Budgeting for National Priorities

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# Plain Talk About Health Care

## Discussion Paper

## Frederick W. Gluck

### PAPER SUMMARY

There is a dramatic disconnect between the design and intent of the U.S. government's health care programs when compared to the real needs of the population and in light of the realities of high-powered, very expensive modern medicine. Tinkering with our current approach simply will not solve our problems. We need a fundamental redesign.

This fictionalized account of a discussion among an erstwhile candidate for president, her key campaign advisor, and a self-styled "person with ideas" outlines the type of fundamental redesign necessary to ensure affordable access to health care for all Americans: mandatory health insurance with identical coverage for necessary medical care. This new system will be the responsibility of the federal government, replacing Medicare and Medicaid and removing the state role in health insurance.

The policy at the heart of this system will be community rated on a national basis, with premiums based solely on the number of people in each household, their age, and their sex. FDA-approved modalities that meet additional tests of personal and societal cost-effectiveness will be covered by this new insurance; for modalities with essentially identical efficacy, only the lowest-cost modality will be covered. Payment of premiums will be the responsibility of the head of household and will be paid primarily through payroll deduction. Annual payments for any individual household will be limited to a fixed percentage—based on a sliding scale—of the household's total annual income and over- or under-deduction will be adjusted through the federal income tax system. The calculation of subsidies will be based strictly on a formula that considers total family income compared to total family premium cost and subsidies will be directed only to those who need them. The tax preference for employer-sponsored insurance will be eliminated.

Fred Gluck joined McKinsey and Co. in 1967 and led the firm as its managing partner from 1988 to 1994. Upon retiring from McKinsey in 1995, he joined the Bechtel group and served as Vice Chairman and Director. In 1998 he retired from Bechtel and rejoined McKinsey as a special consultant to the firm serving in that capacity until 2004. He was the presiding director of HCA prior to its recent buyout and also serves on the boards of Amgen, RAND Health Care, and the Cottage Hospital System of Santa Barbara and is an advisor to the Budgeting for National Priorities project at the Brookings Institution. He served on the board of the New York Presbyterian Hospital for over 30 years before achieving emeritus status in 2006.

## Introduction

Innocentia Pureheart—governor of Rhode Island and surprise winner of the Republican party's nomination for the 2008 presidential election—was getting desperate. The debate with Hillary on health care was coming up in less than a week and Seymour Angles, her super-savvy campaign manager, was losing patience with her: "You were nominated on your manifest record of bringing humanity and innovative thinking to government and your commitment to bringing universal health care to every American, but your health policy thinking sounds to me like a hodge-podge of warmed-over proposals from the established health care bureaucracy and a host of special interests. If you can't go beyond that you're dead in the water."

She'd had enough. "Seymour, I don't need lectures, I need ideas. I agree: Talking to the so-called experts has been an exercise in conventional wisdom spiced with defeatist incrementalism and a dash of pandering to powerful constituencies. Isn't there anyone out there with some new ideas?"

Seymour, as usual, was ready "Well, John MacArthur—you know, the former head of the Harvard Business School—sent me a paper by some guy he knows that makes a lot of sense to me. The problem is he's not part of the health care wonk society."

"That's probably why it makes sense."

"You've got a point. Want me to get you a copy?"

"I don't have time. Let's see if we can get him in here for a face to face. What's his name?"

"Wyatt Knight."

## Posing the Questions

Two days later Innocentia greeted her guest. "Hello Wyatt. Thanks for coming by at such short notice. "

"You're welcome Governor. My pleasure."

"Are you a Republican or a Democrat?"

"Can't make up my mind. But I think we need to do something about health care or risk damaging the country's economy and social structure."

"Well, we can agree on that, but how do you fix it? Where do you start?"

"I think you've got to start by recognizing that the current system was put in place fifty years ago when the country and the practice of medicine were in very different places. The average annual per capita expenditure on health care was $150 then; now it's over $7,000 and has been growing at an average of 2.5 percentage points faster than GDP for the last forty years."

"Yeah, I know. I've heard all that stuff. And in fifty years half the economy will be health care. It can't happen. So skip the general background. What do we do now to make sure it doesn't?"

"Excuse me, Governor Pureheart, I know you want to jump to the answer, but I think the key to getting out of this mess is posing the right questions. And to do that we've got to understand and agree on the underlying causes of the problems before we start discussing possible solutions. So bear with me a little. Cut me a little slack."

"Look Wyatt, I'm not an amateur and I've spent a lot of time speaking to a lot of people about these problems and thinking deeply about them so I know the background, the statistics, and the seriousness of the problem. I know our current approach is unsustainable. Let's get to the point as quickly as possible."

"Fair enough. Then why don't we start with *you* telling me how you see the problem and let's see if we can agree on the underlying causes and pose the questions in ways that they can be dealt with."

"Well, aren't you the clever one? Turning the tables on me like that."

At this point Seymour jumped in. "Go ahead, Inno. Call his bluff. We're all big boy . . . er . . . people here."

"Okay, Wyatt. The conventional wisdom, which I agree with and is probably correct in this case, is that the three dimensions of the problem are costs, access, and quality of the care delivered. You've already made point one: Costs are dangerously close to spiraling out of control and are certainly beyond the reach of much of our population. So I guess the obvious question is, how do we stop the spiral? But I guess we need to go a little deeper into underlying causes before we can pose the right questions."

Seymour came back again: "Yeah, so Wyatt, what's driving the spiraling costs?"

Wyatt was ready. "This is a good news/bad news story. The good news is that the main factor driving spiraling costs has been the enormous progress we have made in understanding disease and applying technology to combat it, which has in turn led to a healthier population and monotonically increasing life expectancies. The bad news is that the broad and continually proliferating arrays of powerful treatment modalities that physicians have at their disposal to keep that population healthy keep getting more and more expensive to deliver. Moreover, increasing life expectancy has a geometric effect on health care costs because the average cost of keeping a person healthy increases with age and accelerates as one grows older. And the ultimate effect of these increasingly expensive interventions inevitably and inexorably shifts from prolonging a fulfilling life to extending a difficult and painful death. So we need to figure out how to manage the introduction of new and ever more expensive technology and how to take care of an increasingly older population. Moreover, these phenomena are exacerbated by the fact that our self-indulgent lifestyles have led to an ever-increasing incidence of chronic diseases (e.g., diabetes, coronary heart disease, cancer), which are expensive to treat at any age, but tend to become more serious and more expensive to treat as one grows older. The net impact is that if we want to control spiraling costs we will be forced to make some very difficult moral and ethical decisions about what the government can afford to spend on subsidizing very expensive treatment regimens, especially those that primarily extend the dying process."

"How do we do that?"

"As you know, Governor, the FDA bases its approval of new modalities only on efficacy and safety. I believe the only way to address the explosion in expensive and marginally effective medical technologies is to add cost-effectiveness as a necessary condition for inclusion of modalities in government-subsidized insurance. Otherwise the people who develop new drugs, prosthetic devices, and medical equipment will continue to focus their R&D on ever more expensive modalities, which is where they perceive the big bucks to be. "

"But Wyatt, won't that slow down the pace of innovation?"

"I prefer to think that it will bring the direction of innovation more in line with what the real needs of the American people are—affordable care for the majority of the medical needs we face in a lifetime rather than ever more expensive ways to prolong the process of dying."

Seymour nodded. "It's a good point, Innocentia."

Wyatt continued. "We'll also have to address the lifestyle problem in much the same way we handled smoking. We didn't have to worry much about spiraling health care costs and moral and ethical judgments when health care costs were a minor component of our GDP and an insignificant piece of the government budgets. But believe me, we do now."

Innocentia came right back. "Okay Wyatt, you're making some good points, but why are you focusing on government's costs? What about the 50 percent of our health care costs that are not subsidized by the government? Aren't they important as well? "

"Of course they are. And the actions I'm proposing will reduce those costs as well. However, if each of us as an individual has to make the judgments on whether the potential benefit of a given therapeutic regime or procedure justifies the cost of either insuring for it or paying for it, I'm willing to let the market shape those decisions. In my view it's a self-correcting problem. The real problems come when the government subsidizes care in ways that favor particular segments of the population, force the development of pernicious cross-subsidies, and essentially ignore the benefit-cost question when approving new modalities for reimbursement. That's when we lose the check-and-balance dimension of personal responsibility for making benefit-cost decisions."

"Hmm, I think I see your point. I'll have to think some more about that."

Wyatt continued. "Actually the way the government has chosen to subsidize health care has led to some other cost problems: mind-numbing complexity, enormous unproductive bureaucracies, and increased inefficiencies and costs for the people and institutions that actually deliver health care. Moreover, government schizophrenia and the inconsistency in the way it has chosen to subsidize health care are at the heart of the access problem as well."

Innocentia was getting more engaged. "Well, Wyatt, the way you've parsed the underlying causes of the spiraling cost problem—the unintended consequence of our superb record in creating ever more powerful medical technologies and our self-indulgent lifestyles—makes sense to me. And the remedies you're suggesting seem to deal with the problems you've defined. But I'm also intrigued by your comments on government schizophrenia and

inconsistency and how that is contributing to both the cost and access problem. Can we move on to that?"

Wyatt responded quickly. "We absolutely can! It seems incontrovertible that the underlying causes of the access problem are the inability of large segments of our population to pay for the insurance that will guarantee access coupled with the government's approach to dealing with the problem. And as I hope to make clear, solving the access problem in the right way can lead to real cost savings as well. Let's start with access.

"On the one hand the government mandates that our providers (e.g., hospitals, doctors) provide care to anyone who needs it, but on the other they refuse to compensate providers for giving care to people who can't pay for it. Moreover, in the case of government-funded programs such as Medicare and Medicaid, the government frequently under-compensates the providers for care provided. This in turn forces the providers to shift some of the cost of providing this care to the private insurers who then are forced to raise prices. Employers then begin to demand more cost sharing from their employees or cut back on benefits, thus exacerbating the problem of inadequate coverage. And those poor souls who don't qualify for government programs or employer-sponsored insurance (ESI) have to pay for their own insurance without the benefit of either group rates or the hidden government subsidies embedded in ESI. They frequently end up either uninsured or underinsured. It's a vicious cycle and we won't be able to solve either our access problems or our cost problems unless we find a way to break out of it.

"To put it another way, the current system of government subsidies is comprised primarily of Medicare, Medicaid, and the tax preferences for ESI.* Medicare and Medicaid are enormously complicated and constitute an administrative and cost burden on both health care suppliers and employers. And the tax preference for ESI funnels subsidies to the portion of the population that least needs it—those people who have steady, well-paying jobs—while ignoring the lower-income segments of society who don't qualify for Medicaid and really need the subsidies. Why is the government subsidizing the health insurance of the likes of Bill Gates and tens of millions of others who could well afford to pay their own way?

"The net result of the way we've structured our insurance programs is that the government provides subsidies to the elderly and the wealthiest and most financially secure segments of the population (those people employed by—or retired from—larger businesses who participate in ESI) through the tax preferences of ESI, partially covers the indigent who qualify for Medicaid, ignores those who neither qualify for Medicaid nor can afford to pay for private insurance, and effectively penalizes self-payers by not extending the same tax preferences to them as it does to those covered by ESI. And since only 25 percent of taxpayers pay more than a 15 percent marginal rate, most of the benefits of the tax preferences for ESI go the higher-paid employees, not to the rank and file.

"And because the Medicare and Medicaid programs are so complex and difficult to understand and interpret, enormous and costly bureaucracies have grown up at both the state and federal level to operate these programs and make millions of fine distinctions on who is entitled to how

* And a few other government agencies and programs like State Children's Health Insurance Program (SCHIP) and the Veterans Administration.

much government-subsidized care. Moreover, all the providers have been forced to create similar bureaucracies to negotiate an endless stream of issues and disputes with these various government agencies."

Innocentia took a minute to digest what Wyatt had to say and responded in a subdued tone. "Well, Wyatt, I knew that we had some problems with the way our private and government insurance systems worked and interacted and that there were some pernicious cross-subsidies out there, but the way you put it sounds like our government programs are—at least in part—seriously misdirected. Not to mention being so complicated that they're beyond the grasp of any normal human being to fathom."

Wyatt was warming to the task. "And that complexity permeates the entire system and drives up not only the costs of the government agencies, but also complicates the jobs of the providers, drives up their costs, and frustrates efforts to introduce new and better ways of doing things. And the employers also take it on the chin because their costs for ESI are artificially inflated because the providers shift the costs of under-reimbursement by Medicare and Medicaid to them and the private payers. It's an overcomplicated and very confusing mess. The best way to clear up the confusion would be for the federal government to embrace the responsibility for ensuring affordable health care for all Americans and to reshape our system to accomplish that end in the simplest and most straightforward way.

"Then the important questions become 'who should the government subsidize and how much?' and 'how can this role be carried out most effectively and most efficiently?' To date we've answered them by saying we will subsidize the elderly, the very poorest segments of our population, and the wealthiest segments of the population and then creating enormously complicated, bureaucratic ways of doing it.

"Another way to answer the question of subsidies is to say—*we'll guarantee an identical high level of health care insurance to every American, but we'll only subsidize it for those who can't afford it.* If we adopt that posture we solve the access problem and eliminate much of the complexity and cost of administering the subsidies."

"I think you're right Wyatt. If ensuring the health of the American people isn't a governmental responsibility, what is? But, Wyatt, wouldn't guaranteeing a high level of health care for everyone be very expensive and simply exacerbate the problem of spiraling government costs?"

"Actually, Innocentia, I believe that we can design this program in a way that will cost no more for the government than today's approach and perhaps less, and will certainly cost less over time."

"And how do we do that?"

"Actually the answer is relatively straightforward conceptually and has five basic elements.

"First, you ensure access to necessary health care for all Americans by mandating that each American be covered by an identical insurance policy. This eliminates the need for the complicated decisionmaking on who is entitled to what coverage and eliminates the enormous bureaucracies that have been necessary to make those decisions. Second, you rescind the tax

preference for ESI. This eliminates the regressive subsidies for the wealthiest segments of the population and will bring in upwards of $200 billion in new tax revenues. Third, you price this mandated, community-rated policy on a national basis for each age and sex cohort but adjusting for differences in regional costs. This will create much more efficient insurance cohorts and allow lower premiums to be charged. Fourth, you require all Americans to pay for this insurance with after-tax dollars, but put a limit on the percentage of a person's total income that will be devoted to pay for this insurance. This both brings personal responsibility for health care costs back into the picture and directs subsidies only to those who need them. Fifth, you only include modalities in the mandated policy that are least cost for a given level of efficacy—generic drugs, for example—and that can be justified on the basis of sensible benefit-cost ratios. This is essential to control the spiraling cost of new technology.

"The resulting system ensures all Americans access to necessary health care, eliminates major parts of the government bureaucracies and the costs that they engender, emphasizes personal responsibility for health care, and provides a mechanism for managing the uncontrolled proliferation of marginally efficacious technology."

Innocentia took the helm. "Well, Wyatt, you've given me plenty to think about on costs and access. I guess quality is next. I'm sure you're familiar with the Institute of Medicine's findings on quality?"

"I am and they're quite sobering. But there's a good news/bad news flavor to the quality challenge as well. The good news is that the best medicine practiced in the United States is generally considered the best in the world. So the problem isn't with our best medicine, it's with the uneven nature of the way care is delivered in different settings and to different segments of the society. That's the bad news. So one way to ask the question about quality that may be a little more useful than simply asking 'how do we fix quality?' or even 'why is quality so mixed?' might be 'how do we accelerate the dissemination of best practices throughout the U.S. health care delivery system—to the doctors, the nurses, the hospitals and all other practitioners?' If we could get that process in motion, accelerate the speed at which evidence-based medicine and best practices are embraced, and catalyze experimentation and innovation in delivery systems we would go a long way toward raising the quality of care. This would pave the way for a self-correcting, systematic approach to continuous quality improvement—something we're very good at in this country and even in certain segments of the health care industry, but that we've never really tried to apply to the health care delivery system as a whole. There's no mechanism or source of initiative to address the problem so we lack even good data indicating where the quality problems are most severe, never mind developing a comprehensive program to address them."

"I see. You're saying the main quality problems are at the point of care and you have to change the basic behavior of the care deliverers and the context in which they operate in order to make a real difference."

Seymour popped in. "And doctors and the AMA are right up there with the Catholic church when it comes to preserving tradition and resisting change. So I guess there are no quick fixes here."

"No, there aren't," rejoined Wyatt, "but as I said, this country knows a lot about continuous quality improvement. The challenge is to figure out how to apply it to the health care delivery system as a whole. And, by the way, the first cousin of continuous quality improvement is continuous cost reduction, which is the key to reducing the *existing* costs of our health care delivery system and the complement to bringing spiraling costs under control. Because our health care delivery system is so decentralized we will probably need to create a national center of initiative to catalyze and guide a long-term change process."

Innocentia's eyes were shining a little more brightly and the hint of a smile was beginning to balance some of the tension she had been communicating.

"Wyatt, your approach is beginning to make some sense to me. Posing the questions in the right way is a powerful way to think about the problem and probably the key to finding solutions. I think I have some ideas on how I can shape a program. Can I talk you into hanging around for a few days and being available to consult as I shape my agenda and approach?"

"I'd be delighted. And honored."

## Innocentia Speaks Out on Health Care

Innocentia spent the next few days preparing for her debate with Hillary and, in particular, working on her opening statement. Here's what she said.

"So much has been said about the mess our health care system is in and so many different solutions have been offered that one hesitates to add to the cacophony. So I'm going to be short and sweet.

"First, the good news. The best health care in the world is delivered in the United States. The centers for innovation in pharmaceuticals, biotech, and medical equipment are in the United States. We are home to a dizzying array of world-class academic medical centers as well as many, many excellent community hospitals, doctors, and other health care providers. *We know how to deliver outstanding medical care in this country.*

"Now, the bad news. First, we haven't figured out how to cope with the costs of increasingly expensive modalities, which frequently deliver uncertain or marginal benefits to patients. Second, the underlying assumptions that are driving the way we think about health care insurance are badly flawed and have led to misdirected government subsidies, large numbers of uninsured and underinsured people, mind-boggling complexity, and enormous bureaucracies that deliver little value and create enormous unproductive costs in and of themselves and for the providers as well. Third, our health care delivery systems are highly fragmented and innovative advances in modalities and best practices are slow to move through the country. Moreover, quality is not monitored on a national, comparative basis and so we have significant differences in the quality—and cost—of care delivered in different regions of the country and to different segments of the population. Finally, increases in chronic disease caused by unhealthy lifestyles are fueling increases in costs.

"In other words, there is a dramatic disconnect between the design and intent of our government's health care programs when compared to the real needs of our population and in

light of the realities of high-powered, very expensive modern medicine. Tinkering with our current approach simply will not solve our problems. We need a fundamental redesign.

"We need to provide affordable insurance coverage to all Americans and subsidize those who can't afford it and we need to do it without breaking the bank.

"Here's what I propose.

1. We will move to a mandatory health care insurance system that will provide every American with identical coverage for necessary medical care. This system will be the responsibility of the federal government, will replace Medicare and Medicaid, and will take the states out of the health insurance business.

2. The policy at the heart of this system will be community rated on a national basis and premiums will be based solely on the number of people in each household, their age and their sex, with no consideration of preexisting conditions. Premiums will, however, be adjusted for regional cost differences.

3. Modalities covered by this insurance will include all FDA-approved modalities that also meet additional tests of personal and societal cost-effectiveness. In the case of modalities (drugs, prosthetic devices, procedures) with essentially equivalent efficacy, only the lowest-cost alternative will be covered.

4. Payment of premiums will be the responsibility of the head of household and will be paid primarily through payroll deduction. There will, however, be no tax preference for employer-sponsored insurance.

5. Annual payments for any individual household will be limited to a fixed percentage—based on a sliding scale—of the household's total annual income and over- or under-deduction will be adjusted through the federal income tax system. The calculation of subsidies will be based strictly on a formula that considers total family income compared to total family premium cost and subsidies will be directed only to those who need them.

6. Coverage for modalities that are approved by the FDA for efficacy and safety but have not been included in the mandated policy will not be subsidized in any way.

7. We will encourage the development of a competitive market for supplementary insurance to service those individuals who wish to acquire coverage that goes beyond that provided by the mandated policy and who are willing and able to pay for it.

8. We will institute a comprehensive program of education and incentives that will reverse the alarming increases in the incidence of chronic diseases, which are helping to fuel the explosive increases in cost."

## Meeting the Press

The debate came to a close and reporters mobbed Innocentia with questions about her health care policy.

She seized the initiative. "Gentlemen, Seymour is distributing a fact sheet that puts some more meat on the bones of the proposal I outlined and I may refer to it as I answer your questions. Now let's get started."

"Governor!! You said this program might cost the government less than we're spending now. How is that possible?"

"Three main reasons. First, eliminating the tax preference for employer-sponsored insurance will immediately generate about $225 billion in new tax revenues. Second, designing the mandated policy to focus on modalities that add maximum benefit for lowest cost and creating national cohorts for insurance will reduce premiums significantly without substantially affecting the overall quality of care. Third, clearly defining the federal government's role as ensuring that every American has access to an identical level of health care by providing subsidies on a formulaic basis only to those who need them will lead to elimination of unnecessary bureaucracies in every state, substantial reductions in the federal health care bureaucracy, and major savings in administrative and operating costs for all participants in the system—the government, the insurers and, most importantly, the providers."

The New York Times reporter was skeptical. "But what would the actual cost to the government be? What you've said sounds like black magic—voodoo economics—to me."

"Not at all." Innocentia replied. "As in most things, the devil is in the details. The ultimate cost to the government will depend on the detailed design of the mandatory policy, the decisions on who to subsidize by how much, and how determined we are to simplify the system and eliminate unnecessary bureaucracies. The material in Seymour's fact sheet elaborates on the cost considerations and shows how a program like the one I've just outlined could cost as little as one-half to three-quarters of current per capita government spending on health care. However, to briefly illustrate the absolute feasibility of the program consider that the government now spends about $900 billion in subsidizing health care including Medicare, Medicaid, SCHIP, and lost revenue from the ESI tax preferences. If we took that $900 billion and used it simply to subsidize insurance for half the population—150 million people—we could provide an average of $6,000 per subsidized person per year for health care insurance. This is clearly sufficient to ensure a high level of coverage for every American even without taking account of any of the savings I just outlined. There is no doubt that ensuring affordable health care for the American people is well within our means. And redesigning the system to reflect cost-effectiveness will keep it within our means.

"The material Seymour just handed out demonstrates this point with a more complete analysis of one specific program. All it takes is recognizing that the only way to ensure universal access is to insure all Americans, make some sensible benefit-cost decisions on what to include in the coverage, and subsidize only those who need to be subsidized. There is no question in my mind that a program like this is both feasible and infinitely more equitable and cost-effective than what we have now. Moreover, from a moral standpoint, it's the right thing to do. Everybody

will be ensured access to a high level of affordable coverage, those who want access to more problematic and more expensive technologies and/or simply want more choice and can pay for it will be free to do so. We can argue about the details, but the necessary ingredients for a solution are all there. Now we need to create an actionable implementation plan and get moving."

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Fact Sheet

## Governor Innocentia Pureheart's Plan for Providing Affordable Health Care for All Americans

This evening in my debate with Hillary I outlined a new approach to providing affordable health care to all Americans. The purpose of this document is to present a more detailed description of the plan, including analyses that demonstrate clearly that such an approach is both feasible and affordable. Making this plan a reality will require an unflinching look at the causes of our country's health care crisis and recognition that our current approach to government intervention is fundamentally flawed. We must rethink our insurance and reimbursement systems—both private and public—by reexamining who they cover, where the subsidies flow, and how the benefit-cost tradeoffs are handled. In doing so we will have to acknowledge the need to be equitable at both the societal and personal levels, and recognize that some individuals have a higher ability to pay than others. Most importantly, we will have to forsake the thinking and redirect the institutions that have led the country with the best care delivery systems in the world (doctors, hospitals, research, and equipment and pharmaceutical manufacturers) to have the highest-cost, least-equitable health care system in the world. If we do, I believe that we can provide everyone in the United States with outstanding health care without bankrupting either our families or our government.

### Outline of the Plan

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 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 as they can today. 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 benefit-cost requirements. For purpose of discussion, the former might include inoculations, annual checkups for selected groups, 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 like 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 all concerns were addressed.

Importantly, 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 by a parent for a child) and therefore don't lend themselves to a workable benefit-cost analysis prior to the care being consumed. Thus, by requiring individuals to pay for it, we can ensure that people would approach treatment with the same benefit-cost mindset that they bring to other important financial transactions. Such an approach would help lower the aggregate demand for health care, and thus 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. We will discuss this, and the broader issue of subsidies, later in this plan.

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 is notoriously inefficient, prohibitively expensive, and often delivers inadequate levels of care.[1] 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 whereby numerous, smaller state- and federal-level 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.[2] On a per capita basis the cost to the government 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 high-deductible health plan (HDHP) policy as our guide. Figure 1 shows how the price of such a policy varies by the policyholder's age.

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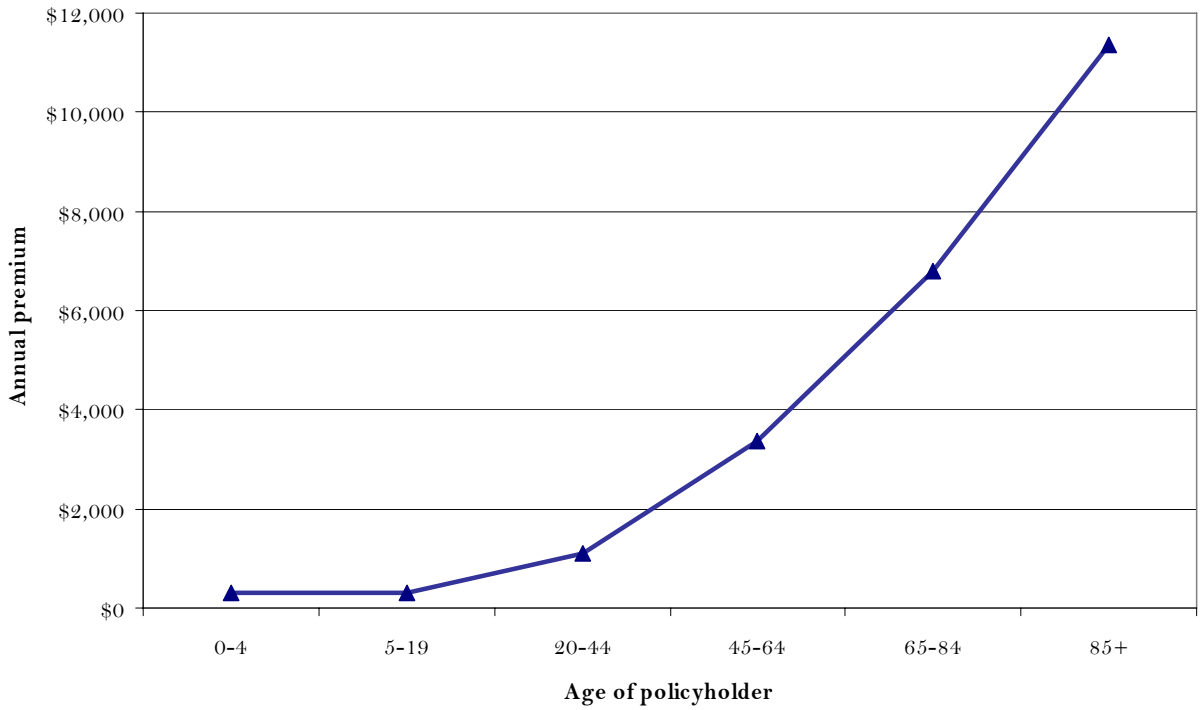
[1] See David Brown, "Crisis Seen in Nation's ER Care," *Washington Post*, June 15, 2006.

[2] 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 spending amounted to $260 billion.

## Figure 1. Typical Premium Cost as a Function of Age




Note: Costs were estimated by simulating the purchase of a form of popular HDHP insurance (Aetna IL High Deductible PPO 1 HSA Compatible) for zip code 60611 in Chicago, Illinois, in 2006. Costs for the age group from zero to nineteen were estimated at $300 per person because data could not be obtained for that cohort (cost for a twenty-year-old is $600). Cost of the policy for a thirty-two-year-old is $1,104 and was used as an estimate of the cost for an HDHP policy purchased by someone in the twenty to forty-four age group. Cost of the policy for a forty-five-year-old is $1,621 and for a sixty-four-year-old is $5,112. The average cost of an HDHP policy for the forty-five to sixty-four age group is estimated to be the average of these costs, or $3,367. The cost of insurance for people sixty-five to eighty-four were interpolated. The cost of insurance for people over age eighty-five is estimated at seven times the cost at age forty-five. Costs were all based on an individual purchase. No allowance was made for group-purchasing discounts or for family-purchase discounts. As a result, the estimates are probably conservative.

*Source*: Author's calculations using ehealthinsurance.com.

This data suggests that the total cost of insuring everyone in the United States between the ages of twenty and sixty-five for one year (61 percent of the population) would be about $385 billion. The cost for those below age twenty (26 percent of the population) would be on the order of $25 billion. Using a similar approach, but estimating the rates for Medicare recipients to reflect actual costs, gives us premiums of $292 billion a year for people over sixty-five. Adding $100 billion to account for including preexisting conditions in premiums brings the total costs for providing insurance for the entire population to $802 billion.[3]

[3] 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 percent) and because the reduction in premium for national risk pools has not been included (~20 percent). Further, the estimate of $100 billion to account for preexisting conditions in the premium is probably too high based on the cost of state high-risk pools.

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

However, 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 sixty-five (to exclude recipients with higher incomes) and 40 percent of the cost for the rest of the U.S. population, the picture changes dramatically as shown in table 1 below.

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 the out-of-pocket costs for routine care for the subsidized population brings us to $739 billion for programmatic costs.[4] Adjusting for the $220 billion in new revenues from eliminating 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 simply on the costs of Medicare and Medicaid and just over half of today's total government per capita spending on heath care.

### Table 1. Programmatic Costs

| Component | Number of People (millions) | Total Cost (billions) | Government Subsidy (billions) |
|---|---|---|---|
| **Insurance** | | | |
| Ages 0-20 | 78 | $25 | $10 |
| Ages 20-65 | 183 | $385 | $154 |
| Over age 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 | All | ? | $50 |
| **Total** | | **$1,049** | **$739** |
| New revenues | | | $220 |
| **Net costs to government** | | n/a | **$519** |
| **Per capita costs** | | | **$1,730** |

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

Better yet, a universal policy that included coverage for preexisting conditions would allow us to create a national insurance pool for each age cohort to spread the insurance risk more efficiently than is currently possible. This would lower the cost of premiums further still. In order to circumvent the problem of preexisting conditions, the federal government could use existing insurance companies to administer the program and reinsure the risk. Alternatively the government could operate a single-payer system for the mandated policy and leave the market for supplementary insurance to the private insurers. This could be done by eliminating Medicaid and reshaping Medicare into a single-payer system using the single mandated policy as its sole vehicle and providing subsidies only to the lower-income groups as outlined later in this document.

Moving to a single, universal policy, subsidizing based only on total income, and eliminating market segmentation to select out preexisting conditions would dramatically simplify the system. Since the costs of carrying out this simple, streamlined program would be far less than with our current complex and redundant bureaucracies we can have great confidence that the total cost to the government would be of the order of one-half to three-quarters of what we spend today, and that 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 U.S. population for considerably less money than we're spending now, but also substantially slow the difference between the growth in health care costs and the growth of GDP.

**How to Administer the Plan**

Under my proposal, the premiums for the mandatory policy would be collected through existing payroll systems via routine deductions. Likewise, the employer would continue to deduct the amount it paid for the insurance. However, the total value of each employee's insurance payments would be added to the employee's taxable income by the employer. 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 U.S. 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 fund 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 U.S. tax filers were in tax brackets higher than the 15 percent 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. For example, an individual earning less than $27,000 a year 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 only an additional amount equivalent to 40 percent of the cost of the original policy. However,

if the policy were cheaper to start with, as discussed earlier, then many employees would be affected even less, and in some cases could even come out ahead if employers fully reflected the prior costs of the policy in compensation.

**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 a full subsidy to 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 increased. All told, this would be roughly equivalent to subsidizing half of the cost of the mandated program. Such a system would subsidize about 90 percent of our nation's old people, as they tend to have lower incomes than people under age sixty-five.

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 for those at the 80th percentile, with graduated intervals in between and beyond. The choice of these parameters reflects the expected cost of the policy given the HDHP policy benchmark described earlier. Since 90 percent of U.S. households include four or fewer people, most household premiums would fall somewhere between $2,000 (single young adult) to around $10,000 (typical family with two children, or two adults approaching retirement age).

Subsidies would be concentrated among families with lower income and high premiums. The richest 20 percent of the population would, for the most part, pay the full amount. Figure 2 illustrates what percentage of a family's premium would be subsidized according to its income and the size of the premium.

For instance, a family of four with a total income of $40,000 and a premium bill of $10,000 would pay a maximum of 7 percent of its income, or $2,800, and the government would pay $7,200. The same family with $60,000 of income would pay 9 percent, or $5,400, and the government would pay $4,600.

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 twelve-month limit of, say, $1,000, and the 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 twelve-month limit—this would ensure a safety net that was not regressive and could be managed with a minimum amount of bureaucracy.

## Figure 2. Percent of Health Insurance Premium Subsidized by Government, as a function of income and size of premium