



SUSTAINING CAPITALISM

A series focused on nonpartisan reasoned solutions in the nation's interest to the central challenges we face in order to provide prosperity for all Americans.

We need a new path on health care

The well-being of every American, and the long-term economic and fiscal well-being of the United States, require an efficient, high-quality, patient-centered health care system. It is clear that the US can, and often does, deliver the finest care in the world. However, it is inaccessible or unaffordable to too many Americans. We must do better. And all Americans must have access to health care.

The COVID-19 pandemic has exposed the system's structural flaws. The unsustainable cross-subsidization of providers and insurers with centrally administered prices has broken down under a pandemic illness whose treatment requires costly care but few reimbursable services. The remedies for the immediate response to the pandemic, and for preparedness for the next one, are addressed elsewhere in this series. But when the pandemic is behind us, we will still need ongoing structural reform. That is the topic of this Solutions Brief.

Beyond the pandemic, the nation debates four alternative paths: the status quo, which is unaffordable and which has not met its ambitions on access to coverage and care; "repeal and replacement" of the Affordable Care Act of 2010 ("Obamacare" or "ACA"), with as yet no defined alternative; "Medicare for All," with highly uncertain consequences; and repairs within the structural boundaries of the ACA.

This policy Solutions Brief will present its own vision, using cost-responsible consumer choice among competing private health care plans, which arguably can drive the US health care system toward quality, affordable health care for all.

A better way...

A better way to address the cost and quality of health care would be to activate the private market through aggressive improvement of the current system. Such a proposed health care system would use cost-responsible consumer choice among competing private health care plans to drive the US health care system toward quality, affordable health care for all. Households would receive single-purpose refundable tax credits sufficient to purchase efficient comprehensive health plans. Consumers would seek their own self-interest by pursuing greater quality at a lower price. Plans, and their providers, would need to reduce cost and improve quality to compete—the same motivation that drives progress in virtually every other industry in the US economy.

This vision is an aggressive revision of the ACA that would achieve the following improvements over the current system:

Replace the ACA's complex subsidy mechanism, which puts a heavy compliance burden on and may mislead families with modest incomes and has proved difficult to administer accurately. At the same time, provide relief from any plan cost sharing for lower-income households.

Restructure the ACA exchange system to align more closely with cohesive geographic health care market areas and to provide better information and decision support.

Broaden the exchange populations to increase the numbers of enrollees and also their risk diversity, especially in small geographic areas.

Expand the ACA's increase in consumer choice of insurance plans—which is the key to competition and innovation.

Further challenge fee-for-service medicine, which continues to shackle competition and process improvement to almost the same unfortunate degree as under the pre-ACA system.

Go further than the ACA to promote potentially valuable disruptive care-delivery models and tort reform.

Reorient the ACA's Independent Payment Advisory Board (IPAB) to provide information for, rather than inject remote government judgment into, the physician–patient relationship. This would include expanding data gathering and research to inform physicians and patients in their own decision making.

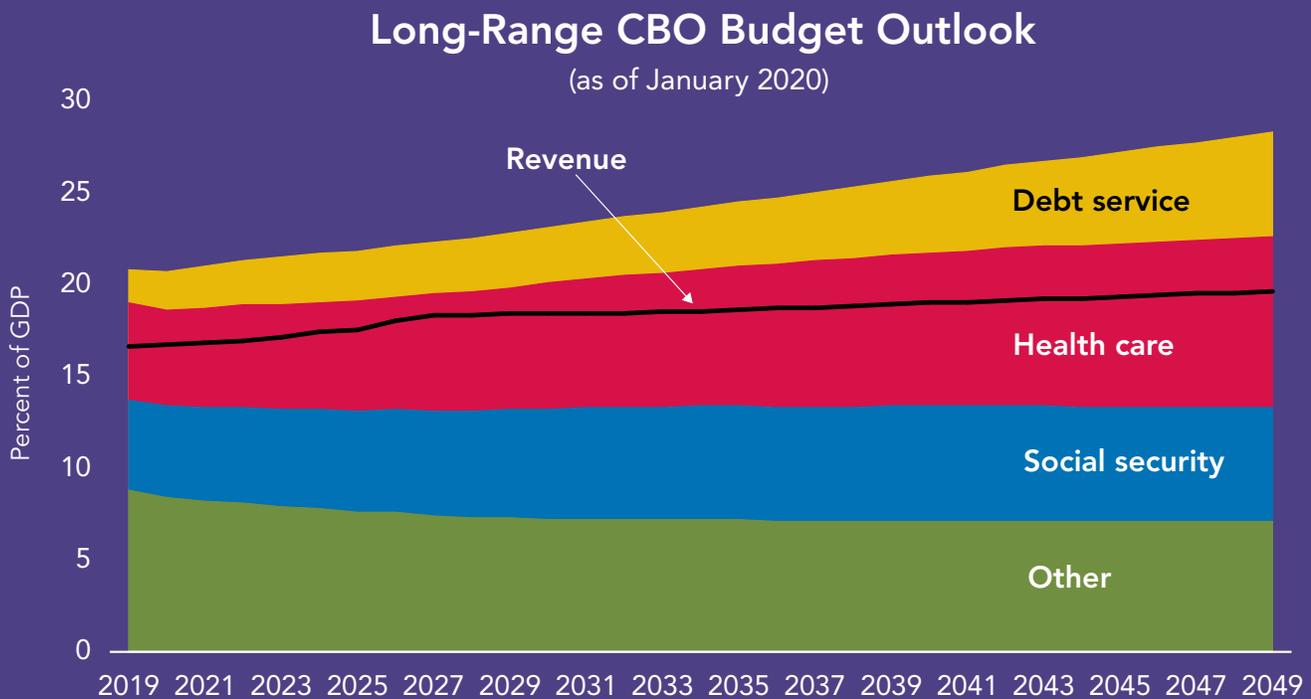
Reduce the ACA's reliance on a system of state regulation that inhibits essential competition and market entry.

THE UNSUSTAINABLE COST OF HEALTH CARE

Even before the pandemic, and surely after it, the rising cost of health care was overwhelming all American budgets: household, employer, and governmental—federal, state, and local—catapulting the issue to the top of the policy agenda among American voters. A promise of universal coverage in an unchanged US care-delivery system would soon be shown to be empty, as society proved unable to pay the bills, and therefore unable to summon the human and physical resources to care for its citizens.

The United States spent \$3.65 trillion on health care in 2018,¹ which accounted for 16.9 percent of the nation’s gross domestic product.² This is significantly more than any other developed nation in the Organisation for Economic Co-operation and Development (OECD). US health care costs are also growing at a rate that is faster than the broader economy.^{3, 4} Yet, despite these high expenditures and although measurement is difficult and controversial, there is ample evidence that the US performs worse than some other OECD countries in critical areas such as life expectancy, infant mortality, and unmanaged diabetes.⁵ Consequently, it is not surprising that according to a Pew Research Center 2019 poll, reducing health care costs ranks among the top tier of public priorities.⁶

The figure below shows that all programmatic (i.e., noninterest) federal spending other than health care (and including Social Security) is projected to grow more slowly than revenues. However, federal spending on health care is projected to grow far faster—and



Medicare is by far the largest contributor to that growth. Although our aging population is an important cause, the cost of delivering care is an even stronger driver.⁷ This rising health care spending creates a rising deficit, which accumulates into a fast-growing public debt, which in turn creates a potentially even faster-growing debt-service bill, and a burgeoning, potentially exploding, public debt.

This problem cannot be solved by increasing revenues or cutting other spending (though those steps are clearly needed). Taxes would need to be increased, and other spending would need to be cut, year after year, in a vain attempt to keep up with the exponentially growing health care costs. Rather, and eventually, the growth of health care costs must be slowed—and the longer reform is postponed, the more difficult it will be.

THE PUBLIC'S ASPIRATIONS FOR THE US HEALTH CARE SYSTEM—COST VERSUS COVERAGE

A growing number of Americans believe that our nation's failure to provide health insurance for all of its citizens is unfair. The share who say health care is a government responsibility is significantly higher than it was from 2008 through 2016 (51 percent in 2016, rising to 60 percent in 2018).⁸ Providing near-universal coverage was the dominant objective of the Affordable Care Act.⁹ But while the ACA did extend coverage to 20 million more Americans,¹⁰ implementation proved extremely disruptive, expensive, and difficult, leaving almost 30 million Americans uncovered.¹¹ The extent of coverage remains a hotly contested issue.

But the cost of health care limits the ability to provide coverage at the same time as it reduces standards of living for even those with insurance. Many uninsured adults, even under the ACA, cite the high cost of insurance as the main reason they lack coverage.¹²

STUCK IN THE ROUNDABOUT

The health care debate in the US has been going in circles, leaving the nation without reasoned solutions. The current system is not financially sustainable. But even unaffordable sums today (and for the foreseeable future) do not buy our nation acceptable levels of quality and access.

Promises to repeal and replace Obamacare have fallen short on the identification of an acceptable replacement. As of this writing, there is no apparent viable proposal.

The most widely debated way of achieving universal health insurance coverage—and avoiding the looming health cost tsunami—is “Medicare for All.” Under the current Medicare program, today's seniors, as well as an expanded group of permanently disabled and those with certain advanced diseases, are guaranteed insurance coverage. So, for other working-age Americans who cannot afford coverage, the Medicare brand is appealing—despite important weaknesses in Medicare's quality in some settings and its unsustainable cost.

But the Medicare for All concept has many flaws. Its truly fatal flaw is that it would make providing quality, affordable health care coverage for all Americans infinitely more difficult. Despite its intended promise, it does not provide a solution on health care that would achieve our nation's shared objectives. There is a better way.

RAISING THE QUALITY OF CARE

Knowledgeable observers have their own short lists of the best health care delivery systems in the United States. Intermountain Healthcare, the Henry Ford Health System, the Geisinger Health System, Sentara Healthcare, Kaiser Permanente, and many others will be mentioned.¹³ Medicare, as a system, will not. A common element of many top-tier plans is finding ways to compensate physicians on salary or on measurable delivery of quality care, breaking the incentive to provide more services in order to collect more fees. The extant Medicare for All proposals would prohibit private health insurance, and thereby would literally outlaw many of the highest-quality health care systems in the United States. All such high-quality health care systems would need to change their business models fundamentally—and in ways that would destroy the incentives and the efficiencies that make such plans successful.

Although there are approximately 30 million Americans without insurance coverage,¹⁴ there are 173 million who have private coverage (either from their employers or purchased in the individual market—including under Obamacare). A large majority of those are happy with their health care.¹⁵ The existing Medicare for All bills would outlaw all private insurance and place all Americans onto a new public plan.¹⁶ Forcing those 173 million people to find new health care in order to extend coverage to 30 million would not only create disruption and increase cost, but also risk the quality of care.

Medicare, of course, is not a coordinated health care program, but rather a collection of all of the US providers—good, bad, and indifferent—that are willing to participate at Medicare’s low schedule of reimbursements for specific services.¹⁷ Medicare for All would follow traditional Medicare (and the fee-for-service part of today’s private system) as a deliverer of uncoordinated care by solo practitioners—with the risk of medical errors (including conflicting prescriptions), incomplete care, duplicative care, and primary-care physicians making potentially self-interested referrals to specialists.¹⁸ And all of this would be on a fee-for-service basis, under which every individual service must be accounted for and billed. The fundamental incentive would be to provide more services rather than to practice patient-centered care.

Some Medicare for All advocates claim that current private insurance denies care to increase profit. They see Medicare as a beneficiary-driven government program.¹⁹ But Medicare is government insurance coverage, not government provision of care. Care under Medicare is subject to the good will and judgment of private providers, each of which seeks “profit” in the form of a higher income for the individual physician or the organization (such as a hospital, even if it is nominally “nonprofit”). The ACA includes provisions that prohibit practices that avoid the provision of care.^{20, 21}

Just about every health care expert—even those who favor Medicare for All—would argue that the nation must move away from uncoordinated fee-for-service care and toward coordinated care under incentives such as those fostered by capitated prepayment, rewarding sound management of care.²² If plans and providers bear the risk from providing low-quality care, they deliver high-quality care. Putting the entire nation under the system of traditional Medicare would be precisely retrograde by that standard. The prospects are far better if the marketplace for health care plans is improved.

SLOWING THE GROWTH OF THE COST OF CARE

The cost of care today is not only high, but rising rapidly. The status quo is therefore unsustainable. Medicare for All would likely increase and accelerate that growth, for seven significant, substantive reasons:

First, if Medicare for All achieved true universal coverage, it would add perhaps 30 million beneficiaries of care. All Americans should be covered, but the cost of doing so cannot be ignored.

Second, the existing Medicare for All proposals would eliminate all copays and deductibles for services and for pharmaceuticals; health care would become totally free. Such cost relief for the most affluent is excessive. That would increase the demand for care. The result would be lower supply and what is experienced elsewhere around the world (e.g., Canada and UK): a triage on treatment and longer wait periods, especially for basic conditions.²³ Third, Medicare for All would widen the range of covered services under most health care plans (including dental and vision coverage, among others), further exacerbating cost in an already unsustainable economic model.

Fourth, and looking now at the current Medicare program, Medicare for All would eliminate the promising cost-effective private alternative of Medicare Advantage. Fifth, Medicare for All would eliminate copays and deductibles not only for current private coverage, but also for all Medicare beneficiaries. Sixth, Medicare for All would pay by the service, and so would encourage the delivery of more services. The incremental cost would be exorbitant.

And seventh, even Medicare for All advocates recognize that current Medicare reimbursement rates would not be tenable for the entire US health care system.²⁴ Under current law, providers lose money delivering Medicare services under low government reimbursement rates (government reimbursement rates for Medicaid are even lower), but make that up by charging higher prices to private patients. Providers—especially small rural hospitals—could not survive at current low Medicare reimbursement rates. Thus, reimbursement rates would have to rise above current Medicare levels, increasing Medicare costs proportionately.²⁵

All of these changes would increase total US health care costs substantially. One current estimate is that total costs would increase by 20.6 percent when a generic Medicare for All proposal was fully phased in. All of that increase in total spending, and more besides,²⁶ would be added to the federal budget, whose health care spending would more than triple. Federal revenues would need to increase by a rough order of magnitude of three-quarters, or equivalent spending cuts would need to be imposed. Such enormous changes necessarily would have adverse effects elsewhere in society.

Against all of this added cost for the US health care system, Medicare for All could save money mainly by making its reimbursement rates lower than the average currently paid under private health care. In other words, Medicare for All would attempt to balance its books by cutting the pay of the nation's physicians, hospitals, and other providers.

The question then becomes just how much physician and hospital reimbursement rates possibly could be cut without breaking the US health care system. Some might believe that US doctors and institutions have nowhere else to go, and therefore can be forced to accept those large pay and reimbursement cuts. However, current older physicians could respond to the reduced reimbursement by retiring early, and students could choose not to pursue careers in medicine; hospitals could be closed, and fewer new hospitals opened.²⁷ Thus, the supply of care would not increase with the demand, resulting in increased waiting times for care, and upward pressure on prices, hurting those at the lower ends of the economic ladder most.

Some Medicare for All advocates believe that there can be significant savings from the elimination of insurance company administrative expense, advertising, and profit. As one example of such claims, a paper advocating Medicare for All estimates that private insurance administrative costs equal approximately 8.5 percent of total spending, and refers favorably to Medicare governmental administrative costs of only 2 percent.²⁸

This is an incomplete picture. Private insurance administrative costs are necessary to ensure accurate billing and reimbursement. Medicare administration prioritizes prompt payment over accuracy, and as a result, inaccuracy (including fraud) is a constant problem. The Government Accountability Office estimates improper payments by Medicare (and Medicaid) at 8.6 percent of total spending, and notes that the Medicare fee-for-service improper payment rate was estimated by the Centers for Medicare & Medicaid Services at 11 percent.²⁹ Thus, arguably more is lost through fraud and other improper payments than is saved by low Medicare administrative spending. Medicare for All would extend these losses from Medicare to all medical services.

Furthermore, traditional Medicare's reliance on fee-for-service medicine requires that every individual Medicare service must be accounted for and billed. Thus, administrative cost under Medicare is not limited to that undertaken by government, but rather includes the costs of detailed billing by physicians, hospitals, and other providers.³⁰

Medicare for All advocates also cite the elimination of health insurance company profit as a potential saving under their vision. Of course, every provider under Medicare for All would seek a "profit"—physicians to feed their families, and hospitals and other institutions to keep the lights on. Even a "nonprofit" hospital needs an "operating surplus," because the alternative is losses and ultimate financial failure. Furthermore, profit is the reward to economic actors for discovering better ways of doing things, and it is the incentive for them to do so. If "profit" is a net loss to society, then the federal government should be the only entity to build automobiles, deliver haircuts, and provide every other good and service in the economy.

Some who are favorable to Medicare for All have suggested that the federal government offer a public insurance plan—a "public option"—to compete with private plans. Their assumption is that the public plan would be cheaper and of higher quality, and so would gradually attract an ever-growing block of customers, and would eventually drive private insurance out of business and achieve Medicare for All without a cataclysmic, instantaneous transition. The putative objective of a "public option" would be to create competition to the benefit of consumers.

However, for the same reasons as for Medicare for All, a public option would be inefficient. The traditional Medicare model involves uncoordinated, fee-for-service care, utilizing “every willing provider” regardless of quality. There is no reason to expect that a public option would be any different. Furthermore, it would be impossible to price a public option fairly so that it could compete on a level playing field with private insurers. No one could assess the value of the federal government’s name recognition or of the administrative support of the entire federal bureaucracy. The federal government could easily miscalculate its prices and take large losses, but there could be no adequate compensation to the private plans that lost their customers in the process. And finally, there could be reasons for either healthy persons or sick persons to choose disproportionately the public or the private side. The result would be adverse risk selection, and a death spiral for whichever plan attracted the sickest patients. If the public option were to attract disproportionately sick enrollees, year after year the federal government would run growing losses, which would add to, not ease, the federal budget and debt problem.

A BETTER WAY FORWARD

A better way to address the cost and quality of health care would be to activate the private market through aggressive improvement of the current system. Such a proposed health care system would use cost-responsible consumer choice among competing private health care plans to drive the US health care system toward quality, affordable health care for all.³¹ Households would receive single-purpose refundable tax credits sufficient to purchase efficient comprehensive health plans. Consumers would seek their own self-interest by pursuing greater quality at a lower price. Plans, and their providers, would need to reduce cost and improve quality to compete—the same motivation that drives progress in virtually every other industry in the US economy.

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- Expand the ACA’s increase in consumer choice of insurance plans—which is the key to competition and innovation.
- Further challenge fee-for-service medicine, which continues to shackle competition and process improvement to almost the same unfortunate degree as under the pre-ACA system.

- Go further than the ACA to promote potentially valuable disruptive care-delivery models and tort reform.
- Reorient the ACA’s Independent Payment Advisory Board (IPAB) to provide information for, rather than inject remote government judgment into, the physician–patient relationship. This would include expanding data gathering and research to inform physicians and patients in their own decision making.
- Reduce the ACA’s reliance on a system of state regulation that inhibits essential competition and market entry.

Notably, this approach is similar to several existing highly successful systems: the Federal Employees Health Benefits Program, the California (CalPERS) and Wisconsin state employees systems, the Stanford University employees system, and several others. Each of those systems has resulted in high enrollee satisfaction and lower costs.³² However, such a system would be vastly more successful if extended nationwide, forcing all health plans and providers to compete, rather than allowing them to retreat to noncompetitive segments of the health care market.

The above recommendations would force health care plans, like all other enterprises in the US economy, to improve quality and hold down cost to attract customers. However, even the recommended plan would not constitute a full and instant answer to our nation’s health care problems. Local monopoly power of plans, hospitals, or other providers could prevent the beneficial competition that CED’s vision would seek, and such market power must be corrected under any reform. Clearly, the US faces a daunting health care challenge even after the pandemic is vanquished. America’s voters must be fully informed and must demand clear and achievable action from our political candidates as we collectively choose a future. These recommended reforms can set us assuredly on a reasoned course in our nation’s interest.

Endnotes

- 1 Bob Herman, [“America’s Health Care Economy Keeps Ballooning,”](#) *Axios*, February 21, 2019.
- 2 [“How Does the US Health Care System Compare to Other Countries?”](#) Peter G. Peterson Foundation, July 22, 2019.
- 3 Herman, [“America’s Health Care Economy Keeps Ballooning”](#); [“US Health Care Coverage and Spending,”](#) *In Focus*, Congressional Research Service, March 21, 2019.
- 4 Yoni Blumberg, [“Here’s Why Many Prescription Drugs in the US Cost So Much—and It’s Not Innovation or Improvement,”](#) *CNBC*, January 14, 2019.
- 5 Peterson Foundation, [“How Does the US Health Care System Compare to Other Countries?”](#); Julie Potyraj, [“The Quality of US Healthcare Compared with the World,”](#) AJMC Managed Markets Network, February 11, 2016. The US performs well in some areas of care, especially complex acute care, and some of our nation’s poor health outcomes can be assigned to social factors (poverty, violence) or even affluence (our high incomes and comparatively cheap food can contribute to obesity).
- 6 [“Public’s 2019 Priorities: Economy, Health Care, Education and Security All Near Top of List,”](#) Pew Research Center, January 24, 2019.
- 7 [“The 2019 Long-Term Budget Outlook,”](#) Congressional Budget Office, June 25, 2019, Figure 1-10, p. 25 and accompanying discussion.
- 8 Jocelyn Kiley, [“Most Continue to Say Ensuring Health Care Coverage Is Government’s Responsibility,”](#) Pew Research Center, October 3, 2018.
- 9 [“The Affordable Care Act in Depth,”](#) RAND Health Care.
- 10 [“Since Obamacare Became Law, 20 Million More Americans Have Gained Health Insurance,”](#) *Bloomberg*, November 15, 2018.
- 11 Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, [“Health Insurance Coverage in the United States: 2018,”](#) US Census Bureau, Report Number P60-267 (RV), November 8, 2019.
- 12 Jennifer Tolbert, Kendal Orgera, Natalie Singer, and Anthony Damico, [“Key Facts about the Uninsured Population,”](#) Kaiser Family Foundation, December 13, 2019.
- 13 [“Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System,”](#) Committee for Economic Development of The Conference Board (CED), November 14, 2007, p. 78.
- 14 [“Federal Subsidies for Health Insurance \(Includes Effects of the Affordable Care Act\),”](#) Congressional Budget Office.
- 15 R.J. Reinhart, [“In the News: Americans’ Satisfaction With Their Healthcare,”](#) Gallup, February 2, 2018. Gallup reports that 75 percent of Americans are satisfied with their health care (although they are not so satisfied with its cost). Another poll found that 71 percent of Americans were satisfied with their employer health plans (see: [“The Value of Employer-Provided Coverage,”](#) America’s Health Insurance Plans, February 2018).
- 16 [“S. 1129, To Establish a Medicare-for-All National Health Insurance Program, Section 107 \(a\)\(1\);”](#) H.R. 1384, [To Establish an Improved Medicare for All National Health Insurance Program, Section 107 \(a\)\(1\),](#) Congress.gov.
- 17 [“How Original Medicare Works,”](#) Centers for Medicare & Medicaid Services.
- 18 [“Quality, Affordable Health Care for All,”](#) CED, p. 2.
- 19 Natalie Shure, [“Does Medicare for All Mean Abolishing Insurance Companies?”](#) *In These Times*, March 19, 2019.
- 20 Jennifer Tolbert, [“The Coverage Provisions in the Affordable Care Act: An Update,”](#) Kaiser Family Foundation, March 2, 2015.
- 21 These provisions would be more effective if they applied to all plans under universal care. The ACA exempted certain “grandfathered” plans that were in existence at the time of the ACA’s enactment. Tolbert, [“The Coverage Provisions in the Affordable Care Act: An Update.”](#)
- 22 Robert Pollin, James Heintz, Peter Arno, Jeannette Wicks-Lim, and Michael Ash, [“Economic Analysis of Medicare for All,”](#) Political Economy Research Institute, University of Massachusetts Amherst, November 30, 2018, p. 59, p. 66.

- 23 The proposals would impose extraordinary restraints, such as price controls, on the prices of pharmaceuticals. While drug costs have been an important part of the increase in total health care costs, the impact that these changes would have on the progress of R&D and further advances is of concern.
- 24 Both current Medicare for All bills would establish new processes to set reimbursement rates, rather than adopting the current fee schedule (see: [S. 1129, To establish a Medicare-for-all national health insurance program, Section 612](#); [H. R. 1384, To establish an improved Medicare for All national health insurance program, Section 612](#), Congress.gov).
- 25 In addition, the current House Medicare for All bill would cover custodial long-term care as well as acute and preventive care, which would increase demand substantially.
- 26 Health care spending by state governments and households would be substantially reduced, and spending by employers would be eliminated.
- 27 In addition, much of the current health care system—including the training of physicians, and the construction and acquisition of hospitals and equipment—has been financed at least in part by debt. Cutting reimbursements runs the risk of cascading defaults and bankruptcies, which would not well serve the affected providers or the public.
- 28 Pollin et al., “Economic Analysis of Medicare for All,” p. 44.
- 29 [“Medicare and Medicaid,”](#) Government Accountability Office, December 2017.
- 30 Traditional Medicare attempts to limit these expansive administrative costs, and to limit the fee-for-service incentive to deliver more services, through “bundling” using “diagnosis-related groups” (or “DRGs”)—that is, reimbursing in a lump sum for all of the services related to a particular ailment. However, providers retaliate by claiming more DRGs for each patient and choosing the most lucrative DRG for each episode (see: Reed Abelson, Julie Creswell, and Griff Palmer, [“Medicare Bills Rise as Records Turn Electronic,”](#) *New York Times*, September 21, 2012). The result is a cat-and-mouse game between Medicare and providers, resulting in greater provider administrative cost and greater fraud, which Medicare can pursue only after the fact (see: “Quality, Affordable Health Care for All,” CED). In contrast, the most efficient current private integrated delivery systems take the financial risk for their patients and have no (or far less) incentive to manipulate diagnoses, and no need to bill for each detailed service or even for groups of services. They need only that administration that makes them more efficient so that they can charge lower premiums and therefore attract more patients.
- 31 “Quality, Affordable Health Care for All,” CED; [“Adjusting the Prescription: Committee for Economic Development Recommendations for Health Care Reform,”](#) CED, April 23, 2015.
- 32 David Riemer and Alain Enthoven, [“The Only Public Health Plan We Need,”](#) *New York Times*, June 24, 2009.

SUSTAINING CAPITALISM

Achieving prosperity for all Americans could not be more urgent. Although the United States remains the most prosperous nation on earth, millions of our citizens are losing faith in the American dream of upward mobility, and in American-style capitalism itself. This crisis of confidence has widened the divide afflicting American politics and cries out for reasoned solutions in the nation's interest to provide prosperity for all Americans and make capitalism sustainable for generations to come. In 1942, the founders of the Committee for Economic Development (CED), our nation's leading CEOs, took on the immense challenge of creating a rules-based post-war economic order. Their leadership and selfless efforts helped give the United States and the world the Marshall Plan, the Bretton Woods Agreement, and the Employment Act of 1946. The challenges to our economic principles and democratic institutions now are equally important. So, in the spirit of its founding, CED, the public policy center of The Conference Board, will release a series of 2020 Solutions Briefs. These briefs will address today's critical issues, including health care, the future of work, education, technology and innovation, regulation, China and trade, infrastructure, inequality, and taxation.



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