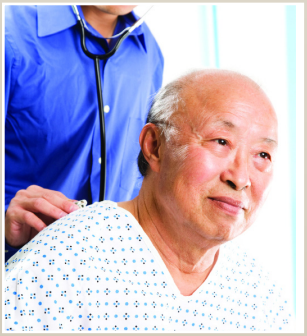
Best of Both Worlds

Uniting Universal Coverage and Personal Choice in Health Care



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Executive Summary

The US health care system suffers from three structural flaws. First, it artificially inflates health insurance premiums for the healthy in an attempt to lower premiums for the sick. This encourages healthy individuals to reduce their insurance coverage or even exit the market entirely, driving up costs for everyone. Mandates to purchase insurance and penalties for lack of insurance can serve as cosmetic solutions, but they cannot erase this fundamental problem. Second, by relying heavily on open-ended fee-for-service public insurance, the present system rewards costlier high-volume care rather than higher-quality care. Perhaps as a result of these incentives to do more, per capita health care spending in the United States is the highest in the world, while patient health outcomes rank much lower. Third, the poor are funneled into a Medicaid system with reimbursement levels well below those of private payers. This relegates the most vulnerable groups in America to a separate and unequal health care system with more limited access and worse outcomes. The current system professes to sacrifice some efficiency to protect the sick and the poor, but ultimately it fails to achieve either efficiency or equity.

We propose an approach to health insurance reform that promotes high-quality, fiscally sustainable health care for *all*. Our solution is a departure from both the current system and the Affordable Care Act reforms that begin in 2014. Our approach reorganizes US health insurance around four principles:

- First, we allow and encourage insurance companies to charge individualized premiums to consumers that reflect their true health care costs. This moves away from the current approach of offering coarse and relatively uniform premiums to the wide range of individuals seeking insurance (through the use of group insurance or state-level community-rating mandates). This reform provides a firm foundation for a health insurance market that no longer motivates healthy individuals to opt out. Insurance offerings would be made available in an open market—for example, through insurance exchanges—with premium transparency.

- Second, to ensure that offers of insurance are *affordable*, we propose government-financed premium supports. The poor, especially the sick poor, gain access to a basic insurance plan at no cost and to more generous plans at significantly reduced costs.

- Third, we propose eliminating the practical and legal barriers to multiyear (long-term) health insurance contracts. Such contracts protect all Americans from increases in insurance rates that could accompany major illness.

- Fourth, we propose to abolish the tax preference for employer-sponsored health insurance plans. This subsidy encourages excess utilization of both insurance and low-value health care services. It also costs the federal government nearly $300 billion in lost revenue—revenue that could be used to fund insurance for the sick and the poor.[1] Finally, it forces an awkward bundling of health care and employment with adverse consequences for workers and firms alike.

Our plan achieves universal coverage by ensuring that all individuals have access to a no-cost "basic plan." It protects the poor and sick by targeting government funds toward subsidies for these groups. Federal and state governments will be able to specify in a transparent fashion the level of spending they wish to incur now and in the future, ensuring fiscal viability. The use of private health insurers allows choice for consumers and exploits the incentives of private firms to encourage the efficient use and pricing of health care services.

In sum, our plan will allow the United States to eliminate the separate and unequal nature of the present health care system that limits the health care access of poor Medicaid beneficiaries because of low reimbursements. All of this is accomplished within a framework that allows the market to do what it does best—pricing risk and controlling cost growth—and the government to do what it does best—ensuring a distribution of health care resources that is just and fair. In addition, the federal and state governments are provided with more flexibility to specify the current and future levels of spending they wish to allocate to the provision of health care.

We believe this plan can unite the country—young and old, sick and healthy, Democrat and Republican—in support of a simplified health care system that improves the nation's well-being.

Introduction

Approximately 50 million Americans are currently without health insurance.[2] Even after the Affordable Care Act (ACA) goes into effect, there will be nearly 35 million uninsured in 2014 and as many as 20 million in 2022.[3] At the same time, US health care spending continues to rise. The Affordable Care Act creates new government liabilities for health care spending that, when combined with the existing federal health care liabilities, threaten the economic well-being of the country.[4] Moreover, the American health care system is increasingly fragmented, with one system of cheaper Medicaid-participating providers for the poor and a much broader and robust system for the rich and middle class.

For decades, health policy has sought to protect the poor and the sick by insulating them from the true cost of their own insurance. Through both incentives for employer group coverage and so-called "community-rating" requirements that forbid individualized pricing, all consumers—rich, poor, healthy, and sick—receive the same premiums despite having different expected medical expenditures. The result is lower prices for sicker consumers but correspondingly higher prices for the healthy.

This core principle fails to protect some groups and imposes a wide variety of unintended consequences on the entire health care system. Healthy individuals face strong incentives to escape the artificially high pricing of the health insurance marketplace. The policy response has been to impose implicit or explicit mandates that force all individuals to purchase insurance—for example, mandates for individual coverage in Massachusetts. By specifying how much coverage individuals must buy, mandates force some people to purchase more insurance than they need or want, further driving up health care expenditures. At its heart, the current health policy approach first destabilizes the insurance marketplace and then relies on a variety of stopgap measures to prevent its collapse.

In this report, we outline a new and different approach to health insurance reform. Fundamentally, we believe the health care system must be built on a foundation of stable markets. This requires a policy approach that allows insurers to charge individualized premiums that reflect the true cost of coverage. Such an approach eliminates the incentive for the healthy to flee the marketplace and encourages all individuals to adopt healthy behaviors by tying health insurance premiums to overall health. At the same time, it protects the poor and sick directly by providing them with premium support payments that facilitate the purchase of a basic insurance plan at no cost or a generous insurance plan at reduced cost. Insurers are free to offer a variety of insurance plans, and individuals are free to choose the plan that serves them best.[5]

Approximately 50 million Americans are currently without health insurance.

In addition, our approach provides health insurance in a fiscally sustainable manner while mitigating the increasing divisions between the health care the rich and poor receive in the US system. We proceed from principles that focus the government on its core mission—correcting inequality by protecting the poor and the sick—and utilize private markets to manage risk and allocate resources. This engenders a working partnership between the public and private sectors. Our plan eliminates a significant number of barriers to the functioning of the private market but also protects the vulnerable individuals who

might otherwise be harmed by an entirely unregulated solution.

We first lay out what we believe are the national health policy priorities that most Americans would agree on, followed by a discussion of key barriers that currently stand in the way of these priorities. Finally, we present our approach to health insurance reform and discuss its implications.

National Priorities

We believe five national priorities should guide health policy:

- Ensuring universal access to basic health care;
- Making health care affordable for the poor and the sick;
- Restraining the growth of public spending;
- Ensuring the efficient provision of health care and health insurance; and
- Respecting the diversity of patient values regarding the quantity and type of health care they wish to receive.

Taken together, these priorities will define the reform proposal we outline later in this paper.

TABLE 1
SOURCES OF INSURANCE COVERAGE, 2010

	Number (in millions)
Private insurance	
Private through employer or union	142
Self-purchase/other	24
Public insurance	
Medicare*	42
Medicaid*	38
Dual (Medicare and Medicaid)	6
Other public	4
Uninsured	
Total	50
Citizens and permanent residents	43

Note: *Excludes the dual-eligible population.

Source: Dana Goldman and Kip Hagopian, "The Health-Insurance Solution," *National Affairs*, no. 13 (Fall 2012): 95–109.

Ensuring Universal Access to Basic Health Care

One of the major motives underlying health policy is to guarantee access to health care for the poor, sick, and infirm. Nearly everyone shares the belief that heart attack patients should not be abandoned if they lack the means to pay for emergency care. A child with a broken leg should not forgo a cast and crutches because his family lacks the means to pay for them. Any comprehensive health care reform proposal must deal squarely with this motive for altruism and make some provision for the care of people in these and similar situations, whether through public or private markets.

Despite the existence of major public programs like Medicare and Medicaid, the United States still has large numbers of uninsured individuals (table 1). Among its 306 million residents, about 256 million have some form of health insurance, of which 166 million are covered by private insurance (either provided by employers or purchased on the individual market) and 90 million are covered by some form of public insurance (primarily Medicare and Medicaid). The remaining 50 million are uninsured, of which about 43 million are citizens or permanent residents.

The ACA was passed largely as an attempt to reduce the number of uninsured, but it is only a partial solution: the Congressional Budget Office projects that the act will leave 30 million Americans still uninsured.[6]

For a variety of reasons, public opinion support for single-payer insurance has been limited, but there is clear public support for covering the uninsured.[7] One of the principal arguments for the introduction

of the Medicare program in 1965 was the substantial number of poor elderly who could not afford expensive, state-of-the-art care. Medicaid was introduced with the statutory goal of integrating care for the poor, sick, and disabled into the mainstream US health care system.[8] Over the years, continued erosion in Medicaid reimbursement, along with growing payment delays and administrative burdens, have compromised the program's ability to achieve this goal.[9] We believe that health policy must return to this principle of a health care system with basic, equal access for all.

Protecting the Poor and the Sick

American health policy has long been motivated by a special concern for the well-being of the neediest groups. Rates of uninsurance are considerably higher among the poor (table 2). Nearly 15 percent of Americans below the federal poverty line (FPL) are uninsured.[10] Uninsured individuals can face prohibitively high out-of-pocket costs for care if they fall ill, and many presumably decide to forgo any expensive care altogether.

The Congressional Budget Office projects that the ACA will leave 30 million Americans still uninsured.

The consequences of uninsurance include decreased access to recommended health care, lower quality of care received, and worse health outcomes. Patients with lower incomes feel these consequences disproportionately. The uninsured are less likely to receive screening and preventive services such as mammography, pap testing, cholesterol testing, and influenza vaccinations.[11] They are also much more likely to report poorer general health status and physical functioning.[12] Overall, uninsured Americans die at younger ages than their privately insured counterparts; studies have estimated that being uninsured is associated with a 25–45 percent greater mortality risk.[13]

To be sure, social scientists debate the extent to which these associations exactly measure the true consequences of being uninsured, which tends to accompany other factors, like poverty that are also associated with poor health outcomes. Yet the broad sweep of evidence—including the recent experience of uninsured low-income Oregonians who participated in a randomized experiment designed to assess the effects of receiving Medicaid coverage[14]—suggests that reducing uninsurance can improve health and financial well-being for a number of vulnerable patient groups.[15]

TABLE 2
DESCRIPTION OF UNINSURED BY POVERTY CATEGORY, 2010

Ratio of Family Income to Poverty Level	Number of Uninsured in Millions (% of Group)
< 100%	14.6 (29%)
100 to 149%	8.0 (16%)
150 to 199%	6.7 (13%)
200 to 249%	5.3 (11%)
250 to 299%	3.9 (8%)
300 to 399%	4.6 (9%)
400% and higher	6.9 (14%)
Total	49.9

Source: Dana Goldman and Kip Hagopian, "The Health-Insurance Solution," *National Affairs*, no. 13 (Fall 2012): 95–109.

Restraining the Growth of Public Spending

If cost were no object, a government program that covered all medical care could easily achieve the objective of universal coverage. Unfortunately, changes in the health care system in the decades since the enactment of Medicare have made this approach fiscally untenable. Even before the adoption of the ACA, public spending accounted for half of national

health expenditures in the United States. Current provisions in the ACA expand Medicaid coverage and introduce additional subsidies for low-income adults to purchase private insurance, adding substantially to public spending on insurance (offset at least in part by additional revenue sources). As it stands, Medicaid spending poses significant fiscal challenges for state governments and, ultimately, the federal government that serves as a backstop for the program.[16]

Medicare expenditures account for 15 percent of federal spending and 3.6 percent of gross domestic product (GDP).[17] Medicare spending per beneficiary grew 2.5 percentage points faster than GDP from 1975 to 2008, compared with 1.9 percentage points for health care spending overall.[18] Under the ACA, the projected per beneficiary spending growth in Medicare is forecast to be below GDP growth per capita in the near term and approach GDP growth after 2035.[19] A somewhat more realistic alternative scenario forecasts Medicare spending growth per beneficiary in the range of 1 percentage point above per capita GDP growth, still substantially below the historic average, and reflects fee cuts that are scheduled to take effect under the ACA but may be overridden. Under either scenario, the demographics of the baby boomers will drive annual Medicare spending growth from under 4 percent now to over 6 percent under the ACA to almost 11 percent under the more realistic alternative scenario.[20]

This trajectory will create substantial fiscal pressure. Alleviating it will require either a dramatic reduction in health care spending growth or a substantial shift of financial responsibility to individuals rather than government. For example, current projections suggest that if Medicare and Medicaid spending continue to grow at their historical rates of 2 percentage points above GDP growth, the nation's primary deficit will grow 5 percentage points faster than GDP over the next 20 years.[21] Without new financing, such a scenario would imply not only that America's debt is growing faster than its income but also that it is doing so at an accelerating rate. Restraining growth in these programs is a broad fiscal challenge that cuts across all sectors of the economy.

One solution to mitigating the debt and deficit consequences of high health spending is to raise tax revenue to compensate. Indeed, the health care Medicare beneficiaries use is financed by a combination of dedicated taxes, general revenues, and health care expenditures paid for by Medicare beneficiaries. Yet economists have long recognized that reliance on taxes has widespread economic consequences. For example, when individuals keep only 80 cents of each dollar they earn, they predictably choose to work less hard than if they kept the full dollar. In this manner, financing health insurance with taxes on earnings, purchases, or dividends creates disincentives to work, consume, and invest, respectively. However, health insurance financed by an individual's own resources does not suffer from these disincentives. Therefore, the economic effects of taxing everyone to provide universal coverage differ from the economic effects of a system that generates the same spending but is financed through private purchases.

Medicare expenditures account for 15 percent of federal spending and 3.6 percent of gross domestic product.

The tax consequences associated with rapid spending growth in Medicare and Medicaid are substantial. Prior to passage of the ACA, the Congressional Budget Office estimated that income tax rates would have to increase by more than 70 percent to finance health care spending that grew 1 percentage point faster than GDP and would have to increase at least 160 percent by 2050 to finance growth at the historical rate of 2.5 percentage points faster than GDP growth.[22] The ACA exacerbates this problem by expanding public insurance coverage, which raises spending further. Specifically, the ACA is projected to increase federal spending by more than $1 trillion cumulatively over its first 10 years of implementation.[23] Ultimately, this higher spending creates social cost through higher taxation, higher debt, or some combination of the two.

Ensuring Efficient Provision and Pricing of Health Care and Health Insurance

An efficient health care system systematically provides health care services whose value for a given individual exceeds the cost. The value of a particular treatment is subjective and will vary from one person to another and, sometimes, so will its objective cost. Services that provide too little value for a given individual should be discouraged.

High-value services, on the other hand, should be encouraged in an efficient health care system. For instance, when physicians began to use coronary artery angioplasty and stenting in patients with coronary artery disease, rates of stenting in patients with stable chest pain witnessed dramatic increases. High rates of stenting have persisted, however, despite high-quality evidence that it has limited long-term impact on mortality, morbidity, and symptoms in patients with stable chest pain. Low-value services such as these should be discouraged, while high-value services such as use of beta blockers, aspirin, and statin medications in patients with coronary artery disease should be encouraged.

The US health care system is notorious for its inefficient use of resources.

Unfortunately, the US health care system is notorious for its inefficient use of resources.[24] To be sure, the need for insurance, and the resulting third-party payment arrangements, contributes to this inefficiency. This problem is magnified by medical care and health insurance prices that do not reflect the marginal costs of providing these services. This is true for many reasons, some of which are closely related to the nature of insurance as a market product and others that have to do with government intervention.

One of the major inefficiencies in health care provision stems from the value of and need for insurance. A key principle of insurance is to shield individuals from facing the full financial costs of their medical care, yet this can lead to inefficiently high use of medical resources when the costs paid at the point of service are less than the marginal costs of provision. Insurers need to have the ability to manage overutilization of low-value services and encourage utilization of high-value services. Not surprisingly, insurers are increasingly designing strategies to manage care and reduce overuse (sometimes called "moral hazard") for low-value services and encourage use of higher-value services; this concept of rewarding the use of valuable services and penalizing use of less valuable ones is sometimes called "value-based insurance design"[25] and may play an important role in improving incentives for health care utilization. Unfortunately, Medicare has lagged behind private insurers in introducing incentives to discourage overuse of ineffective therapies and encourage use of more valuable ones, at least in part because it lacks the legislative authority to do so.

A second inefficiency in health care derives from provider markets that are not perfectly competitive. For example, regional hospitals are allowed to exert monopoly power to ensure adequate care in underserved areas. Physician licensing regulates who can practice medicine, with the goal of ensuring a minimum level of quality and professionalism. And producers of pharmaceuticals and devices are granted patent monopolies—at least for a period of time—to encourage the development of new products. Each of these leads to prices for medical care that can significantly exceed marginal cost. Ultimately, any successful reform will require greater efficiency in delivery and pricing of health care services (and insurance).

Government regulation also promotes inefficiencies in health care and health insurance markets. For instance, many states require private insurance markets not provided by employers to cover a host of services regardless of whether individual consumers in that market value them. As an illustration, California requires all private insurers to cover autism support, infertility treatments, genetic screening, contraceptives, and mental health benefits, alongside a host of other services.[26] And California is not an outlier—every state, as well as the federal government, has

similar laws. These regulations raise health insurance premiums because covering these services is not free.[27] They also create economic inefficiency by requiring some people to utilize more extensive coverage than they would otherwise purchase for themselves, in some instances leading to a decision not to purchase insurance because of the added cost.

Other pricing regulations in health insurance markets create similar economic inefficiencies. For example, many laws, including the ACA, restrict the use of preexisting health conditions and other characteristics in determining individual premiums. Under these community-rating regulations, both sick and healthy consumers pay similar premiums.[28] As a result, sick people pay lower premiums than they otherwise would, while healthy people pay higher premiums.

Community-rating regulations can be viewed as a way to redistribute income from people who are healthy at the time of insurance purchase to those who are sick. Much of the support underlying community-rated premiums, for instance, derives from the idea that it is unfair to charge unhealthier people higher premiums to enroll in health insurance.

Although well-intentioned, an undesirable consequence of this notion is that healthy individuals are pressured to drop coverage when faced with higher premiums. For the over-65 population, the existing health care system addresses this problem by insuring all individuals once they reach the age of 65, with both the sick and the healthy in the same coverage pool. For the under-65 population, employer-sponsored health insurance that combines both sick and healthy employees in the same employer insurance pool partly addresses the problem. Under the Health Insurance Portability and Accountability Act, group health plans are allowed to require individuals to complete a health questionnaire to enroll but are not allowed to deny or restrict benefits or alter premiums based on that information. For those not covered by federal or employer-sponsored insurance, community-rating regulations in many states preclude many healthy individuals from purchasing insurance because of high, regulated insurance premiums.

Short of expanding government programs to the entire population or mandating the purchase of health insurance by all, universal coverage is unlikely to be achieved when community rating exists. Without a government mandate to purchase insurance, insurers who charge community-rated prices will be unable to induce healthy individuals to voluntarily join a health pool that includes the unhealthy. Thus, the controversial mandate to purchase insurance under the ACA is a necessary consequence of its community-rating requirement and its goal to provide universal coverage.

More importantly, community rating combined with a mandate creates a system in which people are subsidized or penalized on the basis of health status alone. As a result, all high-cost people are subsidized, no matter how rich. This introduces regressivity into the system, since healthy low-income individuals subsidize unhealthy rich people. A system that more transparently subsidizes disadvantaged groups can achieve universal coverage with greater efficiency and equity. Presently, group coverage creates an environment in which a 56-year-old CEO with hypertension enjoys health insurance that is partially subsidized by his healthy 19-year-old mailroom clerk.

Regardless of whether markets or government provides care or coverage, both should be delivered efficiently, with a minimum of waste. Regulations such as state mandates and community-rated pricing, which are the cause of economic inefficiency in the health care market, should be reconsidered, and alternative regulations that better enable the market to function efficiently should be promoted in their stead. Equity can be achieved by means of more direct policy approaches, as discussed earlier.

Respecting the Diversity of Consumer Values

Health is intensely personal. People have strong and conflicting preferences about what should happen to them when they get sick. Some people develop long-term attachments to their doctors and medical providers. Others are more concerned about the

out-of-pocket prices they pay for health care. Some are very interested in having their insurance plan advise them about healthy activities, while others would rather their insurance plans leave them alone. Some people want to be able to ask their doctors many questions about their conditions and have their insurance cover a wide range of doctors for second opinions; others are perfectly happy to follow the advice of a doctor they trust who is preselected by their insurance plan.

No single health plan will be optimal for everyone.

Given the diversity of these preferences, no single health plan will be optimal for everyone. Even two people with exactly the same health history and future health risk may want different plans. One, who fears financial risk from poor health but does not care about being limited in his choice of doctors, may choose a high-deductible, catastrophic-coverage health plan with a narrow physician network. Another, who dislikes out-of-pocket payments, may choose a plan with first-dollar coverage.

Ideally, any optimal national health policy should permit individuals to choose a health plan that best suits them, to the extent that those choices do not impose negative consequences on others. It should allow people to spend as much of their own money on health care and health insurance—to buy access to better technologies and better doctors—as they want. In principle, an optimal policy should also permit people to reduce their spending on health care to the extent that such low expenditures do not end up costing others (such as taxpayers who pick up the medical bill when an uninsured person breaks her leg).

In practice, some limits on the diversity of health insurance options may be preferred. For instance, insurance plans can be complex and differ in generosity, costs, and types of services provided (for example, large versus small networks of physicians, and reimbursement for gym memberships). Choosing among a large number of plans with varying characteristics can be challenging for individuals, especially among populations that are sicker or cognitively impaired. Limiting the diversity of health insurance options may facilitate market competition among a common series of plan attributes that individuals can easily understand. We can envision various solutions to this problem. Insurers can establish "categories" of coverage to help consumers search for the plans that suit them best. Or private insurance exchanges or other brokers might provide rating systems or other decision aids.

Economic and Legal Barriers to Implementing National Priorities

The Samaritan's Dilemma

When someone falls ill and requires care, nearly all Americans would agree that the person should be provided with at least a basic level of care. As a society, we will not tolerate seeing someone who is severely injured languishing without care. For this reason, we have national regulations like the Emergency Medical Treatment and Active Labor Act (EMTALA), which require hospitals participating in Medicare to stabilize any patient who arrives in their emergency department. If a patient cannot or chooses not to pay for this care, the hospital absorbs the costs as an unreimbursed expense.[29]

For some individuals, the knowledge that they can receive free care in an emergency department may encourage them to forgo health insurance.[30] This creates a Samaritan's dilemma: society's altruistic desire to help the sick may discourage the healthy from protecting themselves against sickness.

The Samaritan's dilemma creates an obstacle to achieving two of our national priorities: universal coverage and protecting the poor. In the presence of the Samaritan's dilemma, universal health insurance coverage is difficult to achieve voluntarily because some individuals, particularly poor and low-risk individuals, forgo insurance and rely instead on emergency department care. Emergency safety-net care itself is also not very robust. It fails to cover essential care such as prevention and long-term treatment. Finally, the Samaritan's dilemma makes it difficult to figure out who is paying for what. A complex system of federal Disproportionate Share Hospital program payments to hospitals and federal and state tax breaks for nonprofit hospitals finances this care, and the government pays for the cost of uncompensated care that hospitals provide in their emergency rooms,[31] causing some individuals to forgo cost-effective preventive or maintenance care for more costly subsidized emergency care.

Price Distortions

The market can improve efficiency in health care delivery as long as prices are transparent and reflect the full social cost of the care provided. However, when prices are either not transparent to individuals or too low, individuals tend to overutilize care in the sense that the cost of providing that care exceeds its value. Unfortunately, the health care system is littered with price distortions that lead to both over- *and* underutilization of various types of medical care.

The market can improve efficiency in health care delivery as long as prices are transparent and reflect the full social cost of the care provided.

First and foremost, employer-sponsored health insurance benefits are tax excluded. This tax-preferred treatment reduces the price of health insurance—and insured health care—relative to the price of other goods that people value. The result is that individuals who receive insurance through their employers tend to obtain overly generous insurance policies and overutilize medical care as a result of the low out-of-pocket costs.

Second, health insurance—whether employer-sponsored or not—lowers the price of medical care. The purpose of health insurance is to protect individuals from the full cost of health care when they fall sick.

This protection alleviates risk and enables individuals to continue to pay for their food, homes, automobiles, and entertainment. Risk alleviation is a valuable service that improves individual well-being.

Community rating reflects society's desire to promote equality in health care affordability so that higher premiums are not charged to the sick.

However, by lowering the cost of medical care relative to other goods and services, insurance also causes individuals to consume more medical care when they are sick. This additional stimulant to health care consumption can lead to the use of health care that is not worth its cost to society. The tax exemption of employer-sponsored health insurance magnifies this problem by further stimulating the purchase of insurance plans with generously low copays, leading to excessive utilization of health care.[32] Moreover, insurance reduces the sensitivity of individuals to the price of care and thus impedes price-based competition.

Price distortions represent a key barrier to the efficient functioning of markets for both health insurance and health care services. They also play an important role in driving the growth of public spending.

Market Power

The presence of market power in the health care industry means that the prices of health care services exceed what an efficient and competitive market would charge. Physician licensing regulates who can practice medicine, with the goal of ensuring at least a minimum level of quality and professionalism, but economists have long argued that this restriction leads to higher, rather than more competitive, prices. Producers of pharmaceuticals and devices are granted monopoly power—at least, for a period of time—to encourage the development of new products. Regional hospitals in underserved areas exert market power by being the largest, and sometimes only, provider in a region. In addition to distorting prices, the presence of market power can distort quality as well; for instance, highly concentrated markets (in which there is lower competition) have been shown to have lower-quality care for heart-attack patients.[33]

Considerable empirical evidence of market power exists in both the insurance and hospital industries. One recent study found that health insurance premiums in the typical market were approximately 7 percentage points higher because of increased concentration in the insurance industry between 1998 and 2006.[34] On the provider side, large multihospital systems now dominate the market and have been able to increase prices by 17 to 34 percent compared to similar nonsystem hospitals.[35] Estimates of this magnitude underscore the importance of antitrust enforcement to preserve the efficiency of markets.

Ultimately, market power is a barrier to the efficient provision of health care and results in underuse of insurance and health care services in markets where it exists. At the same time, market power makes it more difficult to restrain public spending on health care services because of higher prices. It can also be a barrier to allowing patients greater choice because firms with market power have weaker incentives to provide an array of differentiated products meeting the needs of different consumers. Finally, to the extent that market power limits choice and raises price, it serves as a barrier to the achievement of universal coverage, particularly for the poorest and sickest groups.

Risk Selection in Insurance Markets

The principal reason that purely private markets for health insurance do not always function efficiently is adverse selection. This occurs when individuals purchasing health insurance have different levels of sickness and know this. When this happens, sicker people purchase more health insurance because they value it

more, making the insured population sicker. Under community-rating regulations, this drives up health insurance premiums for all and discourages relatively healthy individuals from buying health insurance (which raises premiums even more).

A similar form of adverse selection may occur, however, even when everyone is mandated to purchase some form of health insurance but can choose how generous of a plan to purchase. In this case, healthy individuals will tend to purchase less generous insurance plans than the sick because the sick will choose more generous plans and drive up premiums in those plans. Although the healthy will be insured, they will still end up with less generous coverage than they would otherwise prefer at a premium that reflects their true cost to the insurer. In effect, the generosity of coverage for the healthy is reduced to keep sicker individuals from joining them in the same health insurance plan.

There are two solutions to adverse selection.[36] The first is a mandate, whereby everyone is forced to purchase a minimum level of health insurance regardless of health status. The second is risk rating, in which insurers are allowed to determine premiums individually based on an applicant's health status. Enforceable mandates solve the adverse selection of low-risk individuals dropping coverage by compelling some individuals to buy a policy that would not be their first choice. Mandates, which generally require reasonably generous coverage, reduce welfare for those who place lower value on health insurance by forcing them to purchase a product that is more expensive than they otherwise would purchase.

In contrast, individual risk rating allows insurers to set premiums based on a patient's expected risk: the sick pay more, and the healthy pay less. Such pricing removes the incentives for healthy patients not to purchase health insurance or to purchase less generous health insurance. The extent to which risk rating addresses adverse selection is limited by only the ability of insurers to adjust for risk—that is, measure predictors of utilization as well as each individual.

The principal impediments to individual risk rating in the health insurance marketplace are the strong incentives for group coverage through employers and explicit community-rating regulation that prohibits employer-sponsored plans from charging fully risk-rated premiums and also blocks health insurers from doing so in the individual and small-group markets in many states. Community rating reflects society's desire to promote equality in health care affordability so that higher premiums are not charged to the sick. This, in turn, disrupts the market's ability to overcome adverse selection. By increasing the scope for adverse selection, these regulations increase premiums for healthy people and lead them to exit the nongroup insurance market. In turn, this boosts premiums for all remaining market participants. Informal support for this theory comes from the fact that that five of the six US states with explicit community-rating regulations are among the states with the highest nongroup premiums.[37]

Current law precludes the types of long-term health insurance contracts that might cure the problem of risk selection in insurance markets.

Impediments to Long-Run Health Insurance

One concern with individual risk rating is that individuals who fall ill are likely to face higher premiums in the future to cover higher expected costs to the insurance company. In theory, this problem would be solved if individuals could enter into long-term insurance contracts that ensure that their premiums will not rise if they become sick after signing the contract. Long-term insurance contracts, like fixed-interest 30-year mortgages, would lock individuals into a schedule of premiums over a number of years.[38] In addition to protecting individuals against premium increases, such contracts create the right incentives for insurers to invest in long-term prevention.

Despite their benefits, long-term health insurance contracts are uncommon today.[39] The main obstacles

are that they are difficult to enforce, both practically and legally, and that insurers have not invested in the capability to anticipate (and price) future medical technologies. Whereas a long-term contract ensures a person who falls ill will not face increased premiums, it also locks a person who does not fall ill into a premium that is higher than he or she may be able to secure from other insurers in the future. This could create incentives for consumers who end up healthier than expected to renege on their long-term contracts and take with them the cross-subsidies they were providing to less healthy members of their insurance group. One solution would lock in the healthy person by requiring anyone terminating a contract to pay a fee equal to the cross-subsidy their participation provided to the insurance pool.

Under current law, however, courts may be reticent to enforce these fees because legal doctrine classifies them as "liquidated damages" that, by rule, must be proportional to the effect they have on the insurance company's profits alone. But the effect on company profits does not include the implicit transfer from healthy to sick beneficiaries. In any event, even if courts allowed such an expansive damage payment, individuals may not have the financial resources to pay those fees out of pocket. Consequently, current law precludes the types of long-term health insurance contracts that might cure the problem of risk selection in insurance markets.

A Vision for Reform

The current approach to health care in America protects the sick through community rating, which prevents private insurers from charging this vulnerable group the true cost of their health insurance. The burden of financing the cost of coverage for the sick falls on healthier consumers, who face higher premiums and muted incentives for healthy behaviors that hold down their health care costs.

We believe the government ought to focus its resources on the disadvantaged, rather than on coarse policies that distort decisions for all consumers. We propose to allow private health insurers to charge individualized premiums to all consumers. We would protect the poor and the sick more directly by providing subsidies to these groups that make health insurance affordable—or even free.

The haphazard marriage between employment and health insurance also perpetuates blunt and uniform health insurance pricing among individuals within large employer groups. As a result, diverse individuals with very different preferences for insurance and health care may be forced into a single plan that may not fit their divergent needs. The existing policy regime relies significantly on employer-based health insurance coverage to forcibly contain a market pulled apart by healthy people seeking to flee artificially high premiums.

Individualized premiums eliminate this rationale for employer-based coverage. In the absence of any compelling rationale for it, we propose eliminating the tax exemption on employer-provided health insurance. The loss of the tax exemption is likely to reduce the prevalence of employer-provided coverage, although employers from continuing to provide coverage should they choose to do so. With more limited employer-provided coverage, employers would face lower health insurance costs. Wages would then be likely to rise, providing employees with additional income they could use to purchase insurance in the marketplace or other goods, if they choose.[40] In sum, eliminating the exemption would save approximately $300 billion in annual federal funds, remove a major distortion in the health insurance market, and end a costly subsidy that benefits richer consumers at the expense of the most vulnerable.[41]

The government ought to focus its resources on the disadvantaged, rather than on coarse policies that distort decisions for all consumers.

Further damaging the integrity of the health insurance market is the Samaritan's dilemma discussed earlier in this paper. Society will continue to provide basic care to patients in dire medical need, regardless of their insurance status. Absent any government action, all patients—rich and poor, healthy and sick—will come to count on the availability of "free" care that protects them against the contingencies of accidents and acute illness. Health insurance becomes less necessary as a bulwark against catastrophe and its use falls, particularly among younger, healthier groups whose participation in health insurance markets could substantially drive down average costs.

We propose that federal or state governments levy a "safety-net tax"—the mechanism of which would be decided by policymakers (for example, income tax, payroll tax, value-added tax, or other approach)—that finances the provision of emergency care to those with acute medical conditions not covered by insurance.

Because the total cost of uncompensated care in the United States is currently around $56 billion, the total tax would be no greater than this.[42] Indeed, current taxation is likely already covering about $43 billion of this amount, suggesting that the incremental tax would be modest.[43] Consumers who have chosen to purchase private health insurance that provides such care are exempt from the tax, as are the poorest consumers. The remaining groups—young, healthy, or wealthy uninsured people—are obliged to pay this tax, which finances the delivery of emergency care.

The total cost of uncompensated care in the United States is currently around $56 billion.

In sum, our proposal for reform rests on three major planks.

1. A private national health insurance exchange in which:
   a) Insurers participating in the exchange are free to charge individualized premiums to consumers according to health and demographic status;
   b) Participating firms can offer as many different plans as they desire, but all must offer a basic health insurance package whose provisions are standardized every year by law; and
   c) The federal government provides premium support to consumers whose basic health insurance premium exceeds a certain percentage of their adjusted gross incomes.

2. Removal of the distortionary income tax exemption for employer-provided health insurance.

3. A safety-net tax levied on all Americans, except the poorest, using the existing tax code; consumers purchasing private insurance covering safety-net services are exempt from this tax.

National Health Insurance Exchange

We propose the development of a private, national health insurance exchange. Firms opting into the exchange would agree to abide by a set of ground rules designed to simplify pricing, provision, and insurance regulation.

Insurance plan pricing and premium supports. Firms participating in the exchange will face *fewer* restrictions on how insurance is risk rated. In particular, we propose eliminating all restrictions on risk rating to the extent constitutionally or politically feasible. For example, we would oppose risk rating across race, national origin, and sexual orientation. However, we would support risk rating on the basis of personal and family medical history.

Coupled with risk rating is an increase in pricing transparency. The data and variables used by companies for pricing decisions must be made available to the exchange, but the pricing algorithm does not need to be disclosed by the firm. As an example, suppose that insurers set premiums on the basis of age, sex, and mother's age at death. All these variables must be known as inputs in calculating premiums and be held in a database at the exchange. To protect confidentiality, insurers are under no obligation to disclose how, or if, they use a particular variable in pricing. The inputs into insurance pricing are standardized and uniform. They may be subject to regulation to avoid a scenario in which some insurers make very stringent informational demands to discourage less affluent, capable, or cognitively sound consumers.

We propose a standardized insurance application process in which individuals answer questions (ideally online) insurers will use to calculate individual medical risk. After a consumer completes the application process, the application is routed to all the insurers participating in the exchange. At that point, all insur-

ers must offer online price quotes for the basic plan to every consumer filling out the application, regardless of their characteristics. Insurers are also free to quote prices for other plan designs, but price quotations on the basic plan permit a simple and objective way to determine premium support payments.

Premium supports are determined for each individual on the basis of lowest bid (or second-lowest bid) quoted to the individual for the basic plan. In the interest of transparency, we support premium costs only, rather than out-of-pocket costs. Since out-of-pocket costs can be limited by specifying a more generous basic plan, especially for the poor, this sacrifices little in terms of progressivity.

As an example, suppose there are two insurers: Insurer A offers the basic plan only, and Insurer B offers the basic plan and a deluxe plan. Insurer A quotes a price of $2,500 for the basic plan. Insurer B quotes a price of $2,700 for the basic plan and $3,500 for the deluxe plan. The consumer receiving these quotes would pay nothing for Insurer A's basic plan, $200 for Insurer B's basic plan, and $1,000 for Insurer B's deluxe plan. To ensure take-up of insurance, consumers are enrolled by default into the lowest-cost basic plan but are free to switch into a different plan—or even to forgo insurance—without penalty. (They would still be covered for safety-net care similar to care covered by EMTALA.) Consumers do not receive the cash value of the basic plan if they do not purchase insurance.

A key feature of this arrangement is that *every* consumer has access to the basic plan at no cost (ensuring universal coverage) but can opt into more generous coverage or into a basic plan provided by an insurer that is not the cheapest. If insurers charging more for the basic plan also offer better customer service, for example, consumers may choose them over the lowest-cost provider. The government can monitor these price quotes to ensure access. For example, if it finds that certain populations—for example, those infected with HIV—are not being offered any plans other than the basic option, premium supports could be increased for people with that condition.

Basic Insurance Coverage. Specifying a basic insurance coverage plan is an important but challenging task. The political question becomes the level of coverage that society deems essential for people in different socioeconomic categories. Under our proposal, determining basic insurance coverage is a prerequisite for calculating premium supports in a fair and objective manner. The essential tenets of our proposal are the same no matter what level of basic coverage is chosen. Moreover, the level of basic coverage itself could vary with income or other measures of wealth. For instance, the basic plan could cover all household medical expenditures above a deductible that is equal to 10 percent of adjusted gross income for the household.

A key feature is that **every** *consumer has access to the basic plan at no cost (ensuring universal coverage) but can opt into more generous coverage or into a basic plan provided by an insurer that is not the cheapest.*

The level of coverage involved in the basic plan has budgetary implications. The only requirement we impose is that per capita spending on premium supports be sufficient to cover the cost of a basic plan. The cost of our proposal ultimately depends on a political determination regarding the appropriate scope of coverage under the basic plan. For purely illustrative purposes, we later provide one example of a (non-Medicare) basic plan that would be more progressive than the ACA but would cost no more than the ACA on a per capita basis (see "Evaluating Our Plan for Reform").[44]

Regulation of Insurers. Health insurers currently face a patchwork of conflicting regulations across states. Regulating insurers at the national level instead

allows greater competition. Insurers doing business in California would then compete against those doing business in Texas. However, state-level regulation currently impedes national competition.

Insurers participating in the health insurance exchange will be exempt from any state regulation and instead regulated in a uniform manner at the national level. This regulation will impose minimum solvency regulations of the form that states currently impose, and it will also ensure that plans offered on the exchange meet minimum standards for benefits accessibility. For example, an insurer marketing a plan to a consumer in Boston must actually include Boston doctors in its provider network.

Insurance for the Long Run. Health insurance contracts today are often short term. Even employer-provided contracts last only as long as an employment relationship does. This may be fine for a tenured university professor but not so effective for a customer service representative or even a white-collar executive in a high-turnover industry. Short-term contracts weaken incentives for insurers to invest in prevention and other types of health interventions that pay off in the long run. At the same time, short-term health insurance contracts provide no protection against future health events. If a consumer contracts HIV while with a particular insurer, he may face dramatic increases in future premiums or may find himself locked into a job purely for the purposes of maintaining his current insurance coverage. Finally, short-term contracts discourage insurers from making investments in preventive care that take longer to pay off.

A solution to these problems is a long-term health insurance contract, but a variety of institutional and legal barriers stand in the way of such arrangements. Under our plan, insurers participating in the exchange will face a regulatory environment that eliminates many barriers to long-term contracting. All insurers will be encouraged to offer at least one long-term insurance contract option to consumers.

As discussed earlier, the current regime makes it hard to enforce long-term contracts. In particular, such contracts are effective only if companies can get beneficiaries to adhere to the contract term. One way to solve this problem would be to require departing beneficiaries to pay a fee equal to the costs they are imposing on remaining beneficiaries. From a practical point of view, this is difficult to implement. As we have discussed, legal rules concerning "liquidated damages" limit the amount of money that can be recovered from a consumer breaching a contract. Courts are likely to rule against an insurer seeking to recover any more than the profits it lost from the departure. However, this fails to count the costs imposed by the departing beneficiary on other insureds. Moreover, even if courts did award sufficient damages, it is not clear that a departing consumer would routinely have enough money to pay them.

To address these problems, we would reform liquidated damages rules so that a jilted insurer could recover an appropriate amount after a beneficiary departs. In addition, we propose that an insurance company unable to recover fees from a departing beneficiary be allowed to recover those fees from the new insurance company covering that beneficiary. The new insurer would presumably pass these costs onto new enrollees. This would, in turn, encourage beneficiaries to consider the costs their departure imposes on their original insurer. Finally, interstate competition across insurers makes competition in the market for long-term insurance contracts more robust. Although local insurance companies may have monopoly power in a state-level marketplace, they would have much less if they were forced to compete with companies from other states. This will ensure beneficiaries are offered a diverse set of long-term contracts and are able to find one that matches their long-term needs.

Removing the Income Tax Exemption for Employer-Provided Health Insurance

To improve efficiency in the health insurance market and finance our proposed plan, we propose eliminating the income tax exemption for employer-provided health insurance and related health insurance and

medical expenditure tax benefits. Economists, regardless of their political leanings, have long recognized that the tax-preferred status of employer-based health insurance encourages employees to overutilize health care because they face not the true cost of health insurance but artificially lower prices subsidized by the tax preference. The lack of individual incentive to curb health care spending—stemming from the subsidization of health insurance—encourages the use of lower-value health care services and potential growth in insurance premiums that outpaces labor earnings. The tax-preferred status of health insurance also promotes "job-lock," a term used to describe the phenomenon in which employees are artificially encouraged to remain with their insurer for fear of being uninsured and losing access to their health care providers and insurance.

The only economic rationale for allowing income-tax exemption of health insurance is to facilitate employer-sponsored insurance that pools individuals of all health risks into a single group, solving the problem of adverse selection.[45] That rationale no longer exists when community pricing is removed in favor of individual-based pricing.

The current tax-preferred status of health insurance also has important distributional impacts on self-employed workers and employees of companies that do not offer health insurance coverage. These individuals receive no subsidy for health care and must pay prices in the nongroup market that are considerably higher than prices in the employer-based insurance market.

The purely fiscal consequences of income-tax exemption for health insurance and certain other medical expenditures are clear. Economists estimated the revenue that the federal government would receive by eliminating the tax-preferred status of employer-sponsored health insurance to be approximately $294 billion in 2011, of which $177 billion (60 percent) was income taxes and $117 billion (40 percent) was payroll taxes. Adding revenue from elimination of other health insurance and expenditures, the total additional revenue would be $313 billion.[46] This substantially exceeds the budget loss to the federal government of the income-tax deduction for home mortgage interest.

In addition to the amount the federal government would save by eliminating the tax-preferred status of health insurance, there may be value to society arising from the elimination of distortions caused by the subsidy policy. For example, employer-based insurance leads to a reduction in choice of health insurance plans: expanding the choice of insurance plans available to consumers by eliminating the tie of insurance to employers has been estimated to be worth approximately one-fifth of premiums.[47]

All insurers will be encouraged to offer at least one long-term insurance contract option to consumers.

Safety-Net Emergency Care for All Americans

Under our proposal, all Americans will be guaranteed some level of health care regardless of their ability to pay. We propose a tax-financed safety net that covers the cost of care that would be guaranteed to all Americans regardless of coverage or ability to pay. The precise set of covered services will be defined by Congress in a manner that reflects Americans' beliefs about which services should be guaranteed to all. Certainly, this includes emergency services necessary to stabilize patients now covered by EMTALA. Moreover, the definition may be expanded to include low-cost, high-value services such as high-value medication used to treat chronic disease or serious illness.

Tax financing of this system is necessary to ensure all Americans pay their fair share of this cost and avoid the free-rider problem, in which consumers slough off the cost of their emergency care on others. We envision the safety-net tax being folded into the general tax system to promote administrative simplicity, and we note that this preserves the progressivity of the tax code. The revenue from the tax will go

into a national safety-net care pool that will be used to pay providers who deliver safety-net care not covered by insurance. To avoid double charging individuals who purchase insurance that covers these services, we propose a tax credit equal to the average cost of safety-net care for those who can demonstrate coverage for this care. Ultimately, those who are not already paying for safety-net care through a qualifying health insurance plan would bear the safety-net tax.

Evaluating Our Plan for Reform

The projected cost of our plan depends crucially on the set of basic insurance plans chosen for premium support. We recognize that the design of the basic insurance plan is a political issue that must be debated as such. Regardless, we believe that the basic plan should be configured so that benefits are greater for the poor and total public costs are no higher than projected under the ACA.

Simply to demonstrate that such an approach is economically feasible, we calculate government expenditures associated with a simple basic plan structure that is free to individuals and meets these criteria. In addition, we calculate family expenditures for households choosing this basic plan and separately for households choosing a more generous insurance plan whose cost is partially reimbursed by premium supports. The budget required to finance our proposed basic plan is roughly the same as that required to fund the ACA from 2014 onward. Revenues to finance the basic plan are drawn from federal and state Medicaid spending and elimination of the tax-preferred status of health insurance and medical expenditures. Medicare and care provided to veterans by the Veterans Administration are left unchanged and are not addressed by our plan.

Revenues

The basic plan will be funded through two sources. First, because we integrate low-income individuals into the exchanges, we propose eliminating all federal and state Medicaid spending except for expenditures on home health and long-term care, Medicare premiums for dual eligibles, and vaccines for children. This would have saved the federal and state governments roughly $332 billion in 2011.

Second, as we have already detailed, we propose eliminating the tax preference for employer-sponsored health insurance, which will not only free up spending to finance the proposed plan but will also improve economic efficiency by removing currently misaligned incentives to overutilize certain types of medical care. This would have eliminated roughly $313 billion in federal tax expenditures in 2011.

We believe that the basic plan should be configured so that benefits are greater for the poor and total public costs are no higher than projected under the ACA.

Together, these two provisions would yield $645 billion in revenue.[48] Note that with the elimination of state Medicaid spending and as a prerequisite for qualifying for federal subsidies to the basic plan, we require states to contribute these savings towards the financing of the basic plan. Overall state contributions to health care may exceed the predetermined amount if states choose to provide a state-specific basic plan that is more generous than the federal basic plan to their citizens.

Expenditures

Government expenditures under our basic plan are determined by the premium support subsidies that individuals receive to purchase the plan. Thus, the federal cost of our proposal depends on coverage under the basic plan. Our proposal allows policymakers a great deal of flexibility in defining the basic plan.

TABLE 3
STRUCTURE OF AN ILLUSTRATIVE FREE, BASIC, HIGH-DEDUCTIBLE HEALTH INSURANCE PLAN

		——Deductible (% of family income)——		
Family income (% of FPL in 2011)	Family income ($ for family of 4)	Not "extremely burdened" family	"Extremely burdened" family	Copayment
50%	11,175	5.0%	0.0%	0%
100%	22,350	10.0%	0.0%	0%
132%	29,502	13.2%	0.0%	0%
150%	33,525	15.0%	0.0%	10%
200%	44,700	20.0%	0.0%	10%
300%	67,050	30.0%	0.0%	10%
400%	89,400	40.0%	5.0%	10%
500%	111,750	50.0%	15.0%	10%
600%	134,100	60.0%	60.0%	20%
700%	156,450	70.0%	70.0%	20%
800%	178,800	80.0%	80.0%	20%
900%	201,150	90.0%	90.0%	20%
1,000%	223,500	100.0%	100.0%	20%

Source: Authors' calculations.

For purposes of illustration, we estimate the cost to the government of a basic plan that provides coverage for "catastrophic expenditures" above a certain plan deductible threshold. A household's deductible and copay for this catastrophic care plan would be set as a sliding-scale percentage of income and a household's expected medical expenditures. The deductible could be adjusted to accommodate different political notions of what constitutes "catastrophic."

Deductibles and copays under this illustrative plan are determined in three steps. First, households are categorized as to whether or not they suffer an extreme burden due to illness. This categorization depends on both income and health expenditures; in other words, the threshold for "burden" is lower for poorer households than richer ones. Second, the plan assigns deductibles that increase with family income but decrease with the burden imposed by sickness. Third, copayment percentages are assigned so that they increase with income.

Our specific formula for calculating deductibles under the illustrative basic plan defines a family as suffering an extreme economic burden due to illness if its income is below 600 percent of the FPL and its medical expenditures are greater than 80 percent of households in America.[49] For example, in 2008, total health care expenditures per household in the 80th percentile were approximately $4,000. To determine a household's deductible as a percentage of income, our formula first calculates a baseline percentage equal to income divided by 10 times the FPL. If a household is categorized as extremely burdened, the formula sets deductibles at this baseline percentage minus 35 percent, subject to the caveat that the deductible cannot be lower than zero. If a household is not extremely burdened, the formula sets deductibles equal to the baseline percentage.

Our formula for copayments above the deductible is also progressive with income. Households with income less than 133 percent of the FPL face no copayments under the basic plan. Households with income between 133 and 600 percent of the FPL face a 10 percent copayment for expenditures above their deductible. Households with income above 600 percent of the FPL face a 20 percent copayment.

TABLE 4
EXPECTED HOUSEHOLD SPENDING UNDER BASIC AND GENEROUS PLANS

		Individuals in the bottom two-thirds of health expenditures ("healthy")						Individuals in the top third of health expenditures ("sick")					
		Basic plan		Generous plan				Basic plan		Generous plan			
Poverty category (% FPL range)	Household income ($)	Net premium ($)	Out-of-pocket (OOP) ($)	Net premium ($)	OOP ($)	Wage increase ($)	Net gain vs. ACA ($)	Net premium ($)	OOP ($)	Net premium ($)	OOP ($)	Wage increase ($)	Net gain vs. ACA ($)
<100%	12,576	0	232	178	77	788	548	0	322	–3,595	3,449	804	975
100–132%	28,515	0	362	333	72	1,158	796	0	920	–1,300	2,050	1,215	571
133–199%	37,689	0	389	358	78	1,502	2,684	0	2,079	–483	2,498	1,794	3,227
200–299%	58,215	0	435	400	87	1,898	3,516	0	2,023	–37	2,055	2,138	4,263
300–399%	74,003	0	523	482	105	1,999	3,762	0	2,475	631	1,926	2,294	4,163
400–499%	90,891	0	554	510	111	2,136	4,064	0	5,555	4,184	1,917	2,320	1,218
500–599%	105,478	0	552	508	110	2,140	4,075	0	7,988	6,706	2,157	2,350	–922
600–699%	122,600	0	616	566	123	2,079	3,894	0	8,991	7,988	2,045	2,263	–2,268
700–799%	133,495	0	601	553	120	1,946	3,626	0	7,908	7,255	1,599	2,227	–1,617
800–899%	157,677	0	563	518	113	1,881	3,521	0	9,744	8,857	2,043	2,077	–3,321
900–999%	167,210	0	602	554	120	1,857	3,438	0	9,551	8,772	1,923	1,966	–3,649
1,000+%	226,249	0	610	561	122	1,732	3,169	0	12,054	11,090	2,411	1,918	–5,625

Notes: To calculate premiums for the basic plan, we use data from the Medical Expenditure Panel Survey (MEPS). We first computed mean individual expenditures from the MEPS and adjusted differences between national spending accounts and MEPS totals. This resulted in mean medical expenditures for individuals in each income strata. For those with incomes below 100 percent of the FPL (those currently eligible for Medicaid), our estimated expenditures were scaled up by 36 percent to account for higher prices that our proposal will pay for Medicaid providers who service nondual Medicaid-eligible beneficiaries. Assuming a conservative 15 percent administrative cost of insurance on these final mean expenditures, we calculated the premiums for households in each income strata. The first column of this table differs from the first column of table 3. Whereas table 3 provides information on deductibles at specific family income levels, this table provides information on average household spending for specific family income ranges. All monetary amounts are in 2008$.

Table 3 lays out what household deductibles and copayments would be under our illustrative basic plan for a family of four, with various levels of income and burden. As an example, consider a household earning $67,050 per year (300 percent of the FPL for a family of four). Past a deductible, all households at this level pay a 10 percent copayment. The deductible itself varies depending whether the household is categories as burdened. "Burdened" households enjoy zero-deductible coverage under the basic plan. An unburdened household at this income level, on the other hand, is assigned a basic plan with a high deductible. However, only households with low expected expenditures are assigned to a high-deductible basic plan, so the expected expenditures are small even under the high-deductible plan, a fact illustrated in table 4.

Critically, the purpose of the basic plan is *not* to determine a universal standard of coverage for all Americans. Rather, the purpose of the basic plan is threefold. First, it guarantees a minimum, generous standard of coverage for the poor and the sick. Households extremely burdened by illness face no deductible.[50] Households with income below 133 percent of the FPL face no copayments, regardless of illness burden.

Second, the basic plan governs the generosity of premium supports that all Americans can use to purchase coverage that meets their needs. Because of the availability of premium supports, which are a more

transparent and progressive way to replace the current tax break for purchase of employer-sponsored health insurance, all health plans offered in the marketplace become more accessible. For most Americans, we expect that premium supports will be applied to purchase this more generous coverage. Among all groups, sicker households would receive greater premium supports than healthier ones; this mitigates the more significant medical cost burden faced by these households (and partially ameliorates concerns about the lack of long-term insurance markets). And for the healthy, regardless of their income, medical expenditures are likely to be quite affordable, even for relatively generous coverage.

The purpose of the basic plan is not to determine a universal standard of coverage for all Americans.

Third, the structure of the basic plan governs the total cost to the public sector of premium supports. A more generous basic plan leads to more cost, and vice versa. Federal cost containment thus boils down to setting an affordable benefit structure for the basic plan.

The first two of these points are highlighted in table 4, which illustrates premiums and out-of-pocket expected health care expenditures (deductible plus out-of-pocket copayments) under both the basic plan and a generous plan with zero deductible and 20 percent copayment. It also provides an estimate of the wage increase that would be enjoyed by households that no longer rely on their employers for health insurance. Finally, we provide a calculation of how total expenditures compare to estimated total expenditures under the ACA.[51]

For the basic plan, the premium charged to each household is zero and the expected out-of-pocket expenditures arise from first-dollar payment until the household reaches its deductible. Above that point, the household faces 10 percent copayments if its earnings are above 133 percent of the FPL and 20 percent copayments if its earnings are above 600 percent of the FPL. For the generous plan, the calculated out-of-pocket expected medical expenditures are the premium paid by households, net of the premium support that they receive, plus 20 percent copayment.

Because households can use the premium supports for the basic plan to purchase a more generous plan, they have a choice between these two alternatives. In general, households will experience lower total costs (net premiums plus out-of-pocket costs) under the basic plan because those premiums are fully subsidized. The generous plan has lower deductibles for most income levels, so it will tend to have higher premiums.

Households with incomes below 350 percent of the FPL and that are extremely burdened are the exception to the rule that the generous plan is more expensive than the fully subsidized basic plan. At these incomes, households face no deductible under the basic plan. As a result, the basic plan offers more coverage and thus costs more than the generous plan for these households. Moreover, the premium supports for the basic plan more than cover the cost of the generous plan. For example, households with extreme economic burden due to sickness and that are below 100 percent of the FPL will be able to pocket $3,595, on average, because premium supports exceed the cost of generous plan premiums. This will help these families offset the $3,449 in out-of-pocket expenditures they typically face. As a result, their average total expenditure (premium plus out-of-pocket) under the generous plan is $469 less than under the basic plan.

This amount is further offset by wage increases that will follow the elimination of the tax preference for employer-sponsored health insurance. After the elimination of the tax break for employer-sponsored health insurance, employers will switch from providing tax-preferred health benefits to paying workers somewhat higher wages. The magnitude of the wage increase depends on whether an individual is employed, the extent of her employer-provided health insurance benefits, and her income tax rate. Many economists have found this pass-through to be nearly 100 percent.[52] We conservatively assume it

is just 90 percent. As a result, families below 500 percent of the FPL will typically be better off under our reform than under either the status quo or the ACA reforms that will be implemented in 2014. Thus, for example, households with incomes between 300 and 600 percent of the FPL can expect to see annual wages rise on average $2,300, typically enough to cover their out-of-pocket expenditures under a generous plan.

In sum, table 4 demonstrates that—compared to the ACA—providing a choice between our free basic plan and the subsidized generous plan benefits all "healthy" households and all "sick" households under 500 percent of the federal poverty line. The only households that would prefer the ACA are the "sick rich" households that face high health expenditures and have incomes above 500 percent of the FPL. In other words, our plan is more generous toward the healthy and sick poor than the ACA. Overall, our plan redistributes from the sick rich to the healthy and the sick poor.

The third purpose of the basic plan is to regulate the growth of federal spending. In that respect, our illustrative basic plan saves roughly $6.1 billion per year relative to the ACA. Specifically, the premium supports required to finance the basic plan (or subsidize the purchase of more generous plans as described above) cost $745 billion in total. After subtracting the $645 billion in revenue we raise from saved Medicaid spending and reduced tax expenditures on health insurance and medical expenditures, our illustrative plan costs $100 billion in its first year. Over 10 years, the annual cost of the plan rises to $145 billion if growth in the medical Consumer Price Index is conservatively assumed to be 4.2 percent per year. By contrast, the ACA costs $127.7 billion per year on average over this period.[53] The net savings is $61.5 billion over 10 years.

The Plan in Practice

Before evaluating how our plan achieves the national priorities outlined earlier, we illustrate with several examples how key features of our proposed plan—risk rating, premium support, and long-term health insurance contracts—may be implemented for individuals of differing health and income. In each example, we compare our plan to the status quo and coverage under the ACA.

Our illustrative basic plan saves roughly $6.1 billion per year relative to the ACA.

Scenario 1: A young mother with schizophrenia receiving Medicaid. The first scenario considers a 25-year-old mother whose health insurance is provided by Medicaid. She suffers from schizophrenia, which has limited her ability to work; her annual income is approximately at the FPL. Although her household's annual expected medical expenditures are nearly $15,000, because she is covered by Medicaid, her out-of-pocket medical expenditures for her and her child are zero.

Under our proposal, because she qualifies as having extreme economic burden due to sickness given her expected medical expenditures and income, she is eligible for a basic plan that has zero out-of-pocket medical expenditures. Both she and her child are unaffected by the transition from Medicaid to our basic plan, but they may see improved access to care because providers would be paid market rates, not Medicaid rates.

Scenario 2: A young, healthy construction worker. This scenario considers a 25-year-old construction worker. He is married with one child. His household earns 200 percent of the FPL annually (approximately $44,700 before taxes) but neither he nor his wife has insurance. Both he and his wife are healthy—they seek medical care only infrequently and have no chronic medical conditions. Because they have no insurance, all of their medical expenditures are out of pocket. However, because they are healthy, their expected medical expenditures are very low.

Under our proposal, the young man would be eligible for a basic plan with zero premium, a deductible of $8,940, and a 10 percent copayment beyond the deductible. Given his level of health, table 4 indicates that this person's expected out-of-pocket medical expenditures are approximately $435 per year, well below his deductible. Yet, because the deductible in the basic plan would be high, he may fear choosing a basic plan with this level of financial risk. He may instead apply his premium support toward a more generous plan.

A more generous plan that offers zero deductible and a 20 percent copayment to someone of his medical risk would require a premium of $400 per year. Net of federal premium support, his expected out-of-pocket expenditures per year would be $487, arising from a $400 premium for the generous plan plus an additional expected out-of-pocket expenditure of $87. Compared to the cost of his coverage under the ACA, this person would be better off by approximately $3,516.

Scenario 3: A lawyer with newly diagnosed cancer. The next scenario considers a 55-year-old man who is a self-employed real-estate attorney. Previously insured through a large employer, he decided not to purchase insurance for himself in the private, nongroup market because he felt it was too expensive. Six months after losing insurance, he began to lose weight, feel more fatigue, and have occasional fevers. He was ultimately found to have lung cancer.

His unfortunate illness places him at an extreme economic burden because his expected annual medical expenditures are in the top 1 percent and his annual household income is 600 percent of the FPL ($134,100). Under our proposal, he would be eligible for a basic insurance plan with a high deductible ($33,535; 25 percent of his pretax income) and a 20 percent copayment beyond the deductible. Although his actual medical expenditures may end up being lower than the basic plan deductible, he may instead seek more generous coverage.

Given his high expected medical expenditures, the premiums charged by private insurers will be high with risk rating, but the corresponding premium support that he receives from the federal government will be substantial as well. For instance, with premium support, he may purchase a generous plan with zero deductible and a 20 percent copayment at a premium cost of $7,988 per year and expected out-of-pocket expenditures beyond that premium of $2,045. This would correspond to approximately 8 percent of his household's pretax income. Compared to the cost of the coverage under the ACA, this individual would be worse off by approximately $2,268.

Note that this is a wealthier person with higher health expenditures. Without any government safety nets, a market-oriented solution will tend to raise premium costs for sicker households and lower them for healthier households. Under our configuration, poorer households are protected from these cost increases. The burden of this approach is borne, therefore, by the "sick rich." Put differently, our approach demands greater contributions from households that use the health care system more and have a greater ability to pay.

Scenario 4: Long-term contracting in a retired CEO with a history of heart disease. Scenario 4 considers a 60-year-old man who has been working for the same midsized company his entire life. He earns a base salary of $400,000 per year that puts him easily in the top 1 percent of all Americans, even before counting bonuses and stock options. Although he has long had difficulty climbing stairs because of chest pain from angina, this year his health took a turn for the worse with a heart attack that he barely survived. This health crisis has left him unable to continue as the company's CEO and forced him into retirement.

Ten years ago, he signed a long-term health insurance contract for him and his family. As part of the contract, the premium payments increase each year at the rate of medical inflation but did not go up when he had his heart attack.

When he first shopped around on the federal exchange, cheaper plans than the one he selected were available, but the plan he chose had an extensive network of specialists, which was important to him. The premium payments were more expensive than for

plans with narrower networks but still only a fraction of his yearly earnings. The premiums were also higher than other available plans because of the guarantee that they would not increase as a result of any changes in this individual's health status. Now that he is retired, the premiums are a bit more of a burden but still easily affordable because they do not increase to reflect his higher expected medical expenditures—indeed, this crucial feature of long-term insurance coverage is what attracted this consumer in the first place.

Scenario 5: Long-term contracting for a young, healthy engineer. Finally, consider a 26-year-old woman who is a software engineer. She has been out of college for only four years and is now earning $150,000 per year. Despite her busy schedule, she is careful to make time for exercise daily and to eat healthy foods. Until last year, she had health insurance through her parents' family health plan, but now that she has established herself in her career, she decides that it is time to seek out her own insurance plan.

At the federal health insurance exchange, this consumer finds a long-term health insurance plan that meets her needs. It is priced at a low premium to reflect her youth and her healthy lifestyle. The plan includes some coverage for preventive care, which she considers important. The plan also has an option to extend coverage to any future members of her family, should she get married or have children (though the premiums will rise in the event of additional family members joining). However, the plan will never increase her premium beyond inflation in the future, even if her health does happen to decline.

The plan includes a substantial deductible and some copayment provisions, which keep premium costs down, but it also exposes her to some risk of out-of-pocket payments. Because she makes so much money, in most cases, she will not qualify for federal subsidies to help cover those payments. However, if her health care expenditures (including both premiums and out-of-pocket payments) do happen to rise above the government cap in any given year, she will qualify for subsidies to help her make those payments.

Achieving the National Priorities

Ensuring Universal Access. All individuals receive premium supports that allow them to purchase the lowest-cost basic coverage plan for free. This achieves universal or nearly universal coverage, since few or no individuals are likely to go uninsured instead of accepting a free insurance plan. In addition, all individuals—including those who opt out of free insurance for uninsurance—will be provided federally funded insurance for emergency care, which will be financed by a general safety-net tax.

Protecting the Poor and the Sick. Our proposal will enable all individuals to purchase some form of health insurance, regardless of income. The poor—defined as those below the FPL—will have no out-of-pocket health care expenditures, as the federal government will pay for both the premiums and deductibles of the privately administered health plans through premium and deductible supports. The middle-income sick will be financially protected by a cap on total health care spending set at a fixed percentage of adjusted gross income. Spending above the cap will be fully subsidized.

Restraining Cost Growth. First and foremost, our proposal is designed to promote competition among health insurers. Sick or poor individuals who might normally suffer uninsurance when competitive firms charge the true cost of coverage will be offered public subsidies that make privately administered insurance either free or affordable. Companies offering the lowest-cost basic plans will be automatically rewarded with default enrollments, appearing free to consumers. Our plan will facilitate price shopping by individuals interested in purchasing something other than the basic plan. All premiums will be quoted in a single place (ideally online). Therefore, companies with premium bids significantly higher than their competitors' cannot expect to succeed over the long term.

If insurers have incentives to hold down premiums, they also have incentives to hold down overhead costs

associated with administration and fraud. Most important, they will seek to manage the use of health care technology in a manner that avoids waste. Private firms have incentives to provide valuable care to consumers, who will not continually select insurers that deny safe, effective, and valuable forms of care. They must balance this against their incentive to hold down premiums and compete in the marketplace.

In contrast, public insurers have much weaker incentives to control cost or to provide value. Although budgetary pressures may ultimately restrain spending by public programs—Medicaid is a prime example—few checks and balances are in place to ensure that public insurers trim "the fat" rather than the services that consumers most value. A public insurer that eliminates services that are highly valuable to consumers does not face the specter of bankruptcy, but a private insurer does.

In the meantime, public insurers that do not face significant and immediate budgetary pressure—like Medicare, recently—tend to avoid approaches that restrain costs. For instance, empirical evidence suggests that variation in Medicare spending across geographic areas is partly driven by varying tendencies of physicians and hospitals to provide aggressive care to Medicare beneficiaries. In at least some well-documented examples, this is the result of wasteful care being provided in some areas.[54] Notably, private insurers exhibit much less of this geographic variation in spending.[55]

Another major cost advantage of private-sector provision of insurance is the possibility of innovation in the design of insurance. It took Medicare 40 years to add coverage for prescription drugs. Private insurers discovered the value of this addition decades earlier. Similarly, private insurers have led the way in value-based benefit design, high-deductible plans, and a variety of other novel health insurance structures.[56]

Medicare Part D provides a useful model of government premium supports for private health insurance. Part D has consistently come in under budget.[57] To be sure, this fact should be interpreted with caution because prescription drug insurance is not entirely analogous to medical coverage, and other forces (such as significant patent expiration for branded drugs, rapid transition to generics, and relatively modest numbers of new drugs arriving) contribute to savings. Yet it is a useful observation demonstrating the success of a smaller-scale approach to ensuring coverage through the use of private health insurance markets.

A final means by which our proposal may limit health care spending growth is by encouraging individuals to invest in their own health. Although health insurance will still be highly subsidized for the sick, individuals will have greater incentive than before to invest in their own health because the insurance premiums they face are tied to their overall health.

Ensuring Efficient Provision. Our plan eliminates a wide variety of state and federal regulations that distort prices in health insurance and health care markets. As discussed earlier, regulations in some states mandate the coverage of particular services that may be valuable to only some individuals. We recognize the value of ensuring access to a certain package of medical services, and our goal for our "basic" health insurance package is to achieve that. However, outside the basic package, insurers are free to offer whatever mix of coverage they believe individuals will value.

Current regulations also prevent insurers from charging different prices to individuals based on risk, a phenomenon that discourages healthy (cheaper) individuals from remaining insured. Our plan ends this practice and allows insurers to charge fair prices to all consumers. At the same time, it is crucially important to recognize that all Americans, including the sick and the poor, need access to basic coverage. Premium supports enable all individuals to afford this.

In the long run, the most important feature of our plan with respect to cost control may be the approach to handling health care innovation. In the current system, Medicare is obliged to cover all or nearly all new health care technologies that emerge. Private insurers are technically able to deny coverage for some of these new technologies, but in practice, Medicare coverage pressures all insurers to cover new technologies. As a result, new innovations are adopted in a

blanket manner without attention to the value generated for consumers. Replacing all or part of Medicare with a privately administered system would have an important advantage by enabling insurers to decide what new technologies to cover. Since long-run cost growth is driven primarily by spending on new technologies, this may be the most important aspect of cost growth under our plan.[58]

Respecting Diversity. Rather than forcing consumers to opt into a single limited plan, our approach allows them to seek out the types of care they value and avoid the rest. Insurers are free to offer many kinds of policies to satisfy alternative consumer needs, and consumers are free to choose among the alternatives. At the same time, we recognize that unfettered choice can be problematic, especially among populations that are sicker or cognitively impaired.

We recommend that the insurance exchange group plans into categories according to a basic set of coverage criteria. For example, a higher-tier category may be different than the category below if its plans allow individuals to seek out-of-network care free of charge. We will also default individuals into the lowest-cost basic plan option. More sophisticated consumers, or those with very different preferences, can opt into different plans without delay or penalty. But those seeking a simple, quick decision are able to receive basic health insurance with little to no action on their part.

Implementation Issues

This report presents a broad framework for health reform, but a number of questions remain to be addressed. The central political question will be around the generosity of the subsidy system, which is determined for each individual by the lowest premium quoted by the market for the basic plan. The overall federal expenditure for the basic plan will be determined, however, by the federal budget. Thus, defining the basic plan becomes central to defining the subsidies and meeting the global federal budget for health care.

Our suggested approach is to define a simple basic plan based on a single deductible for medical and prescription drug services. The deductible can vary with income, and every year could be reset to achieve fiscal and distributional goals. It may be desirable to hard-wire into the system some rate of increase in subsidies (for example, the rate of GDP growth).

Replacing all or part of Medicare with a privately administered system would have an important advantage by enabling insurers to decide what new technologies to cover.

We recognize that not all consumers would prefer a simple deductible plan. However, the basic plan need not be chosen by any consumer. It exists to provide a benchmark for the determination of premium supports. We expect market demand will generate substantially more generous and nuanced benefit designs that attract consumers. For example, value-based insurance design provides lower copayments for highly effective services and higher copayments for less effective services. Such systems, which reward the use of high-value services and penalize the use of low-value services, may be particularly attractive for plans that offer long-term contracts.

Ultimately, defining the appropriate level of basic coverage, and thus subsidy, is a political question that should reflect how society values the provision of health care to all its citizens. Under our approach, policymakers can set subsidies to be as progressive or as limited as they want. In our illustrative example, we have structured the subsidies so that everyone below 500 percent of the FPL is at least as well off under our plan as under the ACA. Because our scheme replaces Medicaid, it should actually improve care for the very poor by improving access to quality care.

An important feature of our plan is that the wealthy sick bear much of the burden for financing health care. Those with both the need and the means

to contribute more toward health care are asked to do so under our proposal. Under the ACA, the distributional consequences for individuals of varying income and health are unclear, whereas in our proposal, the sick poor and middle class are insulated from significant health care costs, which are financed relatively more by the wealthy sick than in the current system.

Success of our plan relies on several important pillars. Compared to the ACA, we rely more heavily on market forces to discipline the health care system. Specifically, in our model, competition among insurers drives the system to generate desirable outcomes. In our plan, insurer bids, facilitated by systems to support search and choice, determine spending without external boards or oversight. Competition among plan providers drives premiums and benefits to economically efficient levels. This requires consumers (at least, a sufficient number of consumers) to effectively shop for coverage.

Our proposal would create institutions to facilitate this search. For example, our plan requires creation of a centralized database that allows insurers to quote prices on the exchange. We envision a database that consists of extant data that are used in many settings and maintained only for the purposes of pricing. Considering the benefits of competition and importance of transparency, we consider this well worth the cost. We should note, however, that insurer pricing algorithms should remain confidential. The underlying data that serve as inputs into these algorithms are held by only the exchange and not shared with insurers.

Much of the data that will be required are already provided to various government entities, so we do not consider this a large expansion in federal data collection. This system of individual pricing eliminates concern over adverse selection, often cited as the reason why competitive markets in health care fail. Our proposal does not preclude group pricing by those organizations that choose to do so but instead lifts restrictions on individual-based pricing.

Nevertheless, uncertainties remain. The market may favor a structure with a few types of alternative plans—like the automobile market with sedans, coupes, convertibles, and so on. This would facilitate consumer choice, price comparison, and price competition among roughly similar plans. On the other hand, it might also favor a great deal of differentiation with many different price choices. The first outcome provides less choice but more plan competition. The second provides many choices, perhaps even an overwhelming amount, but less direct price competition. This trade-off points to the importance of vigilant antitrust enforcement and other approaches to ensure competition, as well as designing health exchanges in a manner that facilitates consumer search and price shopping. For example, the exchange could take the lead in grouping and sorting similar plans.

Consumer search tools will also need to account for how insurers and health care providers interact. Specifically, insurers increasingly provide coverage that incorporates mechanisms to contain costs by negotiating for lower provider rates. For example, insurers define provider networks, adopt utilization review programs, and work with their health care providers to alter the patterns of care. These features add another dimension to the consumer's search problem, which may call for new approaches to delivering information about the scope and quality of insurance plans.

Because of the important role insurers play in influencing access to care, regulations to ensure that plans offer adequate access to care (for example, have sufficient numbers of providers in a beneficiary's market area) will be important to facilitate competition among insurers. Our preference is that such regulation be established with minimal disruption, and we prefer methods that inform consumers as opposed to regulating insurers. As an example, insurers may be required to fully disclose the availability of in-network physicians within every locality of their operation.

Existing evidence suggests that broadening the market to allow more insurers to compete leads to lower premiums.[59] This suggests competition in the insurance industry can benefit consumers. It is not entirely clear how many insurers are needed to approximate a competitive model. At the same time, a small number of more powerful insurers in the marketplace

seem to lower the prices charged by noncompetitive health care providers, presumably because of greater bargaining power by insurers.[60] This requires a thoughtful and evidence-based approach to antitrust enforcement in the health insurance industry. In general, the evidence suggests that more insurers competing leads to better outcomes for patients, but this depends on effective antitrust enforcement in the health care provider market as well.

Another key uncertainty is the extent to which long-term insurance contracts will take root. Our approach eliminates a number of legal barriers to long-term contracting and should allow patients to insure themselves against the risk of becoming sick in the future. Long-term contracts allow the market, rather than the cash-strapped public sector, to assume the spending risks associated with population aging. Yet we recognize that this is largely uncharted territory that will require insurers to take on different kinds of systematic risks associated with aggregate growth in health care spending.

In practice, any plan will likely have to follow our approach of initially pegging the basic plan to traditional short-term insurance coverage. Over time, the basic plan should provide long-term coverage that insures an individual against emerging health risks, but we recognize this requires the development of the long-term insurance market in the interim. On the plus side, the assumption of long-term spending risk also gives private insurers a much larger stake in encouraging the efficient adoption of new technologies.

Finally, there is concern that insurers will not step in to offer generous plans to all Americans. That is, because insurers are free to offer plans to whomever they choose, they may not present quotes to some people with high-cost conditions or markers for high expenses. These concerns are mitigated because first, all insurers must quote the basic plan to any American who desires it, and second, subsidies will be set in a such a manner to ensure all Americans can get a basic insurance plan at no cost. It would not be difficult to tweak the premium support schedule to ensure that generous plans are being offered to all Americans if the financial resources are available.

Ultimately, these uncertainties will never be fully resolved until elements of our proposal are put into practice. Fortunately, an important strength of our proposal is that it can be implemented on a pilot basis to assess its viability both fiscally and in ensuring adequate health care to those involved. Such a pilot program could be implemented in the spirit of existing Medicare demonstration projects. For example, the health insurance exchange concept discussed here could be piloted in a metropolitan area or even a state. As with any pilot program, challenges may arise in securing enough insurers willing to provide coverage in a geographically limited market. However, a state willing to experiment with this strategy for replacing Medicaid would create a substantial incentive for private insurers to enter and cover the influx of previous Medicaid enrollees—all of whom have access to government premium supports—into the private market.

The central innovation in our plan is the proposal to allow individualized pricing in the private insurance market.

Comparison to the Affordable Care Act and Its Competitors

Like the drafters of the ACA, we recognize the value Americans place on the goal of universal coverage and the social imperative to protect the poor. In addition, both plans recognize that adverse selection and other market imperfections may cause the insurance market to unravel. The ACA addresses this concern through the use of mandates and community rating, but our plan uses a system of risk rating, subsidies, and "nudges."

The central innovation in our plan is the proposal to allow individualized pricing in the private insurance market. Neither the ACA nor the Ryan plan, nor

any other alternative we are aware of, contemplates this shift in the marketplace. This tenet serves as the economic linchpin of our approach, which enables private markets to function without a mandate. The absence of individualized premium setting from the policy debate has hamstrung market-oriented approaches, which have relied on efficient markets but failed to solve the deep structural obstacles to a stable marketplace in which consumers will voluntarily purchase coverage. In addition to avoiding the need for a mandate, our plan makes the system of subsidies to the poor and sick more transparent, which we consider a virtue.

Although the progressivity of our model ultimately depends on subsidies, which are a political calculation, we anticipate that for any level of average subsidy our plan will be more progressive than the ACA. This is because the use of community rating to generate subsidies implicitly benefits relatively high-income individuals in poor health, whereas our model focuses subsidies on those with lower incomes. Yet, compared to the ACA, our plan focuses more heavily on the fiscal consequences for public spending and strives to reduce relative costs. As a result, we suggest the basic coverage be less than in the ACA, which typically strove to mandate coverage as generous as a typical plan. The subsidy system we propose is flexible so that it could be ratcheted up if desired, but our intent is to create a basic plan that includes incentives for consumers to be sensitive to the cost of care and means tests the subsidy so that individual medical spending is proportional to income.

Unlike the ACA, which generally builds on the employer-based insurance system, our plan will weaken or potentially eliminate employer-based coverage by removing its tax deductibility entirely. This is a more aggressive approach than the ACA, which caps deductibility in 2018. We consider the demise of the employer-based system an advantage because it removes the regressive tax deductibility of the existing system, eliminates distortions in the labor market, and allows individuals to better match their coverage to their preferences. We recognize that many will be concerned that this will generate a windfall for employers who will no longer be providing coverage (though there is no prohibition against them subsidizing plans). However, extensive evidence suggests that wages will rise to offset the reduction in employer provided coverage—thus workers, not employers will reap the gains.[61] The added income could be used to buy more generous coverage or goods that the consumer values even more than additional coverage.

Whereas the ACA expands Medicaid, we eliminate it for medical services. (We envision it remaining for long-term care services.) This has several advantages and disadvantages. On the down side, Medicaid programs pay 36 percent less than private payers.[62] By eliminating the discount, our plan becomes more expensive, which is built into our calculations. The advantage of this approach is that it avoids saddling the poor with narrower provider networks and potentially lower-quality options. It also transfers spending from state governments to the federal government. The latter more effectively spreads the costs of subsidizing the low-income population, creates more equity across states, and reduces the crowding out of other important state priorities from state budgets.

Conclusion

Most Americans agree that the health care system is not functioning well. Most would also agree that health reform should protect the sick and poor while eliminating waste. Finally, most would agree that both the private sector and the government have substantial roles to play in solving the health care dilemma. The salient political question has revolved around the best way of achieving all of these shared goals.

We believe a fresh perspective is needed on this question. Government and the private market will work best together if we focus each on its strengths, rather than its weaknesses. Government should focus on the mission of creating a level playing field for firms and consumers and on protecting the interests of the disadvantaged. The market should focus on setting prices that reflect value and cost and allocating health care resources efficiently. Neither of these goals has been possible in a system that forces the market, rather than the government, to redistribute resources from healthy to sick under the guise of community-rating regulations.

Allowing individualized health insurance pricing will finally allow the market to operate efficiently. Focusing the government on subsidizing care for the disadvantaged achieves the important goal of equity that most Americans believe is essential in health care. Perhaps most important, this approach concentrates the political discussion on questions of justice and redistribution, rather than on price setting and plan administration. Self-interested firms are poorly positioned to care for the vulnerable in America. At the same time, regulators and legislators lack both the expertise and the incentive to make business decisions about the pricing and administration of health care.

Fundamentally, the health care quagmire in the United States owes itself just as much to the misallocation of government expertise as to the misallocation of doctors, nurses, and hospital beds. Our plan moves to correct this most important imbalance in the system.

Notes

1. Senate Committee on Finance, *Tax Expenditures for Health Care, Prepared by the Staff of the Joint Committee on Taxation,* 110th Cong., 2nd sess., 2008.

2. Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2010* (Washington, DC: US Census Bureau, 2011), www.census.gov/prod/2011pubs/p60-239.pdf. About seven million undocumented immigrants are without insurance (out of 11 million total undocumented). The question of whether US taxpayers should pay for their health care is a political decision. Here we follow the Affordable Care Act and exclude them from our plan.

3. The Congressional Budget Office/Joint Committee on Taxation (CBO/JCT) estimate that, as a result of the ACA, 14 million additional lives will be insured by 2014 and 30 million additional lives insured as of 2022. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, July 2012, www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

4. Some would add quality of care to this list of problems, contending that the American system is inferior to that of many other countries. This claim is hotly contested by others who say that the American health care system is the best in the world. The issue is outside the scope of this report.

5. Our approach shares several significant features with Mark Pauly, *Health Reform without Side Effects: Making Markets Work for Individual Health Insurance* (Palo Alto, CA: Hoover Institution Press, 2010). Notably, Pauly advocates a market-based solution with individualized premium pricing and government redistribution toward the disadvantaged.

6. Dana Goldman and Kip Hagopian, "The Health-Insurance Solution," *National Affairs*, no. 13 (Fall 2012): 95–109.

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9. Peter J. Cunningham and Ann S. O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians?" *Health Affairs* 28, no. 1 (2009): w17–w28.

10. Goldman and Hagopian, "The Health-Insurance Solution."

11. Institute of Medicine, *Care without Coverage: Too Little, Too Late* (Washington, DC: National Academy Press, 2002); J. Michael McWilliams et al., "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *Journal of the American Medical Association* 290, no. 6 (2003): 757–64; David Card, Carlos Dobkin, and Nicole Maestas, "The Impact of Nearly Universal Coverage on Health Care Utilization and Health: Evidence from Medicare" (working paper 10365, National Bureau of Economic Research, Cambridge, MA, 2004); Jonathan Meer and Harvey S. Rosen, "Insurance and the Utilization of Medical Services," *Social Science and Medicine* 58, no. 9 (2004): 1623–32.

12. Institute of Medicine, *Care without Coverage*; David W. Baker et al., "Loss of Health Insurance and the Risk for a Decline in Self-Reported Health and Physical Functioning," *Medical Care* 40, no. 11 (2002): 1126–31.

13. Institute of Medicine, *Care without Coverage*; Baker et al., "Loss of Health Insurance"; J. Michael McWilliams et al., "Health Insurance Coverage and Morality among the Near Elderly," *Health Affairs* 23, no. 4 (2004): 223–33.

14. Katherine Baicker and Amy Finkelstein, "The Effects of Medicaid Coverage—Learning from the Oregon Experiment," *New England Journal of Medicine* 365 (2011): 683–85; and Amy Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *Quarterly Journal of Economics* 127, no. 3 (2012): 1057–106.

15. Helen Levy and David Meltzer, "The Impact of Health Insurance on Health," *Annual Review of Public Health* 29, no. 1 (2007): 399–409.

16. Brian Galle and Kirk J. Stark. "Beyond Bailouts: Federal Tools for Preventing State Budget Crises," *Indiana Law Journal* 87, no. 2 (2012): 600–36.

17. Congressional Budget Office, *The Long-Term Budget Outlook,* 2009, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/102xx/doc10297/06-25-ltbo.pdf.

18. Ibid.

19. Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 2011, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2011.pdf.

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21. *United States Government Supplemental Information (Unaudited), for the Years Ended September 30, 2010, and 2009*, 148, http://fms.treas.gov/fr/10frusg/10suppl.pdf.

22. Congressional Budget Office, *Financing Projected Spending in the Long Run*, 2007, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/82xx/doc8295/07-09-financing_spending.pdf.

23. CBO, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act."

24. Alan M. Garber and Jonathan Skinner, "Is American Health Care Uniquely Inefficient?" *Journal of Economic Perspectives* 22, no. 4 (2008): 27–50.

25. Michael E. Chernew et al., "Impact of Decreasing Copayments on Medication Adherence within Disease Management Program," *Health Affairs* 27, no. 1 (2008): 103–12.

26. California Health Benefits Review Program, *Health Insurance Benefit Mandates in California State and Federal Law* (Oakland: University of California, 2012), www.chbrp.org/documents/ca_mandates.pdf.

27. Jon R. Gabel and Gail A. Jensen, "The Price of State-Mandated Benefits," *Inquiry* 26, no. 4 (1989): 419–31; Joanna N. Lahey, "The Efficiency of a Group-Specific Mandated Benefit Revisited: The Effect of Infertility Mandates," *Journal of Policy Analysis and Management* 31, no. 1 (2012): 63–92.

28. The Health Insurance and Portability and Accountability Act §702(a)(1) prohibits employers from discriminating among employees based on health factors when setting insurance premiums. In 2006, six states had legislated community-rating mandates, while seven others had narrow rating "bands." For more information, see Bradley Herring and Mark V. Pauly, "The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market" (working paper no. 12504, National Bureau of Economic Research, Cambridge, MA, 2006).

29. To some extent this is facilitated by the consumer bankruptcy system, which allows individuals with limited assets to discharge their debts. This encourages individuals to forgo purchase of insurance. See Neal Mahoney, "Bankruptcy as Implicit Health Insurance" (working paper no. 18105, National Bureau of Economic Research, Cambridge, MA, May 2012).

30. Michael Chernew, David Cutler, and Patricia Keenan, "Charity Care, Risk Pooling, and the Decline in Private Health Insurance," *American Economic Review* 95, no. 2 (2005): 209–13.

31. Jack Hadley et al., "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* 27, no. 5 (2008): w399–w415. Up to $42.9 billion may already be indirectly covered by public funds such as Disproportionate Share Hospital (DSH) payments under Medicaid and Medicare.

32. Alan Garber, Charles Jones, and Paul Romer, "Insurance and Incentives for Medical Innovation," *Forums for Health Economics and Policy* 9, no. 2 (2006): article 4.

33. Daniel P. Kessler and Mark B. McClellan, "Is Hospital Competition Socially Wasteful?" *Quarterly Journal of Economics* 115, no. 2 (2000): 577–615.

34. Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," *American Economic Review* 102, no. 2 (2012): 1161–85.

35. Glenn Melnick and Emmett Keeler, "The Effects of Multi-hospital Systems on Hospital Prices," *Journal of Health Economics* 260, no. 2 (2007): 400–13.

36. In principle, there is also a third solution—advantageous selection, in which patients who are low-risk but very risk-averse purchase health-insurance because of their risk preferences, subsidies, or inertia. If this arose, such an outcome would be a further boon for private insurance markets.

37. Sara Rosenbaum and Jonathan Gruber, "Buying Health Care, the Individual Mandate, and the Constitution," *New England Journal of Medicine* 363 (2010): 401–3.

38. John H. Cochrane, "Time-Consistent Health Insurance," *Journal of Political Economy* 103, no. 3 (1995): 445–73.

39. This is in contrast to other markets, like life insurance, where long-term contracting is already common.

40. For studies supporting this conclusion, see Jay Bhattacharya and M. Kate Bundorf, "The Incidence of the Healthcare Costs of Obesity," *Journal of Health Economics* 28, no. 3 (2009): 649–58; Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics* 24, no. 3 (2006): 609–34; and Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84, no. 3 (June 1994): 622–41.

41. Senate Committee on Finance, *Tax Expenditures for Health Care*.

42. Hadley et al., "Covering the Uninsured in 2008."

43. Uncompensated care for the uninsured is estimated to have cost $56 billion in 2008. See ibid. Up to $42.9 billion may already be indirectly covered by public funds such as DSH payments under Medicaid and Medicare. Presumably this is already included in current Medicaid costs. As a result, perhaps as little as $13.1 billion may need to be financed by our safety-net tax.

44. Because the exemplary plan includes coverage for a stable bundle of medical services and products, the cost of the plan rises with the rate of medical price inflation. This is also largely true of the ACA because both Medicaid and the standard plan on ACA health exchanges are pegged to a basic bundle of medical goods, not a capped financial contribution per capita.

45. Jay Bhattacharya and William B. Vogt, "Employment and Adverse Selection in Health Insurance" (working paper no. 12430, National Bureau of Economic Research, Cambridge, MA, August 2006).

46. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2011*, 2010. Table 16-1 indicates $177 billion of income tax expenditures on employer-sponsored health insurance. In addition, there were income tax expenditures of $5.7 billion on self-employed health insurance premiums, $2.1 billion on medical and health savings accounts, and $11 billion on deductible medical expenses. The Joint Committee on Taxation estimates a 60:40 ratio between income tax and payroll tax expenditures for working individuals. See Senate Committee on Finance, *Tax Expenditures for Health Care*. Our estimate of $313 billion conservatively includes $117 billion of payroll tax expenditures for employer sponsored health insurance, but none on self-insured premiums, medical savings accounts, health savings accounts, and deductible medical expenses.

47. Leemore Dafny, Katherine Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange" (working paper no. 15687, National Bureau of Economic Research, Cambridge, MA, 2010).

48. Medicaid spending figures were obtained from Congressional Budget Office, "Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline," 2012, www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf. The federal government spent $275 billion on Medicaid in 2011, of which $74 billion was for long-term care, $8 billion was for Medicare premiums, and $4 billion was for childhood vaccines. Excluding these categories, federal spending was $189 billion. We estimate total state spending on Medicaid to be approximately $142.5 billion in 2011, based on the fact that federal spending accounted for 57 percent of total Medicaid spending. Total Medicaid spending is thus $331.5 billion. The estimated cost for the tax exemption is derived from Executive Office of the President, Office of Management and Budget (OMB), *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2011,* table 16-1, 2010, www.gpoaccess.gov/usbudget/fy11/pdf/spec.pdf; and Joint Committee on Taxation (JCT), "Tax Expenditure for Health Care," US Senate, Committee on Finance, July 31, 2008, which found that the tax revenue is split into 60 percent for income taxes and 40 percent for FICA. In 2011, the tax exclusion cost $284 billion, $170 billion of which was from income taxes (according to the OMB document), while the remainder was from FICA (according to the JCT document). Adding all these numbers together yields $615.5 billion. Finally, we end the tax exemption for all self-insured health insurance premiums, tax credits for health savings accounts, and the deductibility of certain medical expenditures; this increases the tax savings to $313 billion rather than $284 billion. This

leads to the final number of $645 billion. Note that in this scenario, the savings from FICA are used to finance the health insurance program. The rationale is that these monies are already spent financing private health insurance purchases.

49. For illustration purposes, our basic plan is kept relatively simple. However, more complex features—such as gradual rather than sudden phaseout of the free basic plan—could be incorporated if policymakers deem them useful.

50. Theoretically, households could move into and out of "burdened" status over time, according to their income and health care burden.

51. We calculate a household's expenditure under the ACA based on its income. If a household's income below 133 percent of the FPL, we assign it no expenditures under the ACA because it is assumed to be covered by Medicaid under the ACA Medicaid expansion. If the household makes between 133 and 400 percent of the FPL, we assume that premiums for a generous plan cannot exceed 9.5 percent of family income, as roughly intended by the ACA's premium tax credits. Above 400 percent of the FPL, the ACA is assumed not to affect premiums. A household's premium for a generous plan is calculated by estimating mean expenditures for other families in the same region as the household and with the same insurance status (insured or uninsured). To this mean expenditure, we add a load of 15 percent. The load is defined as the administrative and other costs of insurance over and above the expected cost of paying claims.

52. Baicker and Chandra, "The Labor Market Effects of Rising Health Insurance Premiums."

53. Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

54. Elliott Fisher et al., "The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine* 138, no. 4 (2003): 273–87.

55. Tomas J. Philipson et al., "Geographic Variation in Health Care: The Role of Private Markets," *Brookings Papers on Economic Activity* (Spring 2010): 325–55.

56. Michael E. Chernew, Allison B. Rosen, and A. Mark Fendrick, "Value-Based Insurance Design." *Health Affairs* 26, no. 2 (2007): w195–w203; A. Mark Fendrick and Michael E. Chernew, "Value Based Insurance Design: Maintaining a Focus on Health in an Era of Cost Containment," *American Journal of Managed Care* 15, no. 6 (2009): 338–43; Michael E. Chernew et al., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract,'" *Health Affairs* 30, no. 1 (2011): 51–61; Michael E. Chernew et al., "Impact of Decreasing Copayments on Medication Adherence within Disease Management Program," *Health Affairs* 27, no. 1 (2008): 103–12.

57. Jack Hoadley, *Medicare Part D Spending Trends: Understanding Key Drivers and Role of Competition*, Kaiser Family Foundation Issue Brief, May 2012, www.kff.org/medicare/upload/8308.pdf.

58. Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* 6, no. 3 (Summer 1992): 3–21.

59. Leemore S. Dafny et al., "Data Impediments to Empirical Work in Health Insurance Markets," *B.E. Journal of Economic Analysis & Policy* 11, no. 2 (2011): article 8; Amanda Starc, "Insurer Pricing and Consumer Welfare: Evidence from Medigap" (unpublished manuscript, Harvard University, Cambridge, MA, 2010).

60. Dafny et al., "Data Impediments to Empirical Work"; Asako S. Moriya, William B. Vogtand, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries," *Health Economics, Policy and Law* 5, no. 4 (2010): 459–79; Yu-Chu Shen, Vivian Y. Wu, and Glenn Melnick, "Trends in Hospital Cost and Revenue, 1994–2005: How Are They Related to HMO Penetration, Concentration, and For-Profit Ownership?" *Health Services Research* 45, no. 1 (2010): 42–61; Darius Lakdawalla and Wesley Yin, "Insurer Bargaining and Negotiated Drug Prices in Medicare Part D" (working paper no. 15330, National Bureau of Economic Research, Cambridge, MA, 2009).

61. US Department of the Treasury, *Fiscal Year 2010, Financial Report of the United States Government*, Supplemental Information, 148.

62. Medicaid prices are roughly 60 percent of private prices. This does not include premiums paid for dual eligibles, which are roughly 40 percent of Medicaid expenditures. See Katherine Young et al., "Medicaid's Role for Dual Eligible Beneficiaries," Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, April 2012, www.kff.org/medicaid/upload/7846-03.pdf. Thus, we calculate Medicaid spending would rise by 36 percent if Medicaid paid private plan prices for nondual eligibles: $(1.6 * 0.6) + (1 * 0.4) = 1.36$.

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