contract should be, our policy

history makes it clear that it is the de facto social contract under which the U.S. operates.

Our proposal follows naturally from this social contract. 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 only solution is to formalize that commitment up front with insurance coverage. This is an argument for universal coverage. It is not a new argument but one that has been recognized and embraced by intellectuals and politicians across the political spectrum.

Our proposal has two key principles: universal coverage for a basic set of medical services and the option to buy additional, supplemental coverage in a well-designed market. This two-part solution is dictated by a social contract that requires a standard of adequacy but not equality. Hence, a basic, adequate set of medical services would be universally covered, and individuals would also have the option to top it up and buy more.

There's something in our proposal to upset everyone. We'll emphasize that all medical care included in basic coverage must be provided to patients for free; this is heresy to the economics profession and to the many countries that have followed economists' advice and tried to make patients pay out of pocket for part of the cost of their universally covered care. But we'll also insist that basic coverage should be just that: basic. There is a lot of medical care that is desirable but not essential and can be left out of basic coverage. The same goes for many nonmedical aspects of care: the ability to see the doctor of your choice at your preferred timing and location, or semiprivate hospital rooms.

Keeping basic coverage basic will keep the cost to the taxpayer down. Yet, another key element for controlling government health care spending will be a budget for publicly funded health care. Remarkably—and absurdly—the U.S. government has never actually had a health care budget that caps the amount it can spend on medical care. This also has to change.

Our discussion and proposal synthesize the arguments we set forth in our recent book, *We've Got You Covered: Rebooting American Health Care* (Einav and Finkelstein 2023a).

II. The challenge

Health insurance is an economic product, not a medical one. Its purpose is to provide financial protection against the high medical expenses that often accompany acute sickness or chronic poor health. This ensures that individuals do not need to forgo essential medical care or cut back on housing, food, or clothing in order to afford the medical care they need. Viewed from this perspective, the American health insurance “system” has failed.

A. Key problems

Policy attention tends to focus on the 30 million Americans who lack health insurance at a given point in time (Keisler-Starkey and Bunch 2020). This is, of course, a very real and important problem. But the focus on the uninsured masks two other critical problems faced by the remaining 90 percent of Americans who are fortunate enough to have health insurance at any given moment: (1) high out-of-pocket medical expenses for their so-called covered care and (2) the constant risk of losing this coverage.

High out-of-pocket medical expenses.

As a financial product that is supposed to protect its customers against large medical expenses, most U.S. health insurance coverage scores poorly. Every year, about one-quarter of nonelderly American households report trouble paying their medical bills. In more than half of these households, the person who incurred the bill was insured when treatment began and often remained insured throughout their treatment (Hamel et al. 2016).

Medical debt is enormous. In early 2020—before the Covid pandemic started—there was \$140 billion in unpaid medical bills held by collection agencies. To put that number in perspective, that’s more than the amount held by collection agencies for all other consumer debt from nonmedical sources combined (Klender et al. 2021). And here’s the really shocking part: three-fifths of that debt was incurred by households with health insurance (see figure 1).

Partly, this reflects a trend toward higher cost sharing in private health insurance plans. High-deductible health insurance plans, in which the patient

must pay the first couple thousand (or more) dollars of any medical spending for the year, are increasingly common. By 2019, almost one in three workers with employer-provided health insurance were in such plans (Claxton et al. 2020). Another big source of high out-of-pocket medical expenses for the privately insured is the designation by the insurer that certain doctors and hospitals are “out of network.” In this case, the amount the patient has to pay out of their own pocket is typically two to three times higher than it otherwise would be (Cooper and Scott Morton 2016; Cooper, Scott Morton, and Shekita 2020).

Even among the elderly, all of whom have health insurance, about 10 percent report that they have unpaid medical debt (Bennett et al. 2021). In 2016 those enrolled in traditional Medicare spent, on average, over \$5,000 out of their own pocket for their medical care, and a quarter of traditional Medicare enrollees spent 25 percent or more of their income on medical care (Cubanski et al. 2019). These gaps are no accident. They reflect a deliberate decision by the government to make traditional Medicare patients pay for some of their medical care.² In fact, traditional Medicare’s design leaves its “insured” patients exposed to unlimited medical bills, with no limit to how much they may have to pay in doctors’ bills. Every time they see a doctor, they are on the hook for 20 cents of every dollar of their bill, no matter how high those bills get. That’s not how well-designed insurance should work.

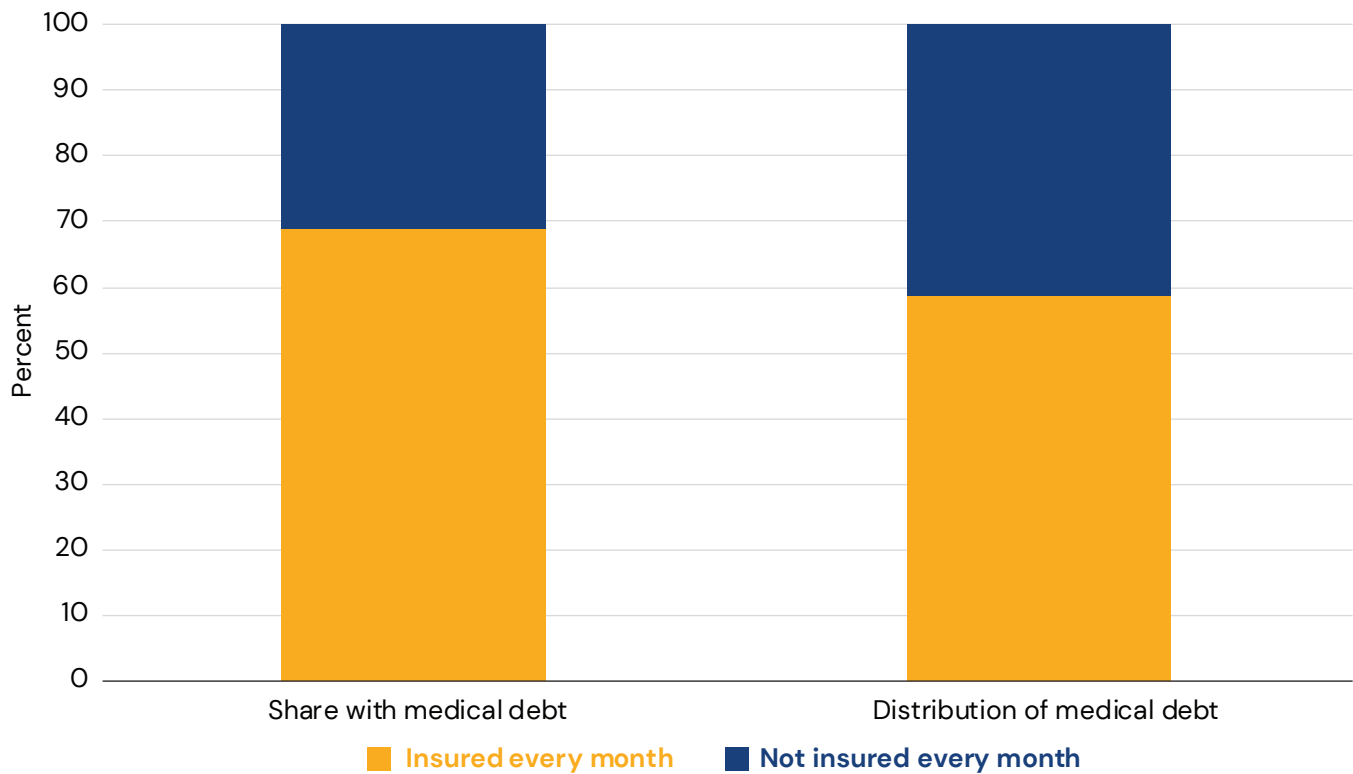
Uncertain coverage.

A second critical issue for those who have insurance is its uncertainty. Insurance is supposed to provide a measure of economic security and certainty in an uncertain world. Yet, perversely, health insurance coverage is itself highly uncertain, and many live with the constant risk of losing their coverage.

Consider this: in any given month, about 12 percent of Americans under 65 years of age are uninsured. But as figure 2 shows, just as many Americans who have insurance will experience some time without insurance coverage over a two-year period. The risk of losing insurance coverage affects all insured Americans under 65, including those who are covered through employer-provided health insurance, Medicaid, or

FIGURE 1

Burden of medical debt by, health insurance status, 2018



Source: Kluender et al. 2021; Survey of Income and Program Participation 2018; authors' calculations.

Note: The left bar considers the set of households who have any medical debt, and shows what share of them are insured or not. The right bar shows the share of total medical debt that is held by households with health insurance and the share held by households without health insurance. Those who are not insured every month are households that reported at least one month of no health insurance coverage in 2018.



private health insurance exchanges. And when people lose their health insurance coverage, they typically don't quickly regain coverage. At least half are uninsured six months later, and over one-fifth are still uninsured almost two years later (Einav and Finkelstein 2023b; Gai and Jones 2020).

The 2010 Affordable Care Act substantially reduced the risk of being uninsured in any given month—from 20 percent of Americans under 65 to 12 percent—but the risk of an insured individual losing their coverage barely changed (Einav and Finkelstein 2023b). That's an inevitable consequence of the incremental approach to health insurance reform that the U.S. has pursued for over half a century.

B. Why start from scratch?

It's tempting to try to design incremental reforms to fix these problems. Extend coverage to those who still lack formal insurance. Change the laws so that getting sick, getting well, changing jobs, or moving states doesn't come with the risk of losing insurance coverage. Make sure all insurance plans meet some

minimum standard for financial protection against large out-of-pocket medical bills.

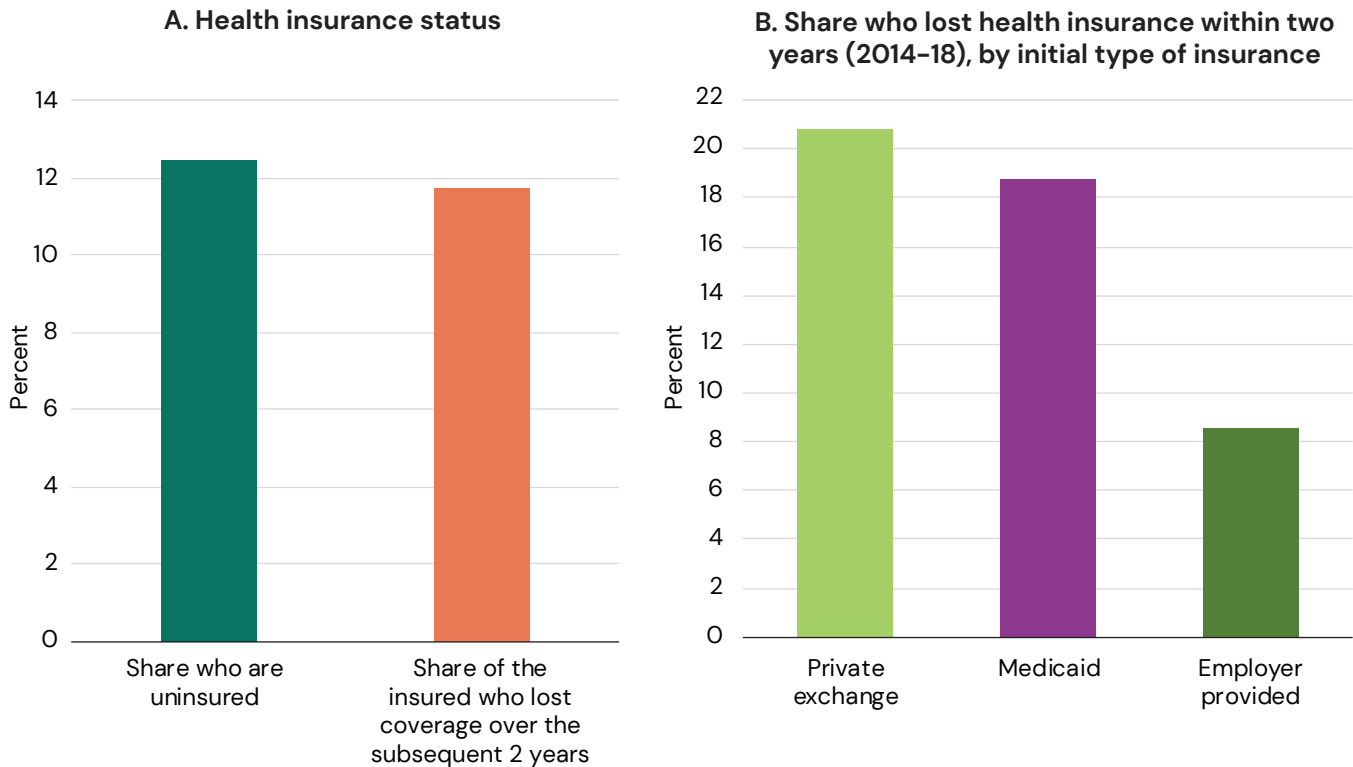
For more than a half century, we've tried this approach. We've created a series of different programs through which individuals can get free or taxpayer-subsidized health insurance if they have the right job, right disease, or right income, or are the right age.

Insurance uncertainty is the inevitable consequence of this patchwork approach. Whenever there are multiple pathways to health insurance coverage, there will always be people who don't find their path or who can't stay on it.

Making people eligible for coverage isn't the same as covering them, even when that coverage is available for free. People can't sign up for programs they don't know about. Moreover, they often have trouble enrolling—or staying enrolled—in the ones that they do learn about. The result is that about 6 out of 10 uninsured Americans are in fact eligible for free or heavily discounted health insurance. Some estimates suggest that over one-quarter of uninsured parents, and as many as three-quarters of uninsured children, are

FIGURE 2

Health insurance coverage



Source: Einav and Finkelstein 2023b; Medical Expenditure Panel Surveys 2014-18; authors' calculations.

Note: The population is limited to Americans under age 65.



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eligible for but not enrolled in coverage that would be completely free (Cox and McDermott 2020).

The existing health insurance coverage “system” was never deliberately planned. Rather, it has emerged haphazardly, with different parts created at different times to deal with different issues that got thrust into the limelight. Since the rise of modern medicine and modern medical expenses in the mid-20th century, our health policy history has consisted of an endless series of patches, repeatedly layered on top of a broken system. Inevitably, gaps emerge at the seams, leaving these patches to punch considerably below their weight, even for the narrow set of people they are designed to serve.

Consider, for example, the policy response to the creation of a life-saving new technology in the early 1960s. The development of dialysis—essentially an artificial kidney—offered a possible reprieve from a death sentence for patients whose kidneys had failed. Yet most patients couldn’t afford the cost. What ensued was a public outcry, sustained advocacy efforts, and public pressure, including a dramatic moment in which a patient was wheeled in and dialyzed in front of a congressional committee (Blagg 2007; Rettig 2011). Congress ultimately responded in 1972 with legislation

that provided health insurance coverage to patients suffering from end-stage kidney disease. Yet the program will not cover medical care that might prevent kidney disease from progressing to the end stage. And should a patient be fortunate enough to have a successful kidney transplant and recover kidney function, they will lose their coverage—since they no longer have *end-stage* renal disease—despite the fact that they now have to be on immunosuppressant drugs that cost thousands of dollars a month for the rest of their life (Gordon, Prohaska, and Sehgal 2008).³

A similar patch-with-a-catch situation is the 1986 federal law designed to ensure access to care for all patients in the event of a medical emergency. Prompted by outrage over infamous cases in which hospitals refused to treat patients in an emergency—and several decades of failed state and federal efforts to prevent this practice of “patient dumping” (Treiger 1986)—Congress required hospitals to screen all patients who came to the emergency room and to stabilize anyone who had an emergency medical condition, regardless of their ability to pay (Lee 2004). One catch is that nothing prevents the hospital from billing the patient for this emergency care, meaning a life-saving treatment can be followed by life-crushing bills. Another is

that the hospital is only required to stabilize the patient, not to actually treat the underlying medical issue or ensure they get the proper follow-up care. Hospitals won't actually treat the cancer or the heart disease, just the emergency it happens to produce at that moment. After that, the patient is not their problem—at least until her untreated condition produces the next emergency.

Sometimes the inadequacy of a policy patch will then prompt additional patches. In the 1980s, for example, Congress was confronted with the spectacle of people who could not afford cancer screening and were dying from breast and cervical cancer that would have been treatable if caught earlier. Faced with low screening rates in low-income communities, in 1990 Congress provided funds to pay for breast and cervical cancer screening (Lee et al. 2014). As a result, screenings increased substantially. But this success highlighted the program's flawed conception: it paid to detect cancer but not to treat it. Powerful advocacy groups—including the National Breast Cancer Coalition and the American Cancer Society—mobilized for change. They argued that it was unethical to diagnose people with a disease without providing them with a means to treat it (Lantz, Weisman, and Itani 2003), and eventually succeeded in creating a second patch. In 2000, Medicaid eligibility was expanded to cover women with breast or cervical cancer. That is, a woman is covered as long as she is the “right age” and her cancer is diagnosed at a clinic funded through the original program, in a state that offers this optional Medicaid program. And, of course, if her cancer goes into remission, her coverage then ends (Kaiser Family Foundation [KFF] 2019b).

That's not how health insurance is supposed to function. This has to change.

C. Defining goals

To do so, we must start by defining the goal. What is the problem that fundamental health insurance reform should be designed to solve? We can't engage in design until we are clear on its purpose.

There are, of course, many possible reasons for government to get involved with health insurance policy: to improve people's health and well-being, to ensure that access to medical care shouldn't depend on income, and because Adam Smith's “invisible hand” can't work its magic in the medical marketplace. The list goes on.

But when we looked carefully, we discovered a need for universal health care that does not stem from any of these familiar reasons. Rather, it is rooted in our unwritten social contract: access to essential health care regardless of resources.

The existence of such a contract may be hard to believe in the only high-income country that has not enacted universal health insurance coverage and a society that also advocates for lifting oneself up by the bootstraps. Yet from colonial to modern times, the record is clear: our country has always tried to provide essential medical care to those who are ill and unable to provide for their own care.

In the 18th century, this obligation led then-Secretary Treasury Alexander Hamilton to champion policy that resulted in the brand-new U.S. government creating the world's first national, compulsory, tax-financed health insurance. It was designed for commercial sailors who had 20 cents per month deducted from their wages while at sea, which was handed over to the federal government. This money helped fund the costs of local hospital care for sailors who, upon returning to port cities ill and far from family members, could become burdens on the local communities that felt compelled to care for them (Levinson 2018; Straus 1950).

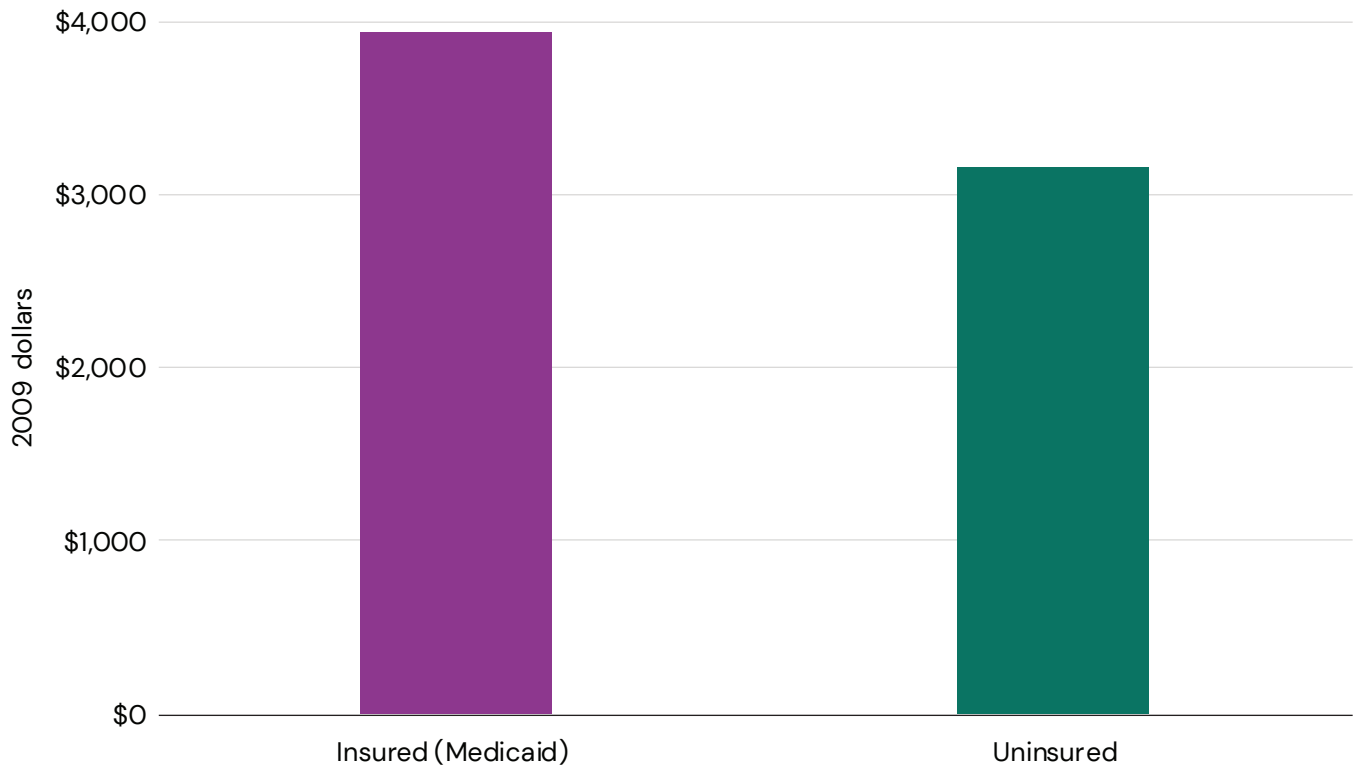
In the 20th and 21st centuries, this same social norm has been the impetus behind much of our history of sporadic and ad hoc insurance reforms that have created insurance coverage for those whose plight has become politically salient. Laws have created coverage for specific groups: people with particular diseases (at least until they recover), low-income children (until they grow up; Brooks et al. 2020), patients experiencing an emergency (until they are “stabilized”; Lee 2004), pregnant women (until shortly after they give birth; Gomez et al. 2022), hostages and their family members (during their captivity and for a limited time after it; Causey 1990), the disabled (after waiting two years; Social Security Administration 2020), prisoners (until they are released from prison; McDonald 1999), and the list goes on.

This same social contract is also behind the piecemeal slew of policies at the federal, state, and local level that has created a large, complex web of publicly regulated, publicly funded programs that provide free or low-fee care for those who lack formal health insurance. The end result of all these policies is illustrated in figure 3: the 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. And they pay for only about 20 cents on the dollar for that medical care (Finkelstein, Hendren, and Luttmer 2019). In other words, the so-called uninsured are not actually uninsured. Of course, like those with formal insurance, they also aren't well insured. It turns out there's a lot more commonality in the medical care received and (not) paid for by the insured and the uninsured than those labels might suggest.

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,

FIGURE 3

Average annual medical expenditures in the Oregon Health Insurance Experiment, 2009



Source: Finkelstein et al. 2012; authors' calculations.

Note: Data are from the Oregon Health Insurance Experiment and reflect the 2009 average annual medical spending on low-income, non-elderly uninsured adults, and the estimated increase in that spending from gaining Medicaid coverage. Finkelstein et al. (2012) provides more detail.



the only solution is to formalize that commitment up front with insurance coverage. Alexander Hamilton articulated this argument over two centuries ago. Within the last few decades, it has been embraced by American leaders from across the political spectrum as a rationale for universal health insurance coverage. Perhaps most tellingly, even libertarians like Charles Murray, who advocate for universal basic income as a way of taking the money that the government currently spends on social transfer programs and returning it to the American public as cash, support compulsory

health insurance. The only restriction he would impose on his proposed \$13,000 annual cash grant is a requirement that \$3,000 of it must be used to purchase catastrophic health insurance (Murray 2016). Otherwise, if someone chooses to spend their income elsewhere and falls ill without the resources to cover their medical care, our history makes the consequences clear. Inevitably, the government will feel compelled to set up policies and procedures to try to provide the essential medical care that the individual cannot afford.

III. The proposal

Our policy proposal for universal basic coverage has two key elements. The first is universal coverage that is automatic, free to the patient, and basic. The second component is a well-functioning marketplace for supplemental coverage, which is available to those who want and can afford more than the basic. We unpack each of these in turn.

A. Universal coverage that is automatic, free to the patient, and basic

Automatic

The United States has already enacted universal coverage; it just hasn't achieved it. When we require people to sign up, not all of them do. To achieve universal coverage, it must be automatic.

The country's experience with the health insurance mandate under the Affordable Care Act makes that clear. Despite the so-called mandate that requires uninsured Americans to purchase coverage on their state's health insurance exchange, about 1 in 10 Americans under 65 years of age remain uninsured (Einav and Finkelstein 2023b).

In contrast, the U.S. experience with automatic Medicare coverage for hospital and physician services has worked much better (Ball 1966). Those who are collecting Social Security are automatically enrolled in Medicare the month they turn 65. Three months before their birthday, they are mailed a Medicare card (Centers for Medicare and Medicaid Services [CMS] 2018). The result is that virtually all of the elderly have health insurance (Keisler-Starkey and Bunch 2021).

Free

Patients would pay nothing for the basic care provided through universal coverage: no premiums and no patient cost sharing. Our argument against individuals paying health insurance premiums follows directly from the need for coverage to be automatic; requiring

people to pay premiums interferes with providing coverage automatically.

Our argument for no patient cost sharing for care covered by the universal basic coverage—no copays, deductibles, or cost sharing—borders on heretical for economists. 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 health care spending will be lower.

The economic theory is simple: if something becomes more expensive, people will buy less of it. Or in other words, demand curves slope down, as we say in Econ 101. Yet many people, particularly non-economists, have found the idea that patient payments can be used to rein in health care spending to be implausible, even absurd. Medical care, they argue, isn't a “good.” No one wants a colonoscopy or chemotherapy (Stone 2011). Rather, the argument goes, the amount of medical care is determined by medical needs (Gladwell 2005). All patient cost sharing does is switch around who pays for that care, moving risk from the insurer to the patient. Some have gone further, arguing that health insurance could even decrease use of medical care, either by improving people's health and increasing the timely and effective use of preventive care and chronic disease management or by getting uninsured individuals out of the expensive emergency room and into cheaper primary care (State of Michigan 2013).

But the empirical evidence is incontrovertible. The demand for medical care is not that different from the demand for other consumer products. When patients must contribute to the cost of their medical care, they use less of that care. This results in 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 (review articles that describe some of this evidence include Cutler and Zeckhauser 2000; Einav and Finkelstein 2018; and Finkelstein, Mahoney, and Noto-widigdo 2018).

Some of the early evidence on this came from the RAND Health Insurance Experiment in the 1970s, which randomly assigned health insurance products with different cost-sharing provisions across about 2,000

nonelderly families for three to five years. The results showed that families assigned to plans with more patient cost sharing used less medical care, and families in the free care plan (with no cost sharing) used the most care. Several decades later, results from the 2008 Oregon Health Insurance Experiment—in which about 10,000 uninsured nonelderly adults below the federal poverty line were randomly assigned Medicaid coverage by the state of Oregon—also found that covering low-income uninsured adults with Medicaid increases health care use across the board. The 2007–2009 Accelerated Benefits Demonstration project—which randomly assigned public health insurance to about 1,000 uninsured adults on Social Security Disability Insurance during their two-year waiting period for Medicare likewise found that those randomly assigned to health insurance coverage used more medical care. There is also a large body of quasi-experimental evidence from policy-induced variation in health insurance coverage that corroborates the same finding.

Often, that additional care—the care that patients wouldn't have gotten had they had to pay for it—is not essential for their health. It's for this reason that economists have consistently advocated for patient cost sharing, which would 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 health care spending (Zare and Anderson 2013).

In the UK, for example, patients nominally face small copays for vision care, dental care, and prescription drugs. However, there are copious exemptions (Delamoth 2008). These exemptions apply to people with particular diseases, those below certain incomes, individuals below and above certain ages, people with disabilities or work-related injuries, full-time students, women who are pregnant or have recently given birth, and veterans of certain wars. There are different exemptions for different treatments (Rivett 2019). In fact, there are so many exemptions that they have proven to be the rule rather than the exception. In 2019, only about 10 percent of all prescriptions in England

involved patient copayments; the rest were dispensed for free (Kulakiewicz, Parkin, and Powell 2022).

Indeed, every high-income country we looked at that has cost sharing in its universal coverage system also has policies to make sure most people don't actually face that cost sharing. A list of Israel's cost-sharing exemptions runs to over six pages long (Clalit 2021). In France, the national health insurance program has high cost sharing but also government programs that cover that cost sharing for low-income individuals, as well as tax subsidies and mandates for employers to offer supplementary coverage (Chevreul et al. 2015; Sagan and Thomson 2016; Zare and Anderson 2013). The end result is that almost everyone in France—95 percent of the population—has coverage for their cost-sharing obligations (Tikkanen et al. 2020a).

U.S. 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 (Johns and Adler 1993). 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 (Deutcher Budestag 2012; Tambor et al. 2011).

There's a reason for this pervasive tendency to eliminate or cover most of the cost-sharing requirements in universal coverage programs. It stems from the unwritten social contract to provide access to essential health care regardless of resources. It is the same driving force that is behind the American patchwork approach to cobbling together health insurance for 90 percent of the population, just played out in these other countries on the smaller scale of cost sharing for universally covered care.

The lesson is clear. Any medical care that is included in basic coverage must be completely free to the patient. There will always be people who can't manage a \$5 copay for a prescription drug or a \$20 copay for a doctor visit (Gross, Layton, and Prinz 2022). This is why the experience of other countries has shown that attempts to include cost sharing in basic coverage inevitably puts us back in the same mess of trying—and not fully succeeding—to come to the aid of patients who cannot afford the required payments for that basic coverage.

Of course, this argument does not apply to supplemental coverage that covers care not included in the basic package. By definition, anything not covered by the basic package is not essential. Therefore, there is no imperative to make sure everyone can access

that care. For supplemental coverage, insurers should be free to impose whatever cost-sharing requirements they wish. In any well-functioning marketplace for supplemental health insurance, cost sharing would be reflected in the pricing of insurance and would thus be internalized by both insurers and potential customers.

Basic

Basic coverage should cover health with minimalist (yet adequate) care and no more; the rest is gravy. The social contract is about providing essential medical care, not providing a high-end experience. 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. And those who have the money and want to do so can upgrade to business class. 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.

Nonmedical amenities would be one aspect by which basic coverage would be limited. There are two distinct words in health care: health and care. When it comes to basic coverage, it's important to separate them. Our social contract is about the health part of health care—maintaining and restoring essential function. But our social contract requires very little when it comes to the care part of health care, all the nonmedical aspects of the experience.

Many countries have taken exactly this approach of separating health from care. In Singapore, for example, hospitals offer a range of hotel-like amenities. The VIP treatment, known as a class A1 ward, gets the patient a single room, with a private attached bath and television; it also comes with air-conditioning, no small matter in Singapore's notoriously hot and humid climate. At the other end of the spectrum, the no-frills accommodation has 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 (Tikkanen et al. 2020b).

Australia's system is similar. Their universal basic system covers no-frills doctors and clinics with patients paying nothing out of pocket. Those who want more need to pay for it, and the government encourages people to take out private insurance for this. The private insurance primarily improves upon nonmedical aspects of care—fewer people in a room, better food, more choice of physician. Physicians who practice in both systems in Australia describe a more relaxed and high-touch environment at the private hospital, where

they can devote more time to establishing a relationship with their patients. But the consensus is that the medical care the public sector hospital delivers, while lacking in amenities, is adequate (Bath 2021; Freed, Turbitt, and Allen 2016; Mihm 2020; Willis and Lewis 2022).

Longer wait times for nonurgent care would be another aspect of basic coverage. In the United States, audit studies have consistently found that patients with Medicaid coverage have to wait longer to get a doctor's appointment than patients with private insurance (Cama et al. 2017; Hsiang et al. 2019; Saloner et al. 2019). But while Medicaid wait times may not be ideal, they nonetheless appear to be reasonable, at least judging by what the U.S. has explicitly delineated to be "reasonable" wait times and travel times for care provided to its veterans through the U.S. Department of Veterans Affairs (VA). Its current standards for veterans' limit wait times are 20 days for primary care and mental health care and 28 days for specialty care, with acceptable drive times set at 30 minutes and 60 minutes, respectively (VA 2019). Typical wait times for Medicaid patients fit within these VA standards (Levinson 2014; Saloner et al. 2019). These VA standards in turn seem to fit within the general consensus of what other countries mean by "reasonable access" (OECD 2020; Siciliani, Borowitz, and Moran 2013). Put differently, a universal basic insurance system that had wait times comparable to what many Medicaid patients experience would provide an adequate standard of care.

Finally, with no cost sharing, the insurer would have to play a more active role in determining the essential elements of medical care that a patient should get. The insurer can help reduce costs by eliminating unnecessary medical care that a patient and a physician—who don't bear the financial costs of treatment choices—might otherwise be tempted to try.

It will be important to build this "gatekeeping" role into basic coverage if it is to remain basic. Examples of gatekeeping include requirements that a patient see her primary care provider to determine if a visit to a specialist is warranted as well as requirements for physicians to get prior authorization for certain medical services. These types of gatekeeping are common for most of the currently insured in the United States. By contrast, traditional Medicare imposes essentially no constraints or guardrails on the medical care that patients can seek or physicians can deliver. Rather, it acts as a passive bill payer. Patients with traditional Medicare are free to see whichever doctor they want, and their doctors in turn are free to order whatever tests and procedures they deem warranted (Berenson and Harris 2002; CMS n.d.b.). The originating statute explicitly prohibits Medicare from interfering with the practice of medicine or limiting patient access to physicians (Ball 1995; Berenson and Harris 2002). This will have to change with basic coverage in order to keep costs down.

Controlling costs

Keeping basic coverage basic will keep the cost to the taxpayer down. Yet, another key element for controlling government health care spending will be a budget for publicly funded health care. Remarkably—and absurdly—the U.S. government has never actually had a health care budget that caps the amount it can spend on medical care. This also has to change.

The idea that we should have a federal health care budget is banal. This is what the U.S. government does for most other goods and services it provides, from infrastructure to education. And it is what essentially every other high-income country does (Emanuel 2020; Hacker 2008; White 1995). Typically, these budgets are enforced by implementing cost containment policies if they are exceeded (Paris, Devaux, and Wei 2010).

But a federal health care budget is also radical, as the U.S. government has never had to live within a health care budget (Skinner, Cahan, and Fuchs 2022). Congress tried to set a budget cap for Medicare spending as part of the 1997 Balanced Budget Act, but it never enforced it and ultimately eliminated it on paper as well (Fontenot et al. 2015; Samuel 2015; Wynne 2015).

This lack of a budget has had extraordinary consequences. Fifty years ago, the health care sector in the United States was about the same share of the economy as it was in these other countries. But for the last half century, U.S. health care spending as a share of the economy has grown twice as fast as the average in other high-income countries (OECD 2022; Skinner, Cahan, and Fuchs 2022). Other countries take costs into account (along with “societal values”) in deciding what new treatments to cover. Not so with Medicare. By law, it is explicitly forbidden from considering costs in making coverage decisions. As a result, Medicare spending has inexorably grown as a share of both the economy and federal spending.

Only once a clear budget exists can policymakers engage in the tough choices of how to meet it—what new technologies to cover, for example—or whether to raise taxes to expand what is covered. Inevitably, those choices will leave some people wanting more, and that’s where supplemental coverage comes in.

B. Supplemental coverage

For many of the currently insured, basic coverage would offer some important advantages. It would provide the certainty of continued coverage that the insured currently lack, and it would eliminate the risk of crushing medical bills that many of the insured face.

Still, for the 60 million people on Medicare, or the 150 million people fortunate enough to have health insurance through an employer (KFF 2019a, 2020), basic

coverage would in many respects be a lot more, well, basic. Which is why, just as in airlines, many will want to upgrade their coverage beyond the basic. 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.

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

Our proposal would allow people to pay on the margin for supplemental coverage rather than having to re-purchase the basic coverage in order to supplement it.

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 allow upgrades 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. And it’s the approach we advocate for on the basic economic principle of efficiency.

One way to implement the upgrade design is to follow the approach that the United States takes in its Medicare program. When individuals want to replace their public Medicare coverage by purchasing private insurance, the private insurer assumes responsibility for all of the basic benefits that would be provided by public Medicare coverage, and the government pays the private insurer what it would have cost the taxpayer to cover the enrollee with the public Medicare plan. In other words, those who are Medicare eligible implicitly receive a voucher, which they can use either to pay for their public Medicare in its entirety or toward paying for a private Medicare plan.

A chief concern with this kind of top-up design is that the government can end up overpaying private insurers to provide basic coverage. This can happen if those who enroll in private plans are healthier—and therefore have lower medical expenses—than those who remain with only basic coverage. Fortunately, there are other tools the government can deploy to try to keep private firms from serving only the cheapest-to-serve customers. In the case of the Medicare

program, for example, the government started customizing the payment to a private insurer for covering an enrollee based on the enrollee's medical history, paying the private insurer less to enroll a healthier customer, at least on the dimensions of health the government could observe. Another tool the government introduced is to limit the opportunities people have to switch between public and private plans (Cooper and Triverdi 2012; McGuire and Newhouse 2018; Newhouse and McGuire 2014). What this means is that a healthy customer who chooses private Medicare can no longer switch out when they get an unexpected diagnosis or start to experience joint pain. Although it's not perfect—Medicare enrollees are still about 1.5 percent healthier than public Medicare enrollees (Curto et al. 2021)—the government's payment system for the private Medicare market seems to work pretty well. This may be why it has mostly flown under the radar despite its substantial size. Outside of health policy circles, most people don't realize that two-fifths of Medicare enrollees have exercised their option to leave the public system.

Preventing erosion of basic coverage

Perhaps 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. But that isn't a reason to outlaw what every place other than Cuba, North Korea, and a few Canadian provinces allows (Flood and Archibald 2005; Pinker 1999; WSJ 2005). It's not inevitable that supplemental coverage will have deleterious effects on basic coverage, and if it does, there are workable solutions in place.

Supplemental coverage poses two potential types of threats to the basic system: economic and political. From an economic perspective, the supply of high-quality medical providers is limited, at least in the medium run. The concern is that the supplementary system may pay physicians and other medical providers more than they are paid in the basic system, in order to attract some of the best doctors and reduce wait times in the supplemental system. And that can mean fewer doctors—or fewer of the best doctors—in the basic system. From a political perspective, if more and more of the higher-income patients opt for private coverage, this can erode political support for the requisite public funding of the basic system. Together, these economic and political 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 health care systems that

are chronically underfunded and widely considered inadequate. Those who are better off buy into an entirely separate private system in a situation that some have likened to "medical apartheid" (Atun et al. 2015). Likewise in Israel, a government committee that was formed to investigate and address concerns about excessively long wait times for appointments in the basic system concluded that the growth of supplementary coverage—which over 80 percent of the population had—was an important cause of the problems with basic coverage; supplemental coverage had eroded the finances of the basic system as well as public support for that financing (State of Israel 2014).

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 and Tapay 2003), and 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 percent 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 and Tapay 2003). Likewise, government policy in the United States has actively encouraged the growth of the private Medicare system (McGuire, Newhouse, and Sinaiko 2011; Patel and Guterman 2017). 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 United States helps "pay for" the care of publicly insured and uninsured patients (Garthwaite, Gross, and Notowidigdo 2018). We are still waiting for the research that may support that hypothesis, but it—and the actions of the U.S. and Australian government—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 in Israel created for the basic coverage. But fortunately, we don't have to. The Israeli experience has underscored that when these problems materialize, there are some rather straightforward government solutions, including a funding increase to the basic system and introducing incentives for physicians to work full time in the public system (State of Israel 2014). The UK had already enacted something similar, requiring physicians who want to work for the public

system to work at least 40 hours a week in the public system before they do any private consulting (Williams and Buchan 2006). Other countries—including Norway, Denmark, and Portugal—have agreed to pay for patients to go to the private sector if wait times exceed what they have deemed to be the maximum allowable limit (Barros, Cristivao, and Gomes 2013; Bath 2021; Denmark Ministry of Health and Prevention 2008; Gomes 2016; Helse Norge 2019; Siciliani, Borowitz, and Moran 2013). The U.S. Congress has adopted

this approach as well for care provided to veterans through the Veterans Administration (VA 2019).

In other words, 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 a free and active market for supplemental coverage can nicely complement—and perhaps even benefit—the basic system.

IV. Questions and concerns

How much will this cost the taxpayer?

Basic coverage will be taxpayer financed. As a result, there's a real possibility that taxes would rise in the United States to finance a universal basic coverage that fulfills our social contract. But that's a choice. Taxes would not need to rise to finance basic coverage.

To see this, consider the level of government health care spending in countries whose basic coverage—automatic coverage with (almost) no consumer payments—looks similar to what we propose. The UK is one example. Canada and Germany are others.

As seen in figure 4, in 2019, total health care spending in these countries was about 8 to 9 percent of their economy, with most of this spending financed by taxpayers. U.S. taxpayers also spent about 9 percent of the economy on health care. To be clear, 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 percent in the U.S. in 2019. This contrasts with 12 percent in the next highest spending country that year and an average of 9 percent across OECD countries. However, this higher U.S. spending primarily reflects higher *private* spending, not higher public spending.

What medical care would be included in basic coverage?

The point of basic coverage is to fulfill our social contract to provide access to essential medical care for those who are ill regardless of resources. Therefore, basic coverage must cover all essential medical care for the critically ill, including outpatient care, inpatient care, and emergency care.

Basic coverage must also include primary care and preventive care for those who are not yet critically ill even though they may not be in our revealed social contract. Primary care is cheap, and among insured individuals in the United States, it accounts for only about 5 percent of total health care spending (Kemp-ski and Greiner 2020; Martin et al. 2020). Primary care should be the first point of contact for preventing illness, for diagnosing and treating new medical issues, and for managing ongoing chronic conditions. It makes no sense to commit to provide care once someone is experiencing a medical crisis but not to provide the

primary care that could prevent or manage a condition before it becomes a crisis. There's also a set of services that obviously wouldn't be included in basic coverage. Purely cosmetic surgery services are probably the most obvious.

But beyond that, there's a large gray area of care that's not obviously essential medical care but also not obviously outside of the basic coverage. For example, infertility treatment, dental care, vision care, physiotherapy, treatment of erectile dysfunction, various forms of long-term care—the list goes on and on. Here, different countries have made different decisions.

We don't specify coverage of these "gray area" services for several reasons. First, it's an area where reasonable people can disagree, and it's not for us to make those calls. Second, it depends on the budget for basic coverage. And third, this isn't a "one and done" decision. Coverage decisions for the basic coverage will have to be made on an ongoing basis as incomes grow, medical technology improves, and notions of what constitutes disease evolve.

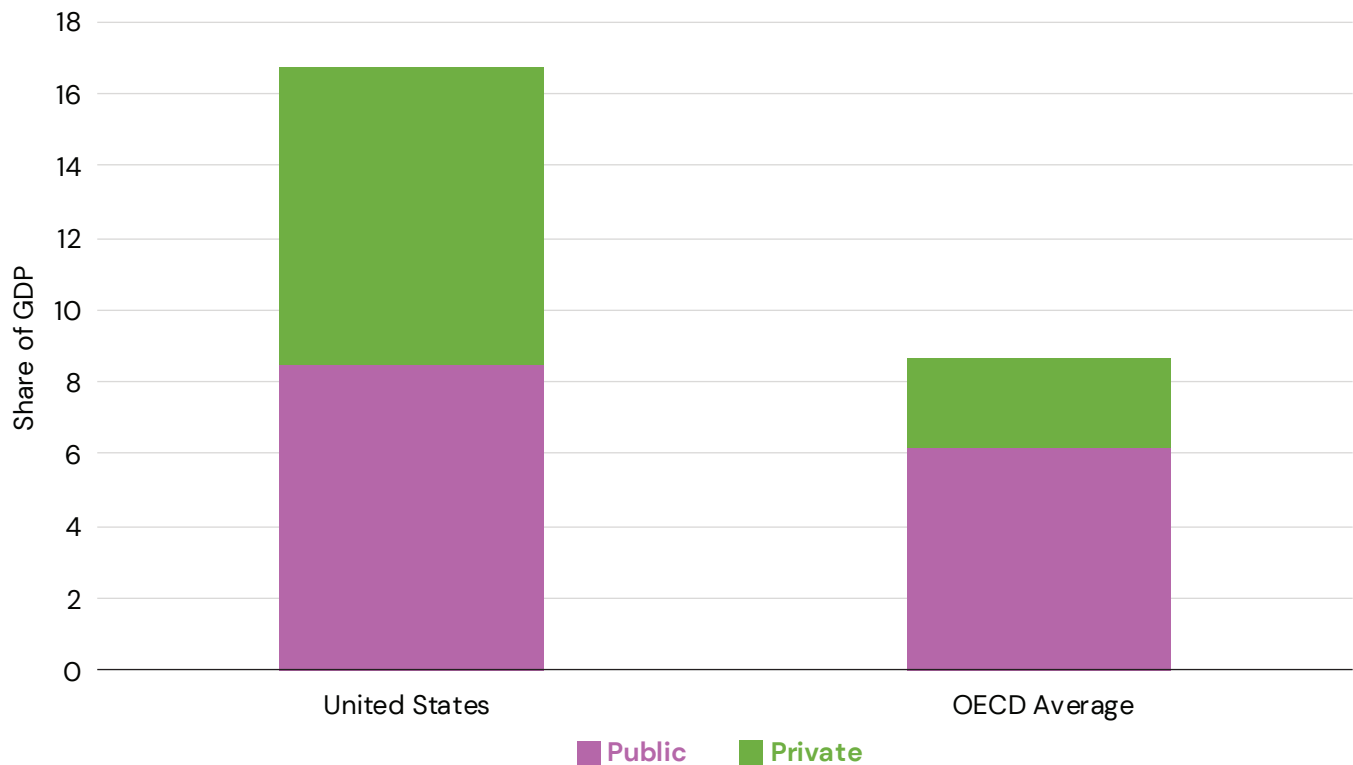
This is why most countries have a formal, multistep process for considering whether to cover new treatments under universal health care. Some countries make these decisions on an "as-needed" basis, while others do it on a preset schedule—annually in the Netherlands, for example, or every five years in Switzerland. They typically use a centralized, two-step process. The first step is a formal assessment phase involving scientific experts that aims to quantify the clinical impacts of the treatment. The ultimate decision, however, relies primarily on a second phase in which other stakeholders—such as health care professionals and government officials—weigh a range of criteria. These include not only the results of that first-phase technical assessment but also of other factors, including "societal values" (Auraaen et al. 2016).

How close is what you're proposing to Medicare for All? What about Medicaid for All?

Our proposal cannot accurately be described as "Medicare for All" nor as "Medicaid for All," yet it does have elements of both. It would preserve the "upgrade"

FIGURE 4

Medical expenditure as a share of GDP, 2019



Source: World Health Organization Global Health Expenditure database n.d.; authors' calculations.

Note: Public and private total to 2019 health expenditure as a percent of GDP. Public spending is general government health expenditure as a percent of current health expenditure. OECD average is an unweighted average of all OECD members excluding U.S.



approach of the current Medicare program, but basic coverage would eliminate the patient cost sharing in traditional Medicare while involving restrictions on patient and physician choices that traditional Medicare does not have. These restrictions could make basic coverage closer to “Medicaid for All,” but unlike the current Medicaid program, people would be able to purchase upgrades without having to repurchase basic coverage.

What about the design details?

There are many additional design questions, and they can be important, both substantively and politically. And they can involve important trade-offs. But their resolution is not a requirement for fulfilling our social contract.

For example, some may ask, would your proposal have a single, public payer, competing private insurers, or both private insurers and a public option? Would providers be paid fee-for-service or through capitation? Would the basic benefit package be uniform nationally (as in Medicare) or allow some state discretion (as in Medicaid)?

All of these are on the table. Focusing on the purpose of health insurance policy clarifies not only the essential elements of universal coverage but also what is not essential. As a result, we have deliberately left unspecified many of the health policy debates that loom large in the public zeitgeist. These include the structure of the insurance provision, the design of payment to health care providers, and the role of federalism.

It is possible to implement the key elements of our proposal in many different ways. The experience of other countries makes this clear. Take the question of who provides the insurance, for example. Countries like the UK and Canada have a single-payer, public health insurance system, akin to the U.S. coverage for veterans. However, countries like Switzerland, Israel, and the Netherlands provide universal basic coverage through multiple, private insurers, akin to Medicare coverage for prescription drugs in the United States. Australia has both a “public option” and private insurers, as does the U.S. Medicare program for hospital and physician care.

Which country's health insurance system does your proposal most resemble?

We arrived at our proposal by using the approach that comes naturally to us from our economics training. We first defined the objective, namely the problem we are trying but failing to solve with our current U.S. health care policy. Once we were clear on the goal, we then considered how best to achieve that goal, which led us to the key design elements we've described. Nonetheless, once we did this, we were struck—and humbled—to realize that at a high level, our proposal contains several key components that essentially every high-income country has embraced: guaranteed basic coverage that must be delivered within a fixed budget (two things the United States currently doesn't have) and the option for people to purchase upgrades.

The experience of other countries provides another reassuring observation. Although we developed our proposal from first principles—by focusing on the problem that must be solved and what is essential to that solution—the proposal does not require new institutions or mechanisms. Nor does it require crazy new contraptions dreamed up on our blackboards and untested in the real world. The lack of universal U.S. health insurance may be exceptional. The fix, it turns out, is not.

However, the specifics of our proposal can't be found lock, stock, and barrel in any existing country's system. They constitute a mix and match of particular aspects that, in our opinion, particular countries have managed to get right. Our insistence that patients be automatically covered and not pay anything for their covered care looks like the universal coverage programs in the UK and Canada and very much unlike the programs in most other high-income countries. But our advice on how to structure payments for the supplemental system is very different from the approach taken in the UK or Canada to the extent that they allow such supplemental coverage at all. Rather, it is closer to the approach found in countries like Singapore, Israel, and Switzerland. These countries, however, also require substantial patient cost sharing in the basic coverage, something that we reject.

How will your proposal reduce the high levels of waste in U.S. health care?

It won't. From Nixon to Clinton to Obama, presidents have bundled proposals for universal coverage with proposals to reduce the level of health care spending (Galvani et al. 2020; Obama 2008; Seervai and Blumenthal 2017). The instinct is understandable. After all, coverage and costs are arguably the two great problems in the U.S. health care system.

But these problems are eminently separable. We do not have to hold our health care commitments hostage to finding a way to get more health for the same total level of spending or the same health benefits at lower cost.

How can this happen politically?

Most conversations about health insurance reform start by asking what we think we can do politically. We don't think that's the place to start. We need to first articulate the ideal, before we can worry about how to get there, or what kinds of compromises we can live with while still achieving the key goals.

Moreover, it's not our comparative advantage to think about the politics. Our hope is to persuade people about the ideal, the "north star." If we succeed, then hopefully others—more skilled than we are—can figure out how it may be possible to navigate to this solution or to keep their eyes peeled for opportunities as policy windows appear.

We've envisioned a solution that involves starting from scratch, but it's possible that others will see a way to achieve it through a series of incremental reforms. We've envisioned a national reform, but it's also possible that—as has so often happened in our health policy system—an innovative state might lead the way.

In short, while we don't know exactly how this would happen politically, we want to end on a note of cautious optimism. For, as we explain in our book's epilogue, our reading of the historical record in both the United States and abroad suggests that it was not our destiny to be—nor is our destiny to remain—the only high-income country without universal health care coverage. The first step is to agree on where we need to go.

Endnotes

1. Wherever possible, we use statistics from 2019 or, if unavailable, as recent as possible up to 2019. We avoid post-2019 numbers because they may be distorted by the Covid pandemic.
2. Some examples of the discussions surrounding the decision to have Medicare patients pay for some of their care can be found in Advisory Council on Social Security (1965), Hearing Before the Committee on Ways and Means (1961), and Hearing before the Committee on Ways and Means (1959; 1961).
3. In a later patch, a law that went into effect in 2023, almost a half century after the original coverage, allows certain patients to maintain Medicare coverage for transplant immunosuppressant drugs—but not related to transplant medications—indefinitely after a successful transplant. For more information, see National Kidney Foundation (2023) and Centers for Medicare and Medicaid Services (n.d.a.).

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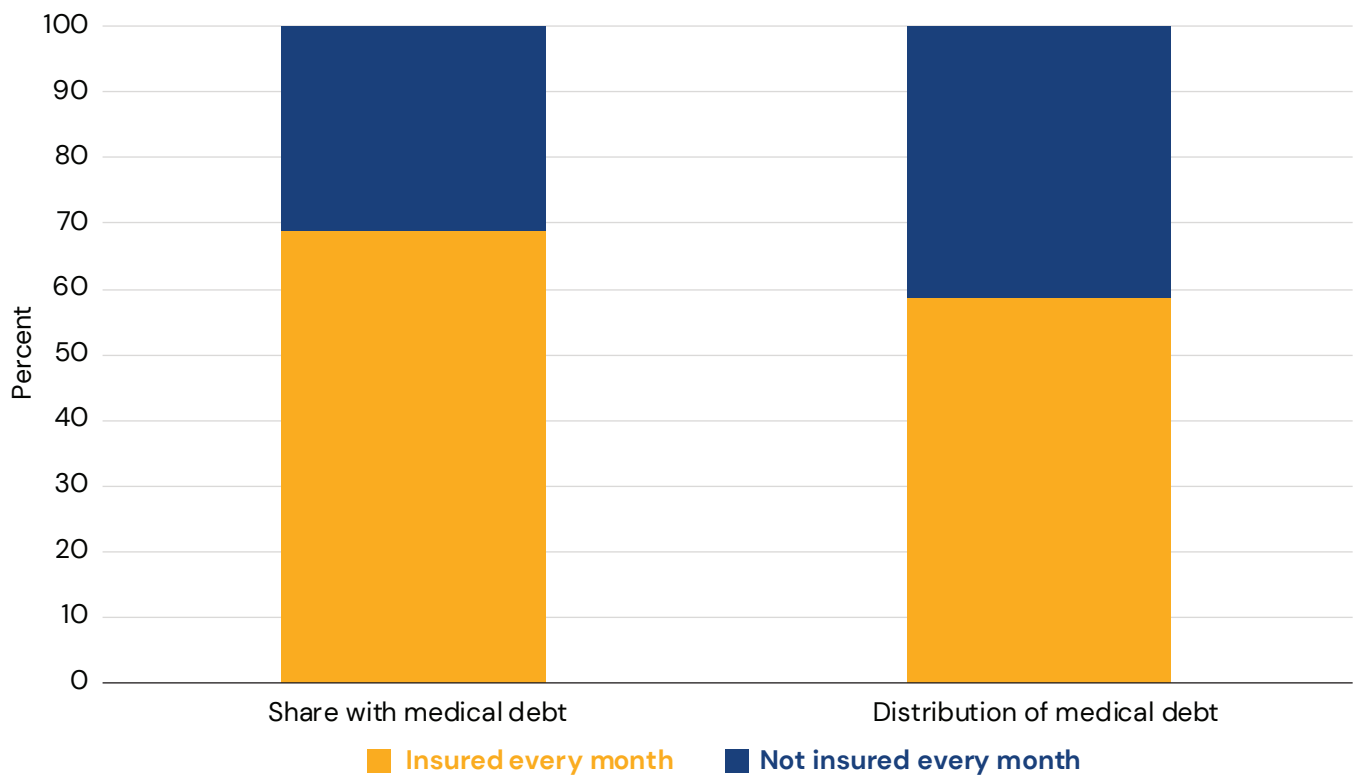
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U.S. health insurance policy has proceeded incrementally, and haphazardly, for over half a century. In this proposal we consider what an ideal system would look like, freed from political, but not economic, constraints. We start by articulating the goal behind our policy history, arguing that it reflects an attempt to fulfill a societal commitment to try to provide access to essential health care regardless of resources. From this perspective, we identify three fundamental issues with the state of U.S. health insurance coverage: the uninsured, the widespread risk of insurance loss for those who have insurance at any given moment, and the potential for catastrophic medical bills even for those who maintain their coverage. The solution we propose is universal basic coverage, with an option to buy supplemental coverage in a well-designed market. The universal coverage would be provided automatically and for free—without any patient fees—but it would be quite basic, similar to what Medicaid enrollees currently receive. A budget would be set and imposed to force decisions about what is included in that basic coverage.

Burden of medical debt, by health insurance status, 2018



Source: Kluender et al. 2021; Survey of Income and Program Participation 2018; authors' calculations.

Note: The left bar considers the set of households who have any medical debt, and shows what share of them are insured or not. The right bar shows the share of total medical debt that is held by households with health insurance and the share held by households without health insurance. Those who are not insured every month are households that reported at least one month of no health insurance coverage in 2018.

