Reforming America's Health Insurance System: YoungMedicare

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We can argue whether health care is a right or not, but surely it is a necessity. Without excellent health insurance, we face a higher probability of death and illness. We also face a high risk of asset depletion and bankruptcy. We can literally be wiped out—personally and financially— if we lack the insurance needed to cover giant health care costs, whether due to a chronic illness or a one-off accident.

Lack of any health insurance is of course a cause for fear. But insurance itself can also be a source of anxiety. Policies that zap families with high deductibles, co-pays, and co-insurance are common. Obamacare not only permits such policies; it requires their availability. The ACA's Bronze, Silver, and even Gold plans expose families to deductibles and other cost-sharing that on average add up to 40%, 30%, and 20%, respectively, of total health costs. The combination of upfront premiums to buy these plans, *plus* the deductibles and co-pays they impose, add to individuals' worries about their financial future even as they alleviate fear of a financial wipeout.

Uninsured health expenses can stress children as well. When parents must agonize about whether to pay the rent, buy food, or take an ailing child to the doctor or a wounded child to the hospital, the dread filters down to the kids. Injecting children with anxiety impairs their physical health, heightens their risk of mental illness, and compromises their chances of success in school. The shadow of growing up in fear can last well beyond childhood, undermining children's subsequent adult decisions about careers, childbearing, homeownership, and life in general.

Because of the severe economic damage that lack of good health insurance can so easily and so quickly inflict, economic security—as well as improved health itself—requires that every American have comprehensive health insurance. It should provide excellent benefits. It should offer a choice of plans and providers. Its structure should controls costs.

Unfortunately, the American health insurance system is none of the above. It is not comprehensive: over 25 million Americans in 2016 remained uninsured, despite the gains made under the Affordable Care Act. Nor do the insured have benefits excellent. Tens of millions among the insured have sparse benefits, exposing them to thousands of dollars of costs for deductibles, co-pays, and co-insurance. Indeed, the ACA's "benchmark" Silver Plan requires that insurance pay on average for only 70% of costs. Nor does everyone have affordable choices among competing health care plans or providers. Nor does the system keep costs under control. Rather, costs continue to exceed inflation each year. Americans have not gotten any healthier in recent years, but the system continues to suck up a growing share of GDP.

Voltaire famously quipped that the Holy Roman Empire was neither holy, nor Roman, nor an empire. In the same spirit, we might say that the American health care system is far less than All-American; delivers neither optimal health nor acceptable care; and is so chaotic and costly that it hardly deserved to be called a system.

The private sector by itself is incapable of fixing the system. Government action is essential. Unfortunately, much of what government has done in the past has made matters worse.

Despite past false starts and dead ends, the nation's dysfunctional health insurance system can be fixed by the federal government's adoption of a fairly small number of major policy changes. The problem America faces in cleaning up the current mess is neither the lack of a proven alternative, nor the cost of the alternative. Rather, the problem is a toxic brew of confusion about the causes of the mess, fear of change, and self-interested clinging to a status quo. Once the federal government gets its policies right, however, it can fairly quickly make the system work right.

This essay spells out a policy redesign that will result in the system that most Americans want: everyone covered, excellent benefits, choice of plans and providers, and costs controlled. I call it YoungMedicare. It resembles Medicare in many respects, but improves on it. In time, the new program, YoungMedicare, and Medicare itself could be merged into a single program.

To put the proposal for YoungMedicare in context, there follows (1) a caution against expecting health insurance reform to dramatically improve health outcomes, (2) a brief account of the evolution of U.S health insurance policy, and (3) an examination of the strengths and weaknesses of Medicare. The YoungMedicare proposal is then spelled out in detail.

Better Health vs. Better Insurance

Before proceeding, we should pause to remember that the single most important step the United States can take to improve the overall health of the American people is *not* to reform the health insurance system. There are many sound reasons for health insurance reform. But even the best redesign will do little to make Americans healthier. Rather, tackling what public health experts call the "economic and social determinants" of health—such as unemployment, poverty, and inequality—will have a far greater impact on health outcomes than any health insurance reform can possibly produce.[1]

[1] See, e.g., Geoffrey R. Swain, Katarina M. Grande, Carlyn M. Hood, and Paula Tran Inzeo, "Health Care Professionals: Opportunities to Address Social Determinants of Health," *WMJ* (Journal of the Wisconsin Medical Society), Vol. 113, No. 6, December 2014.

According to the University of Wisconsin-Madison Population Health Institute, economic and social factors are responsible for 40% of health outcomes, with individual behaviors next in importance (30%) and the health care system itself of less importance (20%).[2] Poverty's negative effect on children's health is especially strong. As the Academic Pediatric Association's Task Force on Childhood Poverty concluded in 2013

> The effects of poverty on children's health and well-being are well documented. Poor children have increased infant mortality, higher rates of low birth weight and subsequent health and developmental problems, increased frequency and severity of chronic diseases such as asthma, greater food insecurity with poorer nutrition and growth, poorer access to quality health care, increased unintentional injury and mortality, poorer oral health, lower immunization rates, and increased rates of obesity and its complications. There is also increasing evidence that poverty in childhood creates a significant health burden in adulthood that is independent of adult-level risk factors and is associated with low birth weight and increased exposure to toxic stress (causing structural alterations in the brain, long-term epigenetic changes, and increased inflammatory markers).[3]

Even if it is true that economic and social factors are the major causes of negative health outcomes, can improving those factors—for example, by reducing poverty—actually make Americans healthier? The answer is a clear yes. There is a growing body of evidence that improving the economic and social determinants of health yields gains in health outcomes. Expanding the value of the EITC, for instance, reduced the incidence of low birth weights for children.[4] Increasing the EITC also improved the health (including the mental health) of mothers.[5] More research is needed to show the full extent to which providing the unemployed jobs, raising wages, increasing earning supplements, and otherwise shrinking poverty will produce which measurable gains in what dimensions of

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[2] University of Wisconsin-Madison Population Health Institute and the Robert Wood Johnson Foundation, "County Health Rankings and Roadmaps," *County Health Rankings*, 2017, http://www.countyhealthrankings.org/about-project/rankings-background

[3] American Academy of Pediatrics, "APA Task Force on Childhood Poverty: A Strategic Road-Map," 4/30/2013, p. 1, http://www.academicpeds.org/public_policy/pdf/APA_Task_Force_Strategic_Road_Map ver3.pdf

[4] David Simon, London School of Economics, "Expansions to the Earned Income Tax Credit Improved the Health of Children Born to Low Income Mothers," June 9, 2015, http://blogs.lse.ac.uk/usappblog/2015/06/09/expansions-to-the-earned-income-tax-credit-improved-the-health-of-children-born-to-low-income-mothers/. *"[F]or mothers who qualify for the credit, an additional $1,000 in the value of the EITC reduces the incidence of low birth weight births by 3 out of every 100 children."*

[5] William N. Evans and Craig L. Garthwaite, "Giving Mom a Break: The Impact of Higher EITC Payments on Maternal Health," *American Economic Journal: Economic Policy*, Volume 6, No. 2, 2014, pp. 258-290.

health. But the cause-and-effect relationship is clear. Economic security makes us healthier.

Thus, reforming the New Deal settlement to greatly improve America's economic security structure (i.e., creating Transitional Jobs, raising wages, increasing incomes, and adopting the other measures proposed in my book, *Putting Government In Its Place: The Case for a New Deal 3.0*) will do much more to improve Americans' health than any cure of the nation's dysfunctional health insurance system. We should nonetheless not slacken in pushing for a vastly better U.S. health insurance system that adds YoungMedicare and improves regular Medicare. Doing so will further enhance economic security. It will also make millions healthier. It would be the icing on the cake.

A Brief Account of Health Insurance Reform: Progress and Frustration

Since the launch of the New Deal in 1933, we have already made enormous progress on a tortuous path. Major milestones marking the way include: the enactment of Medicaid and Medicare in 1965; the creation of the State Children's Health Insurance Program (SCHIP) in 1997; and most recently the passage of the Affordable Care Act (aka Obamacare) in 2010. Much credit also goes to the private sector. Unions and corporations increasingly recognized during and after WWII that worker productivity and business profits would improve if employees worried less about their families' health and could pay for the medical care, occasional hospitalization, and prescription drugs they themselves needed to stay on the job.

But 28.5 million Americans, 8.8% of the population, were still uninsured as of 2017.[6] The number will increase sharply if the Congress and President obstruct Obamacare or fail to fix its problems (some of which arise from the original 2010 law, but most of which result from subsequent legislative or judicial decisions).

Health care costs, meanwhile, continue to rise faster than inflation. From 2005 through 2015 the rate of health care inflation outplaced the Consumer Price Index in 10 out of 11 years.[7] Compared to the long, 45-year stretch from 1960 to 2015 (i.e., from before the enactment of Medicare to after passage of the ACA), the period from 2005 to 2015 shows an improved trend. The gap between health care inflation and the general rate of inflation was worse in the past. It was extremely large during the period from 1980 to 1995. The gap has shrunk—and stayed shrunk—for most of the past two decades. One can make the

[6] Barnett, U.S. Census Bureau, "Health Insurance Coverage in the United States: 2017," P60-264, September 2018, p. 1, https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

[7] Mike Patton, "US Health Care Costs Rise Faster Than Inflation," *Forbes*, June 29, 2015, https://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#11eac1426fa1

case that, while the passage of Obamacare has not solved the problem of hyperinflation in health care, it has helped to diminish the problem.[8]

Yet the problem of excessive health care inflation remains. However measured, and whether accelerating or moderating, what we might call "hyper-inflation without benefits" continues (with only occasional relapses) year after year. American individuals, businesses, and taxpayers keep on spending more and more on health insurance, doctors, hospitals, and drugs. Yet we do not get any healthier.

In short: Despite the important gains in health insurance coverage that the U.S. has experienced since World War II, and despite the recent slowing down in the overall trend of hyperinflation in health costs; the U.S. still has a long, long way to go. To hit the health insurance trifecta—cover everyone, provide excellent benefits while expanding choices, and permanently bring down cost to (or even close to) the rate of inflation—we need to do something different.

Why Not Medicare-for-All?

The current system would be greatly improved if everyone were simply enrolled in Medicare. But that would be a second-best solution. The under-65 population should be enrolled in a health insurance program even better than Medicare. Seniors would benefit if Medicare itself were improved.

Medicare has indeed solved some of the big problems that must be tackled to create a rational health insurance system. It provides the 65+ population with nearly universal coverage. Once seniors select not only Part A but also Parts B and D—or if they choose a Medicare Advantage Plan under Part C that folds in Parts A, B, and possibly D—Medicare pays for the "big three" health care costs: hospitals, doctors, and drugs.

Medicare now also offers lots of choice. Enrollees may choose among *types* of plans (an HMO or PPO under Medicare Advantage, or a fee-for-service plan under regular Medicare). Enrollees may choose among different HMOs and PPOs. Thus, Medicare offers a wide range of choices among providers.

But Medicare is far from an optimal health insurance program. It has three major problems: a benefit problem, a cost control problem, and a set of problems arising from the departure of its financing mechanism from basic social insurance principles.

Medicare's Benefit Problem

Medicare falls short in the benefits it provides. Following is list of the cost sharing that Medicare imposed in 2017 that significantly limits its benefits to seniors:

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[8] Jeanne Lambrew and Ellen Montz, The Century Foundation, "ObamaCare vs. TrumpCare in 10 Charts," March 22, 2017, https://tcf.org/content/commentary/obamacare-vs-trumpcare-10-charts/

- Part A coverage for hospital care required payment in 2017 of (1) a $1,316 deductible for each benefit period, (2) $329 coinsurance per day of each benefit period for days 61-90, (3) $658 coinsurance per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime), and (4) all costs beyond "lifetime reserve days."[9]

- Part B coverage for medical care, in addition to requiring a monthly premium of $134 (which, depending on income, may be lower or higher), also imposed a deductible of $183 per year and co-insurance 20% of the Medicare-approved amounts for most doctor services.[10]

- Part D coverage for prescription drugs requires payment of a monthly premium,[11] imposes an initial deductible that can be as much as $405,[12] then imposes a deductible or coinsurance,[13] and then requires enrollees to pay up to 40% of the plan's cost for covered brand-name prescription drugs during the so-called "donut hole" (coverage gap) that starts after spending out-of-pocket $3,700 and lasts until spending $4,950 on covered drugs.[14]

Medicare recipients who enroll under Part C in a Medicare Advantage Plan may face significantly less cost-sharing in exchange for accepting the limitations that an Advantage Plan imposes. The number of seniors who choose to sign up for an Advantage Plan is rapidly growing. In 2017, enrollment reached 19 million, 33% of Medicare's 57 million total recipients.[15] In some states, the share of Medicare enrollees in Advantage plans has reached 40% or higher. In one state, Minnesota, it is 56%.[16] Nearly two-thirds of those

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[9] U.S. Centers for Medicare and Medicaid Services, "Medicare 2017 and 2018 Costs at a Glance," *Your Medicare Costs*, https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html

[10] *Id*.

[11] U.S. Centers for Medicare and Medicaid Services, "Monthly Premium for Drug Plans," *Costs for Medicare Drug Coverage,* https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

[12] U.S. Centers for Medicare and Medicaid Services, "Yearly Deductible for Drug Plans," *Costs for Medicare Drug Coverage*, https://www.medicare.gov/part-d/costs/deductible/drug-plan-deductibles.html

[13] U.S. Centers for Medicare and Medicaid Services, "Copayment/Coinsurance in Drug Plans," *Costs for Medicare Drug Coverage*, https://www.medicare.gov/part-d/costs/copayment-coinsurance/drug-plan-copayments.html

[14] U.S. Centers for Medicare and Medicaid Services, "Costs in the Coverage Gap," https://www.medicare.gov/part-d/costs/coverage-gap/part-d-coverage-gap.html, and "Catastrophic Coverage, *Costs for Medicare Drug Coverage*, https://www.medicare.gov/part-d/costs/catastrophic-coverage/drug-plan-catastrophic-coverage.html

[15] Kaiser Family Foundation, "Medicare Advantage," October 10, 2017, https://www.kff.org/medicare/fact-sheet/medicare-advantage/

[16] *Id*.

who select an Advantage Plan decide to enroll in a Health Maintenance Organization (HMO), with the remainder largely selecting a Preferred Provider Organizations (PPO).[17]

But choosing an Advantage Plan is not cost free. Both a monthly premium and cost sharing apply. In 2017, the average monthly premium for an Advantage Plan that covers prescription drugs was $36.[18] The average cost-sharing out-of-pocket limit imposed by such plans for services covered under Parts A and B was $5,219.[19] Since 2011 all Advantage Plans have been required to limit enrollees' out-of-pocket expenses for services covered under Parts A and B to no more than $6,700, with higher limits allowed for services received from out-of-network providers, prescription drugs, and services not covered by the plan."[20]

In brief: Whether seniors in Medicare choose regular Medicare or an Advantage Plan, they face significant costs in addition to any premiums they must pay. If they get sick or have an accident, they must pay deductibles, co-pays, or co-insurance that could total thousands of dollars. Compared to the non-existent coverage or paltry benefits that tens of millions of seniors endured before Medicare's enactment in 1964, Medicare's benefits are wonderful. An optimal health insurance program, however, would provide better benefits than Medicare by virtually eliminating its deductibles, co-pays, and co-insurance. And Medicare itself would provide better health care, and achieve better health outcomes, by shedding cost sharing at the time of obtaining care.

Cost sharing at the time of obtaining care in the form of deductibles, co-pays (with rare exceptions), and co-insurance is a bad idea. It is bad for health. It is also a counterproductive, and thus ineffective, tool for controlling costs.

Cost sharing is bad for health because it is health care financing's equivalent of an atomic bomb. The A-Bomb destroys everything. Cost sharing deters everything that it touches. It deters both necessary *and* unnecessary care. It prevents the urgently needed visit to the doctor as well as the pointless trip to the clinic. It discourages ill and injured people from seeking the care they need, just as it equally inhibits them seeking care they really do not need. Imposing deductibles, co-pays, and co-insurance at the point of service thus worsens health outcomes for many at the same time that for others it may improve health outcomes.

Dollar incentives—i.e., simple, understandable, price signals to make or avoid major health decisions—*can be* a good way to improve health outcomes. But the price signal

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[17] *Id*.
[18] *Id*.
[19] *Id*.
[20] Gretchen Jacobson, Marsha Gold, Anthony Damico, Tricia Neuman, and Giselle Casillas, Kaiser Family Foundation, "Limits on Out-of-Pocket Spending," *Medicare Advantage 2016 Data Spotlight: Overview of Plan Changes*, December 3, 2015, https://www.kff.org/report-section/medicare-advantage-2016-data-spotlight-overview-of-plan-changes-limits-on-out-of-pocket-spending/

must be finely designed both to encourage needed care and discourage unnecessary care. Co-pays, and co-insurance at the point of service are the wrong type of price signal to use because they crudely inhibit all care. They inherently cannot distinguish between whether they are deterring better health or worse health.

Human life is too precious to entangle it with such indifference to health. What we need—and what YoungMedicare incorporates—is the use of price signals that promote only positive health decisions. See the Appendix to this essay, "How Price Signals Can Lower Health Costs and Improve Quality Deductibles," for an example of the best way to use price signals to achieve desirable cost and quality outcomes.

The second strike against using cost sharing at the point of service is that it does nothing to constrain overall cost. Deductibles, co-pays, and co-insurance shift costs to patients, thus reducing the health costs that the insurer (whether private or public) bears. But cost sharing does not lower total health costs. Indeed, it may actually increase total health costs, as explained next.

Medicare's Cost Control Problem

Controlling costs has been a huge problem for Medicare. The program now covers 57 million people, and cost $588 billion in 2016, which is 24% of the federal budget.[21] From 2000 to 2010, per-capita Medicare spending rose annually by an average of 7.4%, nearly three times faster than the general rate of inflation.[22]

To its credit, the program has steadily put mechanisms in place that, with growing effectiveness, have help to control costs. Per-capita spending from 2010 to 2016 grew at an annual average rate of 1.3%, somewhat below the general inflation rate. Medicare's cost control problem, however, has hardly been solved. Per-capita growth in Medicare spending is projected to grow by 4.0% from 2016 through 2021, then rise to 5.0% from 2021 through 2026.[23] In short, the recent improvement in Medicare's approach to controlling costs has thrown a saddle on the cost monster, but the monster is far from tamed.

Medicare's historically heavy reliance on cost sharing to control costs is a big part of the problem. There are three major reasons why imposing deductibles, co-pays, and co-insurance at the point of service does little to lower—and may indeed raise—overall Medicare spending on a per-capita basis.

First, there is the pay-me-less-now or pay-me-more-later problem. If an ill or injured person avoids necessary care because of the deductible, co-pay, or co-insurance, the

[21] Juliette Cubanski and Tricia Neuman, Kaiser Family Foundation, "The Facts on Medicare Spending and Financing," *Medicare*, July 18, 2017, https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/
[22] *Id*.
[23] *Id*.

savings may be offset by the higher health costs ultimately incurred when the person finally turns up in the emergency room or operating table. It is both a healthier and a cheaper to fix a wound instead of amputating a foot, or to treat high blood pressure than deal with a full-blown heart attack.

Second, once cost-sharing reaches an Out-of-Pocket (OOP) maximum—which is the case for the increasingly popular Medicare Advantage plans—by definition it becomes impotent in influencing costs. The patient has at that point paid 100% of what the patient will pay, at least for the rest of the year. And a fair number of patients have such serious illnesses or accidents that they quickly breeze past their OOP maximums, at which point the program has no price-based mechanism left to deter costly care. As mentioned earlier, in 2017 the average OOP maximum for Medicare Advantage Plans was only $5,219. Most enrollees in Advantage Plans select HMOs, which have an even lower average OOP maximum of $4, 928.[24] It doesn't take much of an illness or accident to rack up $5,000 or $6,000 in costs. From then on, Medicare's reliance on cost sharing at the point of service to hold down costs because utterly irrelevant.

Third, there may be a "behavioral economics" impulse that causes cost sharing to push up costs even further. Do not all of us have friends who, knowing they have passed their OOP maximum for the year, hurry to schedule an appointment with a doctor or dentist prior to year's end in order to get "free" treatment? Have you, dear reader, not done this yourself? In many cases, of course, the care will be justified. But in some cases, the certainty that "free" care prior to December 31 will turn into a deductible on January 1 may induce us to pressure our doctors and dentists (or agree when they pressure us) to "fit us in" even though the health justification for care at that time is weak.

Medicare has never relied exclusively on cost sharing at point-of-service to control its costs. With each wave of reform, the program has increasingly turned to other tools, such as the Diagnosis Related Group (DRG) hospital payment methodology, to try to constrain costs. The creation of the Medicare+Choice program in 1997, which became Medicare Advantage in 2003, was driven in large part by the ambition of holding down spending. Nonetheless, cost sharing at the point of service remains an integral part of Medicare.

It would be a mistake, therefore, to put all Americans into a Medicare-for-All health insurance program as long as Medicare continues to rely heavily on cost-sharing at point-of-service as both a way to shift costs to patients and a device (albeit an ineffective one) to constrain overall spending. The under 65 population cannot tolerate the high out-of-pocket cost burden that Medicare recipients must endure any more than Medicare recipients themselves can bear the deductibles, co-pays, and co-insurance they are compelled to pay. The American people and economy cannot afford to expand Medicare *per se* until Medicare has created a far better and long-lasting mechanism to keep costs under control.

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[24] Kaiser Family Foundation, "Medicare Advantage," October 10, 2017, https://www.kff.org/medicare/fact-sheet/medicare-advantage/

None of this should be understood, however, as an argument against price signals. The enemy here is the specific use of deductibles, co-pays (with rare exceptions), and co-insurance at the point when health care is received. Other price signals—ones that encourage lower health care costs, higher quality, and better health outcomes without inhibiting patients from seeking or receiving necessary care—are fine. What America needs—both outside of Medicare, and within Medicare—is a new paradigm that uses price signals to control costs in a way that rewards the results we want (universal access, low cost, high quality, good outcomes) and does no collateral damage in the form of avoided necessary care and hyper-inflation in costs.

Medicare's Payment Problem

Medicare's third major structural problem involves its financing mechanism.

Medicare is a social insurance program. The financing of the program's Part A coverage of hospital care takes full advantage of the logic, simplicity, and fairness of social insurance principles. Contributions by workers and employers are obligatory.[25] Payment by workers is automatic, and by employers is routine.[26] The amounts owed are proportionate to earnings.[27]

The financing of the rest of Medicare, however, is another story. Several key features of the social insurance financing model do not apply to Part B for medical care, Part D for prescription drugs, or Part C Medicare Advantage plans.

To begin with, payment is *not* obligatory for Parts B, D, or C. No payroll tax or mandatory premium applies. Seniors must decide not only to enroll (which is technically true for Part A). They must also choose to pay monthly premium for Parts B or D. They likewise must choose to pay monthly premiums for a Part C Medicare Advantage Plan (which folds in Part B medical coverage and, at the enrollee's discretion, may also fold in Part D drug coverage). Not surprisingly, there is a drop-off between the 46.0 million

[25] Workers' earnings are subject to a 1.45% Medicare tax, and their employers pay another 1.45% of earnings. Self-employed individuals pay both the worker's and the employer's 1.45% of earnings.

[26] The vast majority of individuals who pay Medicare taxes do not have to think or worry about whether their payments will be accurate or made on time. They do not have to write a check or instruct their banks to transfer funds. Rather, Medicare taxes are deducted periodically from workers' paychecks by their employers. Employers are responsible for submitting the amounts accrued each calendar quarter, together with their own quarterly payments, to the IRS. Only self-employed individuals have to take the trouble to calculate what they owe (i.e., the combined employee and employer share), and write a check of electronically transfer the funds.

[27] Medicare does not apply a lower tax rate to low-income workers and a higher tax rate to those who earn a lot more. However, the formula—1.45% applied to every dollar earned, with no cap on taxable earnings—causes low-income workers' to make smaller dollar contributions, while high-income workers make larger ones.

seniors in 2015 who enrolled in "pre-paid" Medicare Part A vs. the 42.5 million and 41.8 million who signed up, respectively, for optional, premium-demanding, Parts B and D programs.[28]

The other major way in which Medicare Parts B, D, and C depart from the classic social insurance model is that the premiums they charge do *not* vary with income, unless it is quite high. In 2017, the overwhelming majority of Medicare Part B enrollees, regardless of their annual income between $1 and $85,000 (for single filers) or $170,000 (for married joint filers), paid the same $134 per month. Only those with incomes higher than $85,000/$170,000 paid in relationship to ability to pay.[29] Similarly, the overwhelming majority of Medicare Part D enrollees, regardless of income as long as it is under $85,000 (for single filers) or $170,000 (for married joint filers), pay the same monthly premium for the same benefit package. Only those with higher incomes pay extra.[30]

Medicare departure from Part A's classic social insurance financing principles, when it came to Parts B, D, and C, is not just a matter of inelegance. It helps seniors that their hospital insurance program, Part A, is simple, automatic, and paid for in a way that is proportionate to their income. It may harm seniors that Parts B and D are not obligatory. It particularly harms seniors that, whether their income is $40,000 or $80,000 (if single), or $80,000 or $160,00 (if married), they must pay exactly the same premiums for Parts B and D, as well as for the same Part C benefit package.

To sum up: As long as Medicare remains a program that, despite its many strengths, provides seniors with inadequate benefits, falls short on controlling costs, and does not consistently apply social insurance principles in its financing mechanism, we should refrain from enrolling all Americans in a Medicare-for-All program.

The Shape of Rational Health Insurance: A New Approach

It would instead be better to enroll Americans under 65 in a better version of Medicare, which I call YoungMedicare.[31]. In time, if Medicare itself changes to absorb all of the principles of YoungMedicare into its approach, the two programs could be fully integrated into a single program: an improved Medicare-for-All.

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[28] National Committee to Preserve Social Security, "Number of People Receiving Medicare (2015)," *Fast Facts About Medicare,* February 2017, http://www.ncpssm.org/Medicare/MedicareFastFacts

[29] U.S. Centers for Medicare and Medicaid Services, "Part D Premiums by Income," *Part B Costs*, https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

[30] U.S. Centers for Medicare and Medicaid Services, "How Much Does Part D Cost?" *Costs for Medicare Drug Coverage*, https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

[31] I wish to acknowledge the influence of Stanford University *Emeritus* Professor Alain Enthoven, and his explanation of what he calls "cost-conscious consumer choice," in shaping this proposal.

YoungMedicare would:

1. Provide all Americans under 65 with the resources they need to buy health insurance;

2. Require all participating health care plans to provide excellent uniform benefits (even better than Medicare's);

3. Use the most basic of market forces—competition, choice, prices, and incentives—to deliver low premiums, improve quality of care, and strengthen health outcomes, by driving out the massive error, waste, and inefficiency that permeate our health care system; and

4. Organize and finance the program as new social insurance program that (akin to Worker's Compensation) relies on an employer mandate and payroll-based premiums.

Here are the details:

Universal Coverage: Health Insurance Purchasing Accounts

Every American would have a Health Insurance Purchasing Account (Account) that, every fall, would be replenished with a dollar amount equal to 100% of the lowest premium bid in the individual's county of residence (or, if the individual wishes, another county) by a High-Quality Health Insurance Plan (Plan).

The dollar amount in the Account would be actuarially adjusted for the individual's age and sex. It would also reflect the Plan's obligation to provide a defined, comprehensive, excellent, and uniform package of health insurance benefits that is includes the ACA's Essential Health Benefits (The benefit package is discussed shortly.)

During an open enrollment period in November and December, adults (18 or older) would direct the actuarially adjusted amount in their Accounts to their choice of a Plan. Parents or guardians, on behalf of their children under 18, would direct the amounts in their children's Accounts to the parents' or guardians' choice of a Plan.

Next year, individuals with Accounts could stay in the same Plan (if available) or switch to a different Plan on offer. Those who make no choice would be reassigned to their prior Plans (if available). If they have no prior Plan, they would be assigned to the lowest-bidding Plan.

At age 65, seniors who qualify for Medicare would decide, as they now do, whether to enroll in a Medicare Advantage Plan or regular Medicare.

Excellent Benefits: No Cost Sharing

Every Plan would be an insurance plan that complies with applicable state law. The Plan could be a HMO or anther type of integrated delivery system, a PPO, or a fee-for-service plan.

Each Plan would provide comprehensive benefits. As with the ACA's set of Essential Health Benefits, each plan would cover medical care, hospital care, prescription drugs, and more.[32]

All Plan benefits would also be uniform. No deductibles, no co-pays (with one exception), and no or co-insurance would apply. Thus, the "actuarial value" of all Plans would be nearly 100%. The only exception is that a Plan could charge a co-pay if a physician decides not to prescribe a lower-cost generic drug but instead prescribes a pharmacologically equivalent brand-name drug.

Use of Market Forces to Control Costs, Improve Quality, Enhance Outcomes

Basic market forces—choice, competition, prices, and incentives—would cause YoungMedicare to hold down health costs, improve the quality of care, and enhance health outcomes. Government would not fix prices. Government would no regulate supply. Rather, government's role would be to create a structure of price-based signals and across-the-board incentives (for enrollees, Plans, and providers) that put strong and enduring pressure on Plans and providers to submit low risk-adjusted bids, strengthen quality, and generate better outcomes as the only way to attract customers, increase revenue, and maximize profit. (The Appendix to this essay illustrates how these basic market forces would interact to constrain costs and improve quality.)

As mentioned above, all Americans would have Health Insurance Purchasing Accounts that pay for excellent benefits, and would use their Accounts to make an annual choice among competing Plans.

Unlike the current system, however, the Plans' competition would not be based on (A) denying or limiting coverage for high-risk individuals or groups, (B) shortchanging benefits, or (C) baffling consumers with irrelevant differences among different insurers' cost-sharing arrangements. No American with an Account could be denied coverage or offered a limited benefit package. All Plans would offer the same excellent benefit package. Since cost sharing at the point of service would almost entirely vanish, Plans could no longer compete based on confusing customers about which Plan's incomprehensible matrix of deductibles, co-pays, and co-insurance is worse or better than some other Plan's equally comprehensible matrix of cost sharing.

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[32] Plans would be required to provide all Essential Health Benefits defined in the Affordable Care Act. See "What Marketplace Health Insurance Plans Cover," *Health Benefits and Coverage*, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/n

Rather, as Americans with Accounts decide which Plan to join, their decisions would be based on four differences among the competing Plans: (1) monthly extra price, (2) network, (3) quality, and (4) outcomes.

The most important of these Plan differences: monthly extra price.

Recall that YoungMedicare would guarantee all Americans with an Account that pays for 100% of the actuarially-adjusted dollar amount bid per month by the *lowest-bidding* Plan, but no more. That means that an individual with an Account would be obliged to pay out-of-pocket the full *extra amount* per month that has been bid by any *higher-bidding* Plan if the person wanted to obtain health insurance coverage from such a higher-bidding Plan.

For example, if the Account for a 30-year old male in Milwaukee is credited with $500 per month because lowest-bidding Plan A submitted a $500 monthly bid on an actuarial basis to provide 30-year old males with the required excellent benefit package, then the individual would pay the following extra monthly amounts to join different Plans:

Plan	Amount Bid/Month		Extra Cost to Join/Month
A	$500	$500 - $500 =	$0
B	$525	$525 - $500 =	$25
C	$550	$550 - $500 =	$50
D	$575	$575 - $500 =	$75

The Appendix to this essay provides a visual illustration of how these price signals work.

The formula for actuarial adjustment would of course be designed so that, regardless of an America's age or sex, the difference in each county between the lowest-bidding Plan and each higher-bidding Plan would be the same. In other words, if it were to cost the 30-year old male in Milwaukee to spend an extra $25 per month to join Plan B, any other male or female or any age in Milwaukee (prior to Medicare) would also pay $25 to enroll in Plan B.

The lower price of a product or service is of course a compelling reason to select it in lieu of a higher-priced product or service. But the price signal is only the starting point in making a choice. All of us decide to spend more for any number of products or services because we conclude that the extra cost is "worth it" due to the extra value we obtain. Extra value can be almost anything: greater speed, freshness, color, taste, durability, warranty, popularity, politeness, etc.

In the case of health insurance, three kinds of extra value might well induce a YoungMedicare user of an Account to spend more than the dollar value in the Account,

which is attributable to Plan A's low bid, in order to sign up for a more expensive Plan B, C, or D.

- *Network*: An enrollee may prefer a higher-cost Plan's network of providers. Plans will have different (if sometimes overlapping) networks of doctors, hospitals, and other providers, operating at different (if sometimes overlapping) facilities. At least one For-for-Service plan would provide a network comprised of all providers in the United States. In choosing a plan, an individual may decide to spend extra to join a more costly Plan because of the appeal of its provider network or the location of its facilities. Some may be willing to spend a lot more to join a Plan with no limitation on available providers.

- *Quality*: In YoungMedicare, all Plans would have to meet high standards of quality. Nonetheless, the Plans will have different reputations and rankings for quality of care. This could be a relevant factor in deciding to spend extra to join a more expensive Plan.

- *Outcomes*: Finally, the Plans will also have different reputations and rankings for health outcomes. This too may be a relevant factor in spending more to join a particular Plan.

Prior to bid unsealing, of course, the competing Plans will not know whose bid is the low bid. Each Plan *could* be the low bidder, but only one Plan *will* be the low bidder. Thus, each Plans faces the high probability—and all but one Plan face the reality—of having to persuade individuals to spend money out-of-pocket in order sign up for their Plan. As a consequence, every year each Plan will be under powerful and enduring pressure to do four things to position itself for success:

1. Keep its bid as low as possible: If you cannot be the low bidder, you do not want to cost too much more.

2. Have a desirable network: If you must sell consumers on your higher price, you will want to point to the convenient location of your facilities, your easily accessible hours of service, the reputation of your doctors and hospitals, and so forth.

3. Score well on quality: You will have an edge in persuading consumers to spend more if you can highlight objective (and non-objective) evidence of how excellent your doctors, nurses, hospitals, and other providers have proven to be.

4. Score well on outcomes: Finally, you may be able to induce consumers to spend more if you can highlight objective (and non-objective) evidence that your Plan delivers healthy babies, avoids illness, saves lives, and achieves other health outcomes.

Young Medicare's exertion of relentless pressure on health insurance Plans and health care providers to lower their costs, strengthen their networks, and improve their quality and outcomes is exactly what the YoungMedicare is meant to do. It is a core aim of the YoungMedicare model to inject such strong—and appropriate—market forces into the U.S. health system so that, to make money, the nation's health insurers and providers have no choice but obey the new incentives that surround them and produce the cost-containing, quality-improving, outcome-enhancing health care system Americans have long desired and the nation desperately needs.

But do America's health insurers and providers have "room" to respond to market pressure by holding down costs, pushing up quality, and strengthening outcomes? The evidence points to a resounding: Yes! According to several reports published in 2012, the level of waste in the U.S. health system at the time was roughly $700 billion:[33]

> By looking at regional variations in Medicare spending, researchers at the Dartmouth Institute for Health Policy and Clinical Practice have estimated that 30 percent of all Medicare clinical care spending could be avoided without worsening health outcomes. This amount represents about $700 billion in savings when extrapolated to total US health care spending, according to the Congressional Budget Office.
>
> More recently, an April 2012 study by former Centers for Medicare and Medicaid Services (CMS) administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth estimated that five categories of waste consumed $476 billion to $992 billion, or 18 percent to 37 percent of the approximately $2.6 trillion annual total of all health spending in 2011. Spending in the Medicare and Medicaid programs, including state and federal costs, contributed about one-third of this wasteful spending, or $166 billion to $304 billion ….Similarly, a panel of the Institute of Medicine (IOM) estimated in a September 2012 report that $690 billion was wasted in US health care annually, not including fraud.

This estimate that the U.S. health system wastes $700 billion appeared in 2012. Even if the mindboggling amount lost to waste has been reduced in the last few years, the opportunity remains to lower cost *and* improve quality by squeezing hundreds of billions of dollars of waste out of the health care system. While it is superficially convenient to equate lower health costs with worse health quality, the opposite is true. Higher costs are driven by poor quality. Lower costs and better quality go together, and both result from squeezing out waste.

The following table, summing up findings of Donald Berwick and Andrew Hackbarth, explains that the current U.S. health system is wasting hundreds of billions of dollars

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[33] "Health Policy Brief: Reducing Waste in Health Care," *Health Affairs*, December 13, 2012, pp. 1-2, https://www.healthaffairs.org/do/10.1377/hpb20121213.959735/full/healthpolicybrief_82.pdf

because of three types of poor quality care: (1) failures of care delivery; (2) failures of care coordination; and (3) overtreatment. Three other categories of waste that add up to additional hundreds of billions of dollars—that is: administrative complexity, pricing failures, and fraud and abuse—are not the result of care decisions, but stem from the byzantine design and misdirecting incentives that permeate our health care system. Those design flaws and perverse incentives also expand the niches where "bad actors" (patients, insurers, and providers) can try to fleece the system.

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	**Midpoint**	**High**	**Low**	**Midpoint**	**High**
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of care coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in US Health Care," *JAMA* 307, no. 14 (April 11, 2012):1513–6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 trillion.

The YoungMedicare model opens up two new fronts in the effort to lower cost, and improve quality, by squeezing out waste:

The Incentive Front: Most importantly, the model creates three interlocking incentives that work together to put pressure on wasteful practices:

1. Enrollees' have a strong incentive to select a low cost Health Care Plan that is better in quality, since they must spend cash out-of-pocket to join a higher-

bidding Plan and will tend to shy away from selecting a costlier Plan that ranks worse in quality. Thus…

2. Each Plan has a powerful incentive to be a low-cost, high-quality Plan—which they can best accomplish by squeezing out waste—because submitting low bids (that low cost justifies), and achieving a sterling reputation for quality, positions the Plan to attract more enrollees, earn greater revenue, and make a handsome profit. As a result…

3. Health care providers—doctors, hospitals, and others—have a strong incentive to be affiliated with low-cost/high-quality Plans that they assist in squeezing out waste, since that's how they too most likely will gain the patients, revenue, and profit they also seek.

The tail end of this chain of incentives is a steady reduction in the massive waste that permeates the U.S. health care system. Within the YoungMedicare framework, the *only* way to respond to enrollees' incentive to enroll in low-cost/high-quality Plans is for the Plans themselves, and their affiliated providers, to work together to aggressively attack the waste that saturates the system. Gaming the system, to avoid risk or dump it on others, is longer a possibility. Indifference to cost, quality, and outcomes is no longer a viable business option, but a ticket to failure. A new, stern, market discipline would henceforth issue the following instruction to the health insurance industry and health care providers: "Either lower your costs and improve your quality by driving out the waste you now tolerate, or shrink and vanish."

The Appendix to this essay, "How Price Signals Lower Health Costs and Improve Quality," illustrates in greater detail how the YoungMedicare model would effectively use price signals to reward low-cost/better-quality Plans and discourage enrollees and income from flowing to high-cost/worse-quality Plans.)

The Administrative Front: In addition, YoungMedicare's organizational structure and financial arrangements, because of their simplicity, will help to shrink the portion of waste in the U.S. health insurance system that Berwick and Hackbarth attribute to administrative complexity, pricing failures, and fraud and abuse.

Under the YoungMedicare model, Americans make only two decisions each year with a financial consequence: which Plan to join, and if they do not select the low-bidding plan how to pay the extra required to enroll in their alternative choice. This automatically eliminates millions of dollars in costs that are needlessly piled onto—that is: wasted—within the current health insurance system.

To begin with, since the YoungMedicare benefit package includes virtually no cost sharing, the administrative costs associated with the following practices will disappear:

- *Benefit Manuals:* Since every enrollee in YoungMedicare has the same benefits, few services are excluded, and cost sharing at the point of service (deductible, co-

pay, co-insurance) is essentially gone, the program's benefit manuals will be simpler, shorter, and less expensive to produce. No longer will insurance plans, at considerable expense, need to send out giant volumes with incomprehensible explanations of what cost-sharing you must pay for different services, or what your plan does not cove at all.

- *Explanation of Benefits (EOB):* In addition, EOBs will become dramatically simpler and less expensive. They can focus on the details of the actual care you got. Today's lengthy, indecipherable, and costly lists of billed charges vs. actual charges vs. what your insurer has paid for vs. what some other insurer is being billed for vs. what you might be charged will disappear.
- *Billing*: YoungMedicare will not ever bill any enrollee for any health care service. (If a patient wants to forego a generic drug and purchase a pharmacologically equivalent brand-name drug, the patient will simply pay the extra price at a pharmacy.) The elimination of billing for services will lower administrative costs.
- *Arrears:* Since YoungMedicare patients will never be billed for health care services, they will never fall behind in their payments to Plans or providers for those services. Nor will they ever be hassled by collection agencies, or taken to court, or drawn into bankruptcy proceedings, because of unpaid hospital or medical bills. The only risk of arrears arises if an individual chooses a Plan other than the low-bidding plan, but fails to pay the extra monthly cost. Even here, the patient's liability will be limited to the number of delinquent months times the extra out-of-pocket monthly cost the patient voluntarily chose to incur. This shrinkage in the necessity to chase after patients in arrears will help to lower administrative cost.
- *Coordination of Benefits (COB)*: Finally, YoungMedicare will result in a decline in the need for health insurance plans to coordinate benefits. There will be no need to coordinate with Worker's Comp health care component or Medicaid coverage, since both of those programs would end.[34] Nor will there be a need to coordinate benefits when an individual is covered by two different employer-sponsored health care plans, since one of the effects of YoungMedicare is to make employer-sponsored health insurance unnecessary.[35] Under YoungMedicare, each covered person will have a single plan with the same benefits. COB will not end entirely, but its costs will greatly shrink.

Another cost-related outcome of the YoungMedicare model is that patients will no longer feel pressure to "use up the benefits" before another calendar year starts and a new deductible kicks in. The elimination of deductibles and other cost sharing means that

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[34] See Chapter Seven ("Outside the Labor Market") for a discussion of why the Worker's Compensation health insurance component should be ended. See Chapter Eleven ("Ending Welfare") for a discussion of the logic of ending means-tested welfare programs, including Medicaid.

[35] Employers would of course be free to continue to offer other kinds of health-related insurance, e.g., dental and vision, as well as a variety of other insurance and non-insurance benefits, e.g., life insurance, supplemental disability insurance, defined benefit annuities, etc.

patients will seek care at the time of need, not at a time arbitrarily dictated by the calendar.

Organization and Finance: A New Social Insurance Program

The final facet of YoungMedicare to consider is its organization and financing. The program would be organized outside the structure of the federal government. Akin to what typically happens with Worker's Compensation, employers of all sizes would be required to carry Young Medicare coverage by remitting payroll-based premiums. (The premiums paid by self-employed persons and small firms may need to be treated as taxes, rather than mandatory payments, in order to satisfy the U.S. Supreme Court's narrowing vision of what regulations of commercial activity are allowed under the Commerce Clause of the Constitution.)

YoungMedicare would be run by a new government-sponsored enterprise (GSE): the National YoungMedicare Corporation (NYMC). Employers' premium revenue would be used immediately to enable the under-65 population—overwhelmingly workers, workers' spouses, and workers' children—to purchase an excellent health insurance plan. All funds would flow into and out of the NYMC's independent trust fund.

The Medicaid program would be eliminated. Its long-term care function would be taken over by Medicare. In the future, it may make sense for YoungMedicare and Medicare to be combined into a single program.

How many people would YoungMedicare cover? What would YoungMedicare cost? How would it be funded? Estimates for coverage, cost, and funding are as follows. (These estimates assume that employers would require their workers—as permitted—to absorb half of the cost, via payroll deductions, of the payroll-based premium that the employers would be required to remit to the NYMC.)

Covered Individuals (2015)	254.0 million
Estimated cost (2015)	$1,326.5 billion
Medicare Part A Taxable Earnings (2015)	$7,580.0 billion
Total Employer Premium: 17.5% of Part A earnings	$1,326.5 billion
Maximum Worker Deduction: 8.75% of earnings	$ 663.2 billion
Minimum Employer Share: 8.75% of wages/salaries	$ 663.2 billion

There would be no individual mandate to obtain health insurance. Rather, individuals under 65 would just automatically *have* health insurance. Their Health Insurance Purchasing Accounts would include the funds necessary to pay 100% of the premium of the lowest-bidding, high-quality, health care plan available in their county. The same dollar amount would pay close to the full premium of other available plans. If individuals do not select a plan, they would be automatically enrolled in the lowest-bidding, high-quality health care plan available, which would impose no additional cost.

Although individuals would face no individual mandate to obtain insurance, workers would be subject to the possibility that their employers would exercise the right to deduct from the worker's paycheck up to 50% of the payroll-based premium that employers themselves are obliged to remit to the NYMC. Employers could of course implement a smaller payroll deduction, or none at all, for individual workers or the entire workforce.

No worker, however, would bear the full cost of any deduction. Rather, all workers would be able to claim a refundable tax credit for a large portion of it—up to 70%—when they submit their annual federal income tax returns. This would reduce workers' out-of-pocket share to less than they now pay for premiums.

The employers' premium (assuming they deduct half from their workers' paychecks) would also be *less* than what employers as a whole actually spend on private health insurance premiums.

These fiscal details are explained in full in my book, *Putting Government In Its Place: The Case for a New Deal 3.0*.

Collateral Benefits

This essay began by arguing that greatly improving the U.S. economic security structure (via measures such as guaranteeing Transitional Jobs, raising the minimum wage, and substantially increasing incomes for workers, the disabled, and retired seniors) is the most important way to improve the American population's health. The converse is also true. A topnotch health insurance system for all Americans under-65—one that provides excellent benefits, a choice of health insurance plans and care providers, and an effective incentive-based mechanism for controlling costs—will strengthen economic security. Bankruptcies will decline. Savings will rise.

Beyond improving economic security, YoungMedicare has several other important collateral benefits. One obvious consequence is that workers' health, including their mental health, will be somewhat improved. As a result, more individuals will be able to find jobs and stay on the job. Workers will be able to keep more regular hours, and they will experience less on-the-job stress. All this means a gain in employee productivity, which translates into business profits and national wealth.

Yes, some firms will have to spend more for their workers' health insurance than they now get away with. But the firms that spend little today do not do so because they are

smart at buying good insurance. They typically save on health insurance via three different types of cost shifting: skimming, sticking, and skimping.

Skimming: To begin with, some employers intentionally favor hiring younger or otherwise healthier workers in order to reduce their health insurance costs. The responsibility for insuring older or less healthy workers thus gets shifted to the taxpayers or other employers.

Sticking: Some employers "stick it" to the taxpayers the by requiring their workers (or their workers' spouses and dependent children) to make use of Medicaid, the Affordable Care Act, or government employee health plans if at all possible. Alternatively, the employers may offer cash bonuses to workers who enroll (or arrange for spouses or children to enroll) in government insurance arrangements.

The taxpayers are not the only victims of such schemes. Some employers—including public employers as well as private ones—insist that their workers enroll (or have their spouses or children enroll) in available private employers' health insurance plans. An alternative is often to offer cash bonuses to workers who agree to "stick it" to a different private firm.

Skimping: Finally, some employers try to save money—for themselves, not for the overall health care system—by providing skimpy benefits. They typically saddle their workers with high deductibles in order to slice the price of their premiums. The cost of the deductibles, however, does not vanish. Workers absorb them. And where workers are unable or unwilling to pay up, the unpaid health care providers will attempt to embed their lost revenue in the charges they collect (or try to) from other individuals, employers, or government.

A government-overseen system that offers excellent coverage to all Americans, and finances it fairly, avoids all of these forms of cost-shifting. Everybody's covered. Every worker and every employer pays a fair share, based on a simple formula, for the national necessity of excellent health insurance for all Americans under 65. Just as doctors no longer bleed their patients, skimming, sticking, and skimping by employers in order to save a buck would become relics of a bygone era.

The biggest boon to business is likely to be the liberation of employers from the burden of thinking about, worrying over, and being frustrated by the complexity and cost of health insurance. For most employers, public and private, health insurance is not a "core business." Rather, preoccupation with health insurance diverts them from their core business. Its baffling rules and ever-escalating costs soak up energy and creativity that should be focused on the stuff that matters: employee recruitment and management, product development, marketing and sales, and customer relations. YoungMedicare would liberate America's private sector to concentrate fully on its primary mission.

Both large and small businesses will gain when, for a simple and predictable price, they can get the health insurance monkey off their backs. Small firms will benefit in particular.

One reason is that a program like YoungMedicare will promote the formation of more small businesses. All over American, would-be entrepreneurs are locked into their jobs in government agencies or large firms because they cannot go without insurance. If their incomes exceed 400% of the poverty line (not that much for a single person in the middle-or-upper ranks of a high tech corporation), Obamacare offers no subsidy if they quit their insured job and go off on their own to invent the next Apple computer or launch the next Facebook.

Only in the U.S. are such entrepreneurs thus trapped inside government agencies of big corporation by their fear of losing health insurance for themselves, their spouses, and their children. Their Chinese, British, French, German and Japanese competitors—insured in very different ways no matter where what ventures they may pursue—face no similar handicap. YoungMedicare would instantly eliminate "job lock." Entrepreneurs could immediately begin to form the start-ups they dream about, and hire other adventurous employees, knowing that all of them (and all of their spouses and children) will retain excellent health insurance via a choice of health care plans.

A final collateral benefit will be the slowing down in the share of U.S. GDP that is poured into the health care sector (without making us any healthier). This is not merely a matter of getting in line with how much our international competitors spend on health care as a percent of their GDP. The reason for slowing the flow of dollars into health care is to accelerate the flow of dollars into the other sectors of the economy that (directly or indirectly) make the overall U.S. economy more productive, competitive, and wealthier.

Summary

Whether health insurance is a "right" or not, it is a necessity. Every American should have it. Coverage should include medical care, hospitalization, prescription drugs, and all the other types of care listed in the Affordable Care Act. Benefits should also be excellent. This means getting rid of deductibles, co-pays (except in rare cases), and co-insurance. The harm they do in preventing sick and injured Americans from obtaining necessary care far exceeds any good they do in preventing frivolous or inappropriate care, particularly when a better price signal mechanism exits to avoid unneeded treatment. To achieve the five essential goals of a good health insurance system—(1) universal coverage, (2) excellent benefits, (3) choice of health care plans and providers, (4) effective control of insurance premiums and health care costs, and (5) improved health care quality leading to gains in health outcomes—we should create a new model, here called YoungMedicare, for the entire under-65 population.

Under YoungMedicare, all covered individual would have a Health Insurance Purchasing Account credited with a dollar amount equal to the lowest premium bid by competing health care plans, on a risk-adjusted basis, to provide a uniform set of excellent health insurance benefits in the county where they live or work. Individuals could buy the uniform benefit package from any of the competing plans. If they passed over the low-bid plan in order enroll in a higher-bid plan, however, they would pay out-of-pocket the full difference between the low bid and the higher premium bid by the plan they selected.

This use of clear and simple price signals will cause market forces to exert powerful and enduring pressure on insurers and providers to lower their prices and costs by squeezing out the enormous waste that pervades the U.S. health care system, amounting to as much as one-third of all health spending.

To pay for the amounts credited to every owner of a Health Insurance Purchasing Account for the purpose of choosing a YoungMedicare health care plan, the program would be organized as a new social insurance program. Akin to Worker's Compensation, YoungMedicare would require employers to remit payroll-based premiums. Workers' could be required to absorb payroll deductions for up to half of the employer's premium cost, but workers would be able to reduce the burden by claiming a refundable federal income tax credit for up to 70% of their cost. Both workers and employers would (in aggregate) pay less than the health insurance premiums they now pay.

Medicare would continue to operate as is for the 65+ population. In time, it may make sense to integrate the two programs—YoungMedicare and the existing Medicare program—into a single program.

Appendix

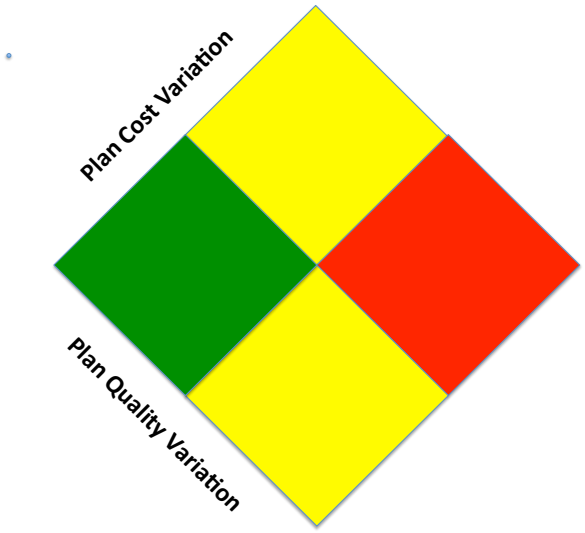
How Price Signals Lower Health Costs and Improve Quality

Price signals, *if* properly designed, can lower health costs and improve health quality. Two assumptions underpin the following explanation—and visual guide—of how properly designed price signals can lead to both lower costs and better quality.

First Assumption: Most Americans already gain access to health care through a health insurance plan (Plan), i.e., a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), or Fee-for-Service (FFS) plan. The Plan insures that, when covered individuals need a defined set of health care services from the Plan's network of doctors, hospitals, and other health care providers, the individuals covered by the plan will pay less far less than full cost of their care. The Plan instead will bear most of the cost. If an individual needs a lot of care, the Plan is likely to pay most of the total cost and nearly all of the "latest" cost (until at least the end of the year).

Second Assumption: Despite these common features, Plans vary a lot. They vary in the location of their facilities. They vary in their networks of providers, i.e., which doctors and hospitals are in their respective networks. HMOs have narrower networks, PPOs broader networks, and FFS plans the widest (often unlimited) networks. Most importantly for this discussion, Plans vary in how much they cost. Even if providing exactly the same benefits for exactly the same persons of the same age, sex, and other risk factors, premiums (or equivalent) will differ. They also vary in their quality of care.

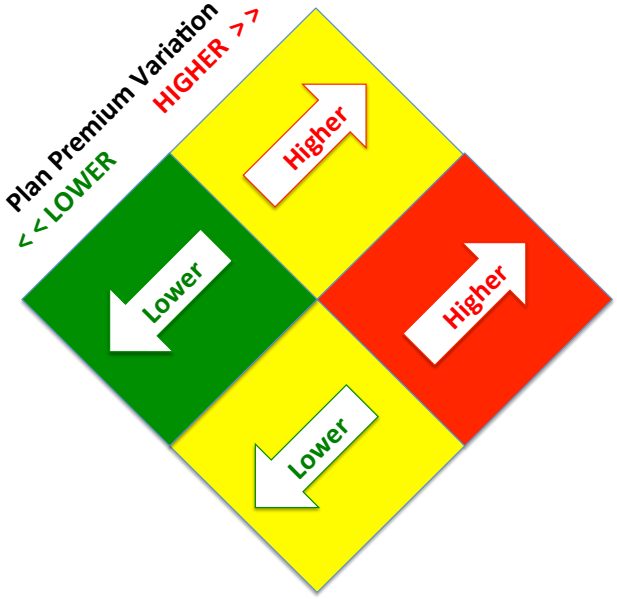
The following four-square shows the two axes along which Plans vary. Along one axis, Plans vary by cost. Along another axis, Plans vary by quality.



Cost Axis: Let us begin by looking at Plan variation based on cost. Let us further assume that all plans' benefits and enrollment "risk profiles" are identical (or have been actuarially risk-adjusted to be identical), and that our cost focus is each Plan's benefit-adjusted, risk-adjusted, per-person premium.

Along the cost axis, some Plans have figured out how to operate more efficiently. Thus, they can keep costs down and charge lower premiums. Other Plans have not succeeded in delivering health care as efficiently. Thus, they suffer from higher costs and must charge higher premiums.

In the diagram below, the more efficient, low cost, lower premium Plans occupy the green square and the lower-left yellow square. The les efficient, high cost, higher Premium plans occupy the upper-right yellow square and the red square.



Quality Axis: Now let's look at Plan variation along the quality axis. Again, even if Plans' benefits and risk profiles are identical, Plans quality varies.

Many Plans provide superb service and excellent care. They give their customers clear and timely information, always treat patients with respect, keep appointments, and provide good follow-up. Their doctors, nurses, and other providers are highly qualified. They make few errors. Care itself is delivered quickly, correctly, and efficiently. These Plans get the highest scores from HEDIS on three measures: customer satisfaction, prevention, and treatment.[36] Their hospitals they get high grades from Leapfrog.[37]

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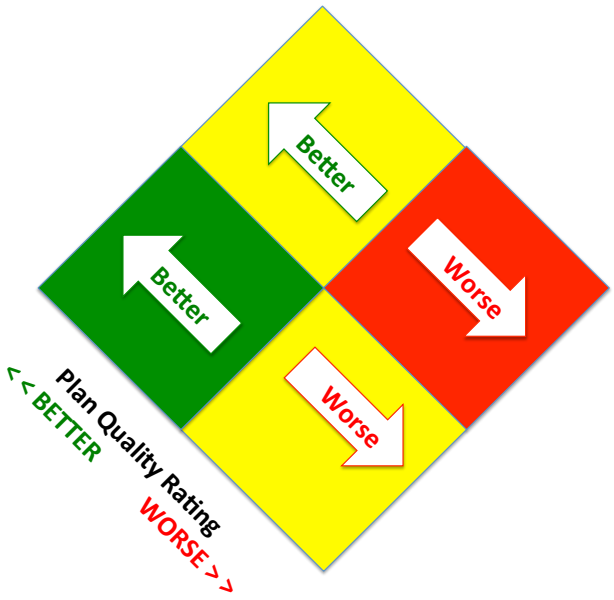
[36] HEDIS is the Healthcare Effectiveness Data and Information Set. It is a tool used by more than 90 percent of America's health plans to measure performance on important

By contrast, other Plans deliver mediocre-to-terrible quality. Some patients may be quite happy with the service and care they get. But applying objective HEDIS and Leapfrog measures as well as subjective assessments, such Plans fare poorly in quality.

It is typically the efficiency of the Plan—more efficient management, more efficient recruitment and use of personnel, more efficient IT systems, more efficient coordination of the Plan's many complex pieces—that drives its rankings for quality. The more efficient Plans are likely to have higher quality, which helps them keep costs down and keep premiums in check. The less efficient Plans are likely to have lower quality, which inhibits their ability to control costs and pressures them to charge higher premiums.

In the diagram below, the more efficient, better quality Plans occupy the green square and the upper-right yellow square. The less efficient, worse quality Plans occupy the lower-left yellow square and the red square.



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dimensions of care and service. Altogether, HEDIS consists of 81 measures across 5 domains of care. See: http://www.ncqa.org/hedis-quality-measurement and http://healthinsuranceratings.ncqa.org/2017/Default.aspx

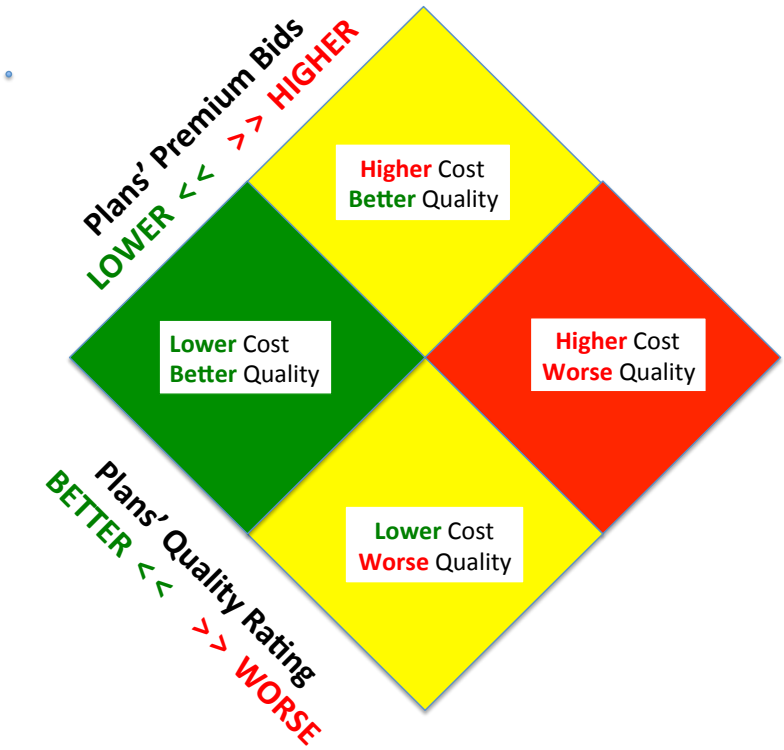
[37] Part of the Leapfrog Group for improving U.S. hospital care, the Leapfrog Hospital Safety Grade assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections. See: http://www.leapfroggroup.org/about

Combining the Cost Axis and the Quality Axis: Because Plans vary along *both* a cost/premium axis *and* a quality axis, it is possible to group them into four categories:

• Green square Plans do the best on both measures. They have a lower cost structure; thus they have the potential to bid lower premiums. They also deliver excellent quality.

•Yellow square Plans score well on one measure, but they fall short on the other measure. Either (as with the lower-left yellow square) their costs and premiums are low, but their quality is mediocre-to-poor. Or (as with the upper-right yellow square) their costs and premiums are high, even though their quality is good-to-excellent.

•Finally, red square Plans do the worst on both measures: They not only suffer from higher costs, compelling them to bid higher premiums. They also have the worst quality.

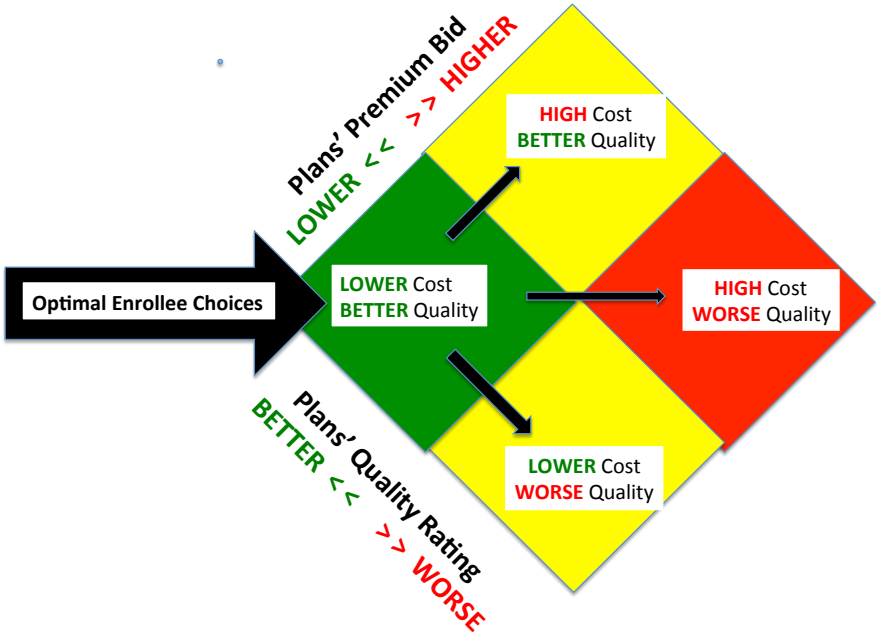


People are funny. But it is likely that Americans, if they have the choice of enrolling in any one of several health care Plans and get accurate information, will at least *say* that they are more likely to enroll in the Green Square Plans whose lower cost justifies lower premium *and* that earn high ratings for better quality.

It is also likely that, given a choice, Americans will *say* that they will shy away from a Yellow Square Plan that only do well on one measure (cost/premium *or* quality), but fare badly on the other measure (cost/premium *or* quality).

And of course it is likely that Americans will *say* that they will never enroll in a Red Square Plan. Who in their right mind, they might indignantly ask, would go out of the way to enroll in a costly plan that charges higher premiums yet delivers terrible health care quality?

The following diagram illustrates what Americans are likely to *say* about their behavior in choosing among competing health care Plans (or any other product or service, for that matter). Who does not want the lowest cost product or service that also happens to be the best product or service? Who would spurn such a choice, in order select the highest cost option that also has the worst record of quality?



But in the absence of a clear and simple price signal that creates a powerful incentive—a strong economic reason—to pick a low-premium/high-quality plan, many Americans will not bother to do so.

They may be suspicious of the lowest-cost option. ("If it's so cheap, how can it possibly be so good?") They may not wish to spend time looking at HEDIS, Leapfrog, or other information about comparative quality. Even if they have no objection to low-cost options *per* se and pay careful attention to quality rankings, they may nonetheless

decide—if no cost signal makes them think twice about choosing a more expensive, worse quality Plan—to enroll in it solely based on familiarity.

The lack of price signals to induce Americans to select low-cost, high-quality plans is not just a theoretical concern. It drives up the overall cost of the U.S. health care system, causing health care to absorb an ever-growing share of GDP without improving health outcomes, and thus choking off resources for other public and private investments that could better improve U.S. health and wealth. The lack of price signals also takes the pressure off the improvement of the quality of care. As a result, more people die and sicken than would otherwise be the case.

It is fairly simple, however, to create clear and simple price signals that encourage Americans to prefer low-cost/high-quality Plans. Such price signals would not deprive anyone of choice. Americans would be free to select any Plan they want, regardless of premium and quality.

What the price signals would do is induce the Plans to become more efficient, hold down their costs, lower their premiums, and improve their quality. No Plan would be required to do anything. They could manage their costs, set their premiums, and try to improve their quality anyway they want. But they would face the stern and constant discipline of the market. They would gain price-sensitive customers, increase revenue, and make higher profits by greatly improving their efficiency, lowering their costs, holding down their premiums, and enhancing the quality of the care they provide. Conversely, they would lose customers, revenue, and profits if they failed to become more efficient, cost more, charged higher premiums, and offers worse quality care.

The next set of four-square diagrams show how a clear and simple system of price signals would operate. It illustrates one basic concept: a coin whose two sides are stated below:

- When enrollees pick a Plan, they *must personally save money* when they select a Plan that is lower in cost, bids a lower premium, and delivers high-quality care.

- Conversely, enrollees *must personally lose money*—out-of-pocket—if they join a plan that is higher in cost, bids a higher premium, and delivers lower-quality care.

For this price-signal mechanism to work, five things are necessary:

1. The Plans must be required to bid on a single, uniform benefit package.

2. The actual monthly dollar amount that enrollees *personally will either save or lose out-of-pocket* cost in joining each Plan must be clearly presented, along with objective information (e.g., HEDIS scores, Leapfrog rankings, etc.) on the competing Plans' quality.

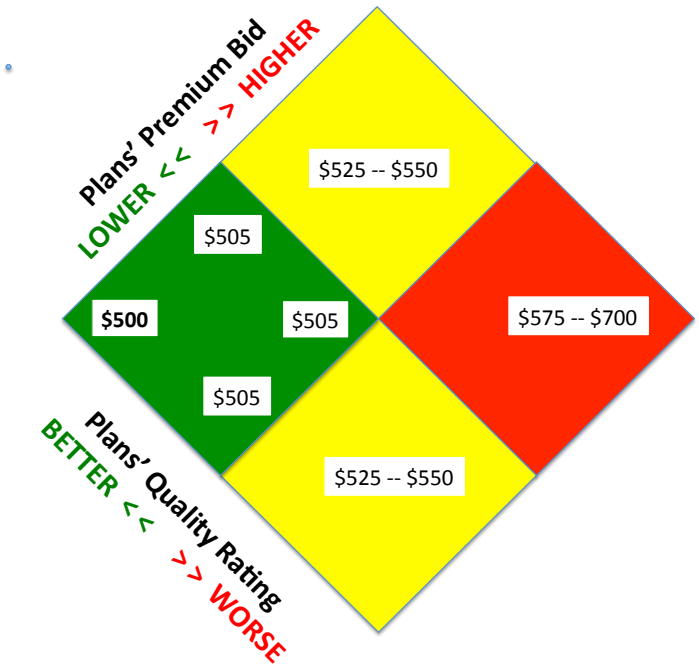
3. Enrollees must *save the most money* (i.e., pay the least) if they join the Plan that bids the lowest premium. Ideally, they should be able to join for free the lowest-

bidding Plan with high quality ratings.

4. Enrollees must *lose money* (i.e., pay more) if they enroll if any Plan that bids a premium greater than that of the lowest-bidding Plan.

5. Enrollees must *lose more and more money* in proportion to the difference between the lowest-bidding Plan's premium bid and the premium bid by the Plan they actually join. Ideally, they should pay out-of-pocket the *full entire extra cost* of enrolling in a higher-bidding Plan—that is: 100% of the difference between the lowest-bidding Plan's premium and the premium bid by the Plan they select.

This diagram shows how a hypothetical variety of monthly premiums bid by competing health care Plans. The actual dollar amounts are arbitrary. It is the relationship between them—lowest premiums in the Green Square, higher premiums in the Yellow Squares, and the highest Premium in the Red Square—that matters. Remember: all the Plans are assumed to have the same benefits (or are actuarially adjusted to achieve that outcome, and all the premiums are risk-adjusted.)



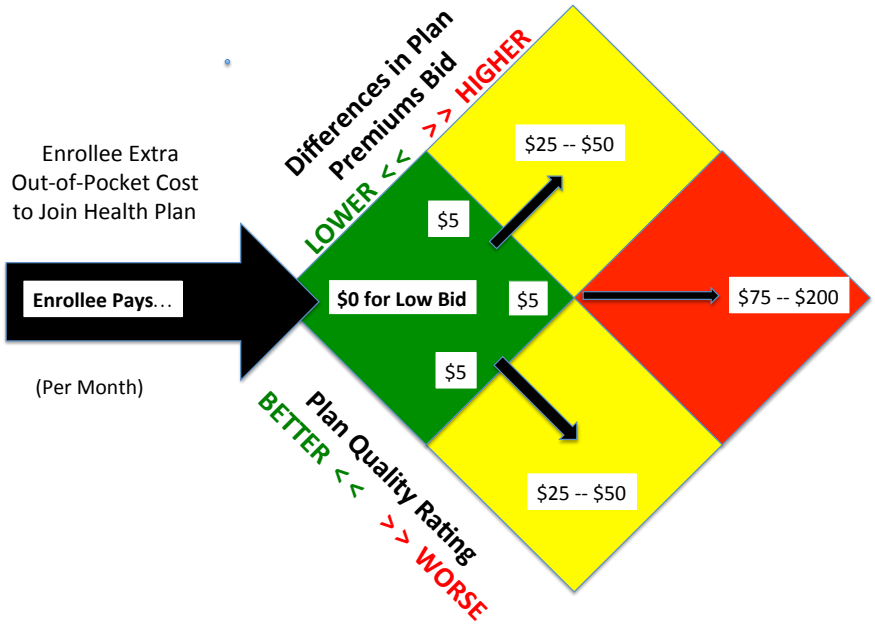
The diagram on the next page—keying off the above—shows how much *extra* an enrollee would be obliged to pay, out-of-pocket, to join the various Plans available:

- Ideally, if the enrollee joins the Plan with the very lowest bid (i.e., in the above illustration, the Plan with the $500 monthly premium) and high quality, the enrollee's extra out-of-pocket cost would be zero.[38]

- If the enrollee joins any other Plan, the enrollee's extra out-of-pocket cost would be the difference between the lowest premium bid and the higher premium bid by the more expensive Plan selected. (In the diagram, the extra cost ranges from an extra $5 extra per month to an extra $200 per month.)

Any insured individual would be free to join any plan. But with strong price signals like this, enrollees will have a powerful incentive to choose the lowest-bidding Plan, or at least a relatively low-bidding Plan, in order to avoid the substantial additional extra out-of-pocket cost of enrolling in a higher-bidding Plan.

This inducement to enrollees creates exactly the kind of market pressure needed to impel the more expensive Plans and their networks of providers to improve their efficiency, lower their costs, constrain their premiums, and improve the quality of their care.



[38] If an enrollee is obliged to pay something to enroll in the lowest-bidding Plan (e.g., a monthly percentage of the premium bid by the lowest-bidding Plan, or a monthly flat fee), then the enrollee's monthly out-of-pocket cost to join any higher-bidding plan should be (A) the resulting dollar amount *plus* (B) the entire monthly difference between the premium bid by the lowest-bidding Plan vs. the premium bid by the higher-bidding Plan that the enrollee has chosen.

Isn't this picture that we want? An American health insurance system where:

- Everyone has coverage;
- Benefits are excellent;
- All individuals can select the specific Plans and health care providers they want;
- Individuals can freely change their Plans every year:
- Many of the choices require enrollees either to pay none of the premium or only a modest monthly amount; and
- The price signals that flow through the system create powerful and enduring incentives to health insurers (whether HMOs, PPOs, or FFS plans) and health care providers (hospitals, doctors, and drug companies) to improve their efficiency, lower costs, hold down premiums, improve quality, and perhaps even improve health outcomes.