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Commentary Article

Two Novel Pathways to Universal Health Coverage in the United States – A Physician's Perspective

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Abstract

The United States' health system is fragmented, opaque and too costly. Universal Health Coverage remains a dubious specter with an uncertain future. The two proposed pathways to Universal Health Coverage presented herein comprise either (1) a leveled solution through Medicare-expansion for the uninsured only or (2) a more complex solution through a national 2-tier healthcare system for all Americans. Both pathways have in common that they do not dismantle the historically grown framework of our current health system. Either pathway will result in a better, fairer, more efficient, more transparent, less costly, and truly equitable public good. Universal Health Coverage must be embraced by all Americans as an essential human right and must no longer be an illusion that continues to haunt our society in the 21st century.

Keywords: Universal Health Coverage – Medicare-expansion – 2-tier National Health Insurance – Health policy – Health economics

Introduction

The United States' health system is fragmented, opaque and too costly. Despite the 2010 enactment of the Patient Protection and Affordable Care Act (ACA) with subsequent enrollment of millions of formerly uninsured Americans, true Universal Health Coverage remains a dubious specter with an uncertain future. In 2022, 27.6 million Americans of all ages did not have health insurance. The uncompensated cost for healthcare services to the uninsured is estimated to average between $30 to 50 billion per year. Sadly, most uninsured Americans are people of color and people from low-income families with at least one worker in the family. Aside from personal tragedies falling upon uninsured Americans including bankruptcy, poor medical care, emotional and mental hardship, pending bills have to be paid eventually by someone. Notwithstanding federal and state governments chiming in, it is in the end the common taxpayer who pays for the lack of Universal Health Coverage. Hence, it is in the best interest of our society as a whole to elicit financially sound pathways to accomplish the long-awaited objective of Universal Health Coverage in the United States.

Using or even indiscriminately copying other nations' National Health Insurance (NHI) systems of universal coverage is impractical and unrealistic given the historically grown framework of the complex mix of public and private sector health coverage in the United State (U.S.). Hence, the existing health system can and should not be completely overturned and dismantled in pursuit of Universal Health Coverage. Rather, incremental changes and modifications must be integrated and added to the existing system without collapsing it.

The two pathways to Universal Health Coverage discussed herein present a "small" and a "big" solution for goal achievement. The "small" solution is Medicare-expansion to all uninsured Americans, the "big" solution is the creation of a national 2-tier system within most of the existing healthcare structure. Both approaches are based on sound financial funding.

Either approach to Universal Health Coverage will result in a better, fairer, more efficient, more transparent, less costly, and truly equitable public good. Universal Health Coverage must be embraced by all Americans as an essential human right and as a crucial component of a better and more comprehensive U.S. health system.

Option #1: Medicare–expansion for Universal Health Coverage

Medicare-expansion is the small solution for Universal Health Coverage in the U.S. It is considered "small" because in this proposal, Medicare-expansion retains all other components of the current health system.

Universal Health Coverage under this proposal will provide health insurance to every uninsured American through public coverage. One might argue that the federal and state governments can ill-afford such a program but the proposed Medicare-expansion for the uninsured compares positively with other costly programs such as the six COVID-19 relief laws enacted in 2020 and 2021 ($4.6 trillion for pandemic response and recovery [1]) or the Student Loan Relief program (projected at $30 billion annually over 10 years). [1,2]

This proposed Medicare-expansion builds on the landmark Patient Protection and Affordable Care Act (PPACA, short ACA, or "Obamacare"). According to the U.S. Department of Health and Human Services, as of early 2023, more than 40 million Americans have enrolled in ACA coverage through Medicaid expansion, Marketplace coverage, and the Basic Health Program in participating states. [3]

But despite the legislative passage of the ACA, according to the Centers for Disease Control and Prevention, 8.4% or 27.6 million Americans of all ages, including 4.2% or 3 million children, did not have health insurance in 2022. [4]

To achieve truly Universal Health Coverage in the U.S., Medicare-expansion on the federal level, and not Medicaid-expansion on the state level, is required. The reason for federal vs. state funding is as simple as unfortunate. Although the U.S. Supreme Court upheld the ACA's constitutionality in 2012, it allowed individual states to opt out and forego the Medicaid expansion. As of September 2023, 10 states (AL, FL, GA, KS, MS, SC, TN, TX, WI, and WY) have not (yet) adopted the ACA. [5] It is estimated that more than three million Americans would gain health coverage if the remaining states were to expand Medicaid eligibility. [6] One of the main arguments of the 10 states for opting out was the notion that the ACA was a direct assault on state sovereignty that costs the states billions of dollars and forces cutbacks in other important areas. However, the unpaid bills of uninsured Americans are paid eventually – by the taxpayers. It has also been shown that (1) states that have adopted (vs. not adopted) ACA expanded Medicaid have seen markedly lower rates of uninsured Americans (8.1% vs. 15.4%); (2) Americans without ACA coverage have worse access to care than people who are insured [7]; and (3) Medicaid-expansion has "not only shielded low-income Americans from out-of-pocket medical costs, but has also improved their overall financial health" [8] and access to health care in general. Furthermore, the remaining "hold-out" states still have to prove that their taxpaying citizens are equally or even better off without ACA implementation. Without full compliance by all states for an additional Medicaid-expansion and in the absence of federal laws mandating it, Universal Health Coverage cannot be accomplished under the joint federal-state Medicaid program.

Hence, federal health insurance is required. Since Universal Health Coverage will be required basically free of cost, there is no individual mandate as in the case of the ACA where a U.S. Court of Appeals ruled in 2019 that the individual mandate was unconstitutional because Congress had repealed the tax penalty enforcing the mandate. The real issue at heart is how to pay for Universal Health Coverage under the proposed Medicare-expansion.

Financeability

In FY 2022, the federal government spent $6.5 trillion and collected $5.0. trillion in revenue. [9] It spent $0.75 trillion on Medicare and $0.59 trillion on Medicaid. [10] In addition, it spent about 0.1 trillion for veterans medical care, the VA being the nation's largest health care system [11,12];

it also spent about 0.05 trillion to fund the Military Health System [13]. In total, the federal government spent about $1.5 trillion on health care in 2022 which accounted for 17.4% of the gross domestic product (GDP). [14]

Information about health care expenditures by states is harder to come by. In 2020, state and local government spending on health and hospitals was estimated to be about $ 0.35trillion.[15]

In 2019, the median per capita expenditure estimates for all U.S. states were $8,436 (for children: $3,556) and for adult ACA Medicaid expansion $6,709. [16]

If the presumed 27 million uninsured Americans would be enrolled in this proposed Medicare-expansion program at an annual cost of $7,000 per enrollee (comparable to adult per capita ACA Medicaid expansion) total expenditures would amount to almost 0.19 trillion, a staggering number -- that would have increased FY 2022 U.S. discretionary spending from 1.7. to 1.9 trillion.

What mechanisms can offset some of these expenditures?

Aside from budget cuts in other areas ($30-50 billion, specifically from U.S. discretionary funds), funding/financing for Universal Health Coverage could be provided through:

1. (Small) increases in federal taxes (each 0.25% increase generates about $12 billion in revenue);

2. Reduction of federal funds for state healthcare and hospitals because individual states will no longer be burdened by health-related costs for the uninsured (e.g., federal reduction of Medicaid support in 5%-increments would generate about $25 billion in savings per each 5%-increment);

3. Increase in the pharmaceutical industry's financial contribution ($20-30 billion). This can be accomplished in two ways: (1) indirectly through savings from the Biden administration's-Medicare drug negotiations program which is part of the Inflation Reduction Act, and (2) directly through higher corporate taxation (the effective tax rate for most of the big pharmaceutical companies on the profits is only about 10%; in fact, the eight largest US pharma companies pay only about 3% of their global profit to the US Treasury). To offset higher taxation, the pharmaceutical industry could substantially decrease or even eliminate its wasteful and inefficient, direct-to-consumer marketing (the only other country that allows prescription drug advertisements is New Zealand); the pharmaceutical industry in the United States spent $6.9 billion on direct-to-consumer advertising in 2021. [17,18]

4. Close auditing of medical services by Medicare case managers to avoid, for example, adverse selection and moral hazard issues by new enrollees (each 5%-decrease of the proposed adult per capita Medicare-expansion cost below the current adult per-capita ACA Medicaid expansion cost would save about $20 billion per each 5%-increment);

5. Creation of programs with an emphasis on enrollees' (re-)integration into the workforce in order to decrease the number of eligible Americans for the proposed Medicare-expansion program and, conversely, increase the Employer-Sponsored Insurance ratio (workforce [re-]integration for each 100,000 uninsured Americans would save this Medicare-expansion program an additional $0.7 billion).

Option #2: A modified 2-Tier System for Universal Health Coverage

A national, 2-tier healthcare system is the big solution for Universal Health Coverage in the U.S. It is considered "big" because this proposal does not retain all other components of the current health system.

Traditionally, the 2-tier healthcare system as enacted, for example, in Canada, Australia, and many Western European countries such as Germany and France, is based on (1) government-provided basic healthcare for all citizens and (2) voluntary, but frequently only complementary or supplementary, private insurance for some citizens who choose higher premiums for supposedly better care quality and faster access to healthcare. However, the 2-tier system as outlined in this proposal is different from the traditional 2-tier system

in that every American has the choice between either full government or full private health insurance coverage.

It is obvious that for realistic reasons a new 2-tier healthcare system providing Universal Health Coverage can and should not just simply dismantle our current US healthcare system with its historically grown structures. Specifically, under this proposal, the constitutionally guaranteed arrangement of federalism as it pertains to our health system and the existing governmental structures (e.g., DHHS) will not change in their organizational and administrative setups. Rather, the components of this new 2-tier healthcare system will be added and integrated into the current system in such a way that Universal Health Coverage at long last is guaranteed to every American.

Enrollment into this new 2-tier Universal Health Coverage system will not be optional but mandatory. Its nationwide implementation will be enforced through our judicial system.

Basically, every American will have the choice (based on financial circumstances) between government-provided and private health insurance. The cornerstones of this proposed U.S. 2-tier Universal Health Coverage system are:

1. Existing government programs with their federal (Medicare, Veterans Health Administration, Military Health System, Indian Health Service) and joint federal-state (Medicaid and CHIP) components will be fully retained. These programs already provide health care services to at least one-third of Americans. They will continue to cover the elderly, the poor, the disabled, ACA enrollees, and children as well as veterans, military personnel, and American Indians. In addition, Medicare-expansion (as outlined under Option #1) will also cover all uninsured Americans. The administrative U.S Departments (Department of Health and Human Services, Department of Veterans Affairs, Department of Defense) and their respective divisions (e.g., Centers for Medicare and Medicaid Services) will ensure equal access to healthcare and the full array of treatment options in a timely manner irrespective of gender, race, ethnicity, income etc.

2. In this new 2-tier Universal Health Coverage system every employed American will have the choice between the public (Medicare) or private insurance option:

If the public (Medicare) option is chosen, employers will continue to pay about 70% (for employees with families) and 80% (for single employees). Employees can no longer opt out of health insurance coverage in exchange for seemingly attractive incentive payments unless they are already enrolled in an insurance plan through their spouse or parent(s). The Medicare premium has yet to be determined but will be based on the average national monthly health insurance cost for one person (range between $400 – 1,000 in 2022). [19,20]. Providers (e.g., hospitals, physicians) cannot opt out.

If the private option is chosen by employees, employers will pay their share of the standard Medicare-expansion premium and the employee the remaining balance for the private insurance premium (which, of course, will be higher than the standard employee Medicare-expansion premium).

In addition to all access and medical services provided by the Medicare-expansion program, additional "perks" of private insurance for an "extra-premium" include, for example, choice of physicians and hospitals, and single hospital room accommodation. In contrast to Medicare-covered patients, private-insured patients' treatment options are not held to medical necessity (e.g., cosmetic surgery) if this is part of the insurance contract. However, there will be much more governmental oversight of private insurance providers regarding prize transparency and accountability. Furthermore, private health insurers must comply with ACA requirements such as inclusion of preexisting conditions, guaranteed issue and renewability, and absence of lifetime and annual dollar limits.

3. Pricing and reimbursement rates with provider organizations (e.g., American Hospital Association, physician organizations) as well as medical and pharmaceutical industries will be negotiated through a national health insurance committee consisting of public/Medicare representatives (2/3 of

members) and private insurers (1/3 of members).

4. This new 2-tier Universal Health Coverage system will render the current and opaque system of HMOs, PPOs, POSs, EPOs etc. superfluous (some of these programs have already retrieved to low utility, limited access, and huge profits). In contrast, supplementary health care services such as rehabilitation centers as well as nursing homes and assisted living or residential facilities (i.e., post-acute care systems) will be retained.

5. Current complementary or supplementary insurance for dental or vision care will be eliminated as separate coverage since dental or vision care under this proposal will also be provided by Medicare or private insurers ("one-stop health care plan shopping"). Most likely, both insurance systems will outsource these services to the existing providers to prevent them from discontinuing their services or even going out of business.

Financeability

This proposed 2-tier Universal Health Coverage will be financed through the following mechanisms:

1. Financing of the existing government programs with their federal (Medicare, Veterans Health Administration, Military Health System, Indian Health Service) and joint federal-state (Medicaid and CHIP) components will remain the same. Existing ACA funding will also be retained.

2. Financing of health insurance for the 27 million uninsured Americans will be as outlined under Option #1.

3. The mandatory health insurance for employed Americans is paid directly (preferably online) to Medicare or the private insurer.

Employed Americans who opt for private insurance coverage may have to pay an additional premium that cannot exceed the Medicare premium by 200%. In return, providers may bill private insurers up to twice the Medicare rate for hospital services and drugs and up to three times the Medicare rate for physician providers. All private insurance companies must disclose premiums and services on standardized forms for transparency, comparability, and auditing. Hospital and physician providers may receive higher reimbursements for their services from private insurance payers than from Medicare. In that case, private insurers will be taxed at a higher rate to disincentivize them from exclusively treating privately insured patients. Also, patient "dumping" will be penalized.

Conclusions

The two proposed pathways to Universal Health Coverage in the United States as presented herein have in common that they do not dismantle the historically grown framework of our current health system. The "smaller" solution focuses almost exclusively on additional health coverage for the 27 million uninsured Americans through Medicare-expansion. The "bigger" solution envisions a national 2-tier healthcare system with choices between public (Medicare-expansion) vs. private insurance coverage. It would only eliminate the opaque system of existing HMOs, PPOs, POSs, EPOs etc. in favor of transparent pricing irrespective of reimbursement schemes. As shown, both options can be financed through existing and yet untapped mechanisms. For the sake of forming a more perfect union (and society) as stated in our Constitution, Universal Health Coverage in the United States must no longer be an illusion that continues to haunt us in the 21st century.

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