

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

*Liran Einav and Amy Finkelstein*

United States (U.S.) health insurance policy has proceeded incrementally, and haphazardly, for over half a century. While these reforms have made gains, tens of millions are still without coverage. Even for those who do have health insurance at the moment, 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 care that is notionally covered.

In their Hamilton Project policy proposal, Liran Einav (Stanford University) and Amy Finkelstein (Massachusetts Institute of Technology) consider what an ideal health insurance system would look like if one could start from scratch, freed from political—but not economic—constraints. Einav and Finkelstein 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.

Their solution? 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. 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.

This “north star” goal—universal basic coverage—fulfills a societal commitment to try to provide access to essential health care regardless of resources.

## The proposal

There are five key elements to Einav and Finkelstein’s Hamilton Project proposal to achieve universal basic health coverage in the U.S.

1. People must be automatically enrolled.
2. Enrolling and then using the basic package of services must be cost-free for everyone.
3. There must be a fixed federal budget for health care spending.
4. Basic coverage must cover the basics and the basics only; but, what constitutes the basics should be regularly reassessed given the budget and societal goals.
5. There must be an option to purchase supplemental coverage to upgrade coverage and amenities.

**Automatic enrollment.** Einav and Finkelstein argue that the U.S. has already enacted universal coverage; it just hasn’t achieved it. When people are required to sign up, not all of them do. To achieve universal coverage, it must be automatic. For example, for hospital and doctor coverage in Medicare, those who are collecting Social Security are automatically enrolled the month they turn 65. Three months before their birthday, they are mailed a Medicare card. The result is that virtually all of the elderly have this coverage.

**Free for everyone.** In this proposal, patients would pay nothing for the basic care provided through universal coverage: No premiums and no patient cost sharing. Any medical care that is included in basic coverage must be completely free to the patient. The authors’ 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. Their argument against cost-sharing in the basic plan stems primarily from the experience of many other countries that have tried to implement cost sharing in basic coverage but have ended up exempting most expenses from that coverage, rendering the cost sharing moot and ineffective. For supplemental coverage, insurers would be free to impose whatever cost-sharing requirements they wish.

**A fixed budget.** Under this proposal, the U.S. government would cap the amount that taxpayers spend on health care, as it already does in other areas. Only once a clear budget exists can policymakers engage

in the tough choices of how to pay for basic coverage—what new technologies to cover, for example—or whether to raise taxes to expand what is covered. Anything that falls outside basic coverage given the set budget would overflow into supplemental coverage that can be purchased.

**Basic coverage.** There are two distinct words in health care: health and care. When it comes to basic coverage, it's important to separate them. Basic coverage is about the health part of health care—maintaining and restoring essential function. It should cover health with minimalist (yet adequate) care and no more. 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.

**Supplemental coverage.** Einav and Finkelstein propose supplemental coverage to “top-up” that would allow purchasers to upgrade along two dimensions: The suite of covered services beyond basic and desirable nonmedical aspects of health care. Their proposal would allow people to pay on the margin for supplemental coverage rather than having to repurchase the basic coverage in order to supplement it.

## Questions and concerns

**What medical care would be included in basic coverage?** 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, preventing illness, diagnosing and treating new medical issues, and managing ongoing chronic conditions. Of course, that still leaves many details where the choice to include or not in basic coverage is not as straightforward. The authors recommend processes, which may depend on the budget for basic coverage, for regularly considering and updating the bundle of covered services as incomes grow, medical technology improves, and notions of what constitutes disease evolve.

**How close is what they are proposing to Medicare for All? What about Medicaid for All?** This 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” 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?** 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, the authors deliberately have 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; and, all of these design options are on the table.

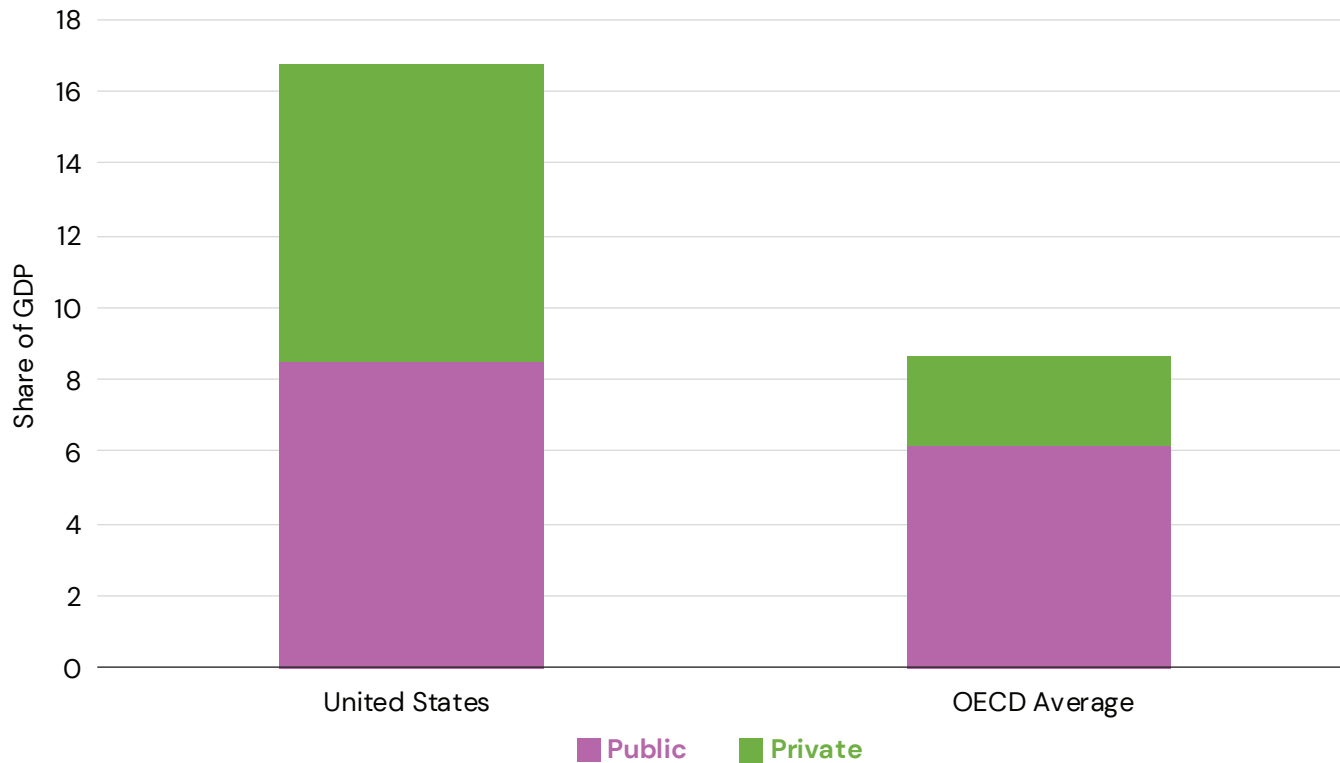
**Which country's health insurance system does their proposal most resemble?** At a high level, their proposal contains several key components that essentially every high-income country has embraced: Guaranteed basic coverage that must be delivered within a fixed budget (two things the U.S. currently doesn't have) and the option for people to purchase upgrades. The experience of other countries provides another reassuring observation, as the proposal does not require new institutions or mechanisms. However, the specifics of the proposal can't be found all together in any existing country's system.

**How much will this cost the taxpayer?** Basic coverage will be taxpayer financed. While there's a real possibility that taxes would rise in the U.S. to finance a universal basic coverage, taxes would not need to rise to finance basic coverage. The level of government health care spending in countries with basic coverage similar to what Einav and Finkelstein propose. In 2019, total health care spending in these countries was approximately 8 to 9 percent of their economy, with most of this spending financed by taxpayers. U.S. taxpayers also spent approximately 9 percent of the economy on health care, the remainder privately (see Medical expenditure as a share of GDP).

**How will their proposal reduce the high levels of waste in U.S. health care?** It won't. Coverage and costs are arguably the two great problems in the U.S. health care system. This proposal separates the problem of coverage from cost. One does 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 a lower cost.

**How can this happen politically?** The authors' hope is to persuade people that their proposal for universal basic health care coverage is the “north

## Medical expenditure as a share of GDP, 2019



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

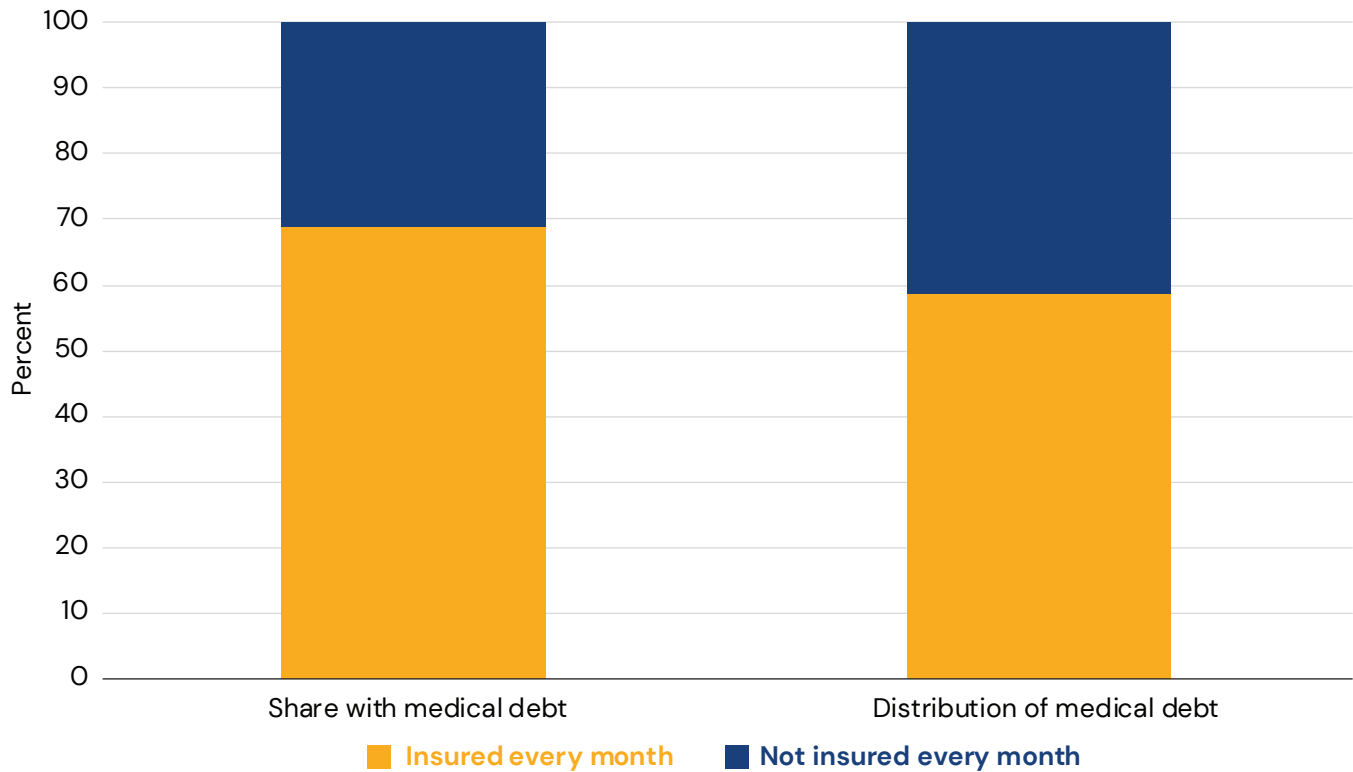
Note: Public and private total to 2019 health expenditure as a percent of GDP. Public spending is general government health expenditure as a percent of current health expenditure. OECD average is an unweighted average of all OECD members excluding U.S.



star” for goal-oriented policymaking in the U.S. The authors leave it to others to figure out how it may be possible to navigate to this solution or to keep their eyes peeled for opportunities as policy windows appear. While they’ve envisioned a solution that involves starting from scratch, it’s possible that others will see a way to achieve it through a series of incremental reforms. They’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.

United States 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.

