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Short Communication

Two Novel Strategies to Implement Universal Health Insurance in the United States

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Abstract

Universal Health Insurance does not exist in the United States for two reasons:

- There is a general unwillingness to dismantle the historically grown framework of the world's most complex mix of public and private sector health coverage and
- Mere cost considerations.

The first concern can be abated by establishing a Universal Health Insurance system which retains many or most of the historically grown infrastructure. Cost containment of such a reform is addressed herein in that the two proposed pathways comprise either:

- A levelled solution through Medicare-expansion for the uninsured only or
- A more complex solution through a national, 2-tier healthcare system for all Americans.

Both pathways are based on solid financing without major tax increases by using existing and/or yet untapped funding sources. Universal Health Insurance must no longer be an illusion that continues to haunt U.S. society in the 21st century.

Keywords: Universal Health Insurance; Universal Health Coverage; Medicare-Expansion; 2-tier Health Insurance; Health Policy; Health Economics

Short Communications

The United States has the world's largest economy but remains the only major industrialized country without Universal Health Coverage [1,2]. Instead, its health system is fragmented, opaque and too costly.

Despite the 2010 landmark enactment of the Patient Protection and Affordable Care Act (ACA) with subsequent enrolment of millions of formerly uninsured Americans, true Universal Health Insurance remains a dubious specter with an uncertain future.

In 2022, 27.6 million Americans of all ages did not have health insurance according to the Centers for Disease Control and Prevention [3]. The uncompensated cost for healthcare services to the uninsured even after ACA enactment averaged $42.4 billion per year between 2015 and 2017 [4]. Sadly, most uninsured Americans are people of colour and people from low-income families with at least one worker in the family [5]. Aside from personal tragedies falling upon uninsured Americans including bankruptcy, poor medical care, declines in overall health, potentially life-threatening conditions, emotional and mental hardship, pending bills must be paid eventually by someone. The bulk of these unpaid bills "are compensated through a web of complicated funding streams, financed largely with public funds from the federal government, states and localities [4]." In the end it is the common taxpayer who pays for the lack of Universal Health Coverage. Hence, it is in the best interest of the U.S. society to elicit financially sound pathways to accomplish the long-awaited objective of Universal Health Insurance in the United States.

Although there has been no lack of proposals for Universal Health Insurance by prominent American politicians including Hillary Clinton and Bernie Sanders, these programs did not come to fruition mainly for two reasons [5]. First, they would have required partial or complete dismantlement of the historically grown framework of the world's most complex mix of public and private sector health coverage. Secondly, cost considerations were not realistic [6]. Hence, not only the U.S Congress, but also the American public turned against these proposals.

The early 21st century saw the hard-fought 2010 passage of the landmark U.S. federal statute called Patient Protection and Affordable Care Act (PPACA, short ACA) or "Obamacare". Under the original ACA, the "individual mandate" requires that most citizens and legal residents have health insurance. Notably, the ACA did not create single-payer Universal Health Coverage. Rather, it represented a compromise that maintained the complex mix of public and private stakeholders in the existing healthcare system.

The ACA was a huge step forward in addressing many unresolved or conveniently suppressed shortcomings of the existing healthcare system. The new ACA members represented the uninsured population:

- Unemployed individuals who could not afford Employer-Sponsored Insurance (ESI) and did not qualify for Medicaid.
- Employed individuals without ESI and who could not afford it on their own.
- Employed individuals who chose not take ESI that was available to them; and
- Individuals with means who chose not to be insured.

Existing government health insurance plans (Medicare, Medicaid, CHIP, health insurance for veterans and the military) were retained under ACA [7].

The ACA came at the prize of major deficiencies and shortcomings. Financed in large part through new federal taxes (about $1trillion), 4.7 million Americans lost their insurance plans, average premiums increased substantially, lower reimbursement rates for physicians resulted in many physicians refusing to treat Medicaid patients, and Medicaid potentially "crowding out" private health insurers. Eventually, 40% of the American public had an unfavourable opinion of the ACA [8].

Despite the legislative passage of the ACA, by the end of 2022, 8.4% or 27.6 million Americans of all ages including 4.2% or 3 million children remain without health insurance [3]. The question then is what realistic approaches to Universal Health Coverage are, and what obstacles need to be addressed. The latter is an issue of convenience and

culture. The status quo is deeply entrenched In U.S. health policy which is remarkably resistant to change. This goes along with the fact that Americans with healthcare insurance are by and large satisfied with their coverage and are suspicious of attempts to possibly unsettle their own health care arrangements. Two additional factors for not changing the current system are high cost and expansion of federal authority [5].

These factors are impacting Bernie Sander's "Medicare for All" proposal. It would implement a 7.5% payroll tax plus a 4% income tax on all Americans (with higher-income citizens subjected to higher taxes), higher estate and property taxes, special or one-time only taxes/fees (on large financial institutions and corporations) and/or establishing a "wealth" tax are politically hardly feasible and *viable* [9]. Moreover, his proposed Medicare-for-all single-payer health care system would in fact completely dismantle the current system with its private insurance component and immediately obviate present insurers. This is unrealistic given the fact that in 2021, private health insurance coverage was more prevalent than public coverage at 66.0% and 34%, respectively. There were 174 million Americans enrolled in employer-sponsored health insurance [10].

From a physician's perspective, there are two pragmatic pathways to Universal Health Insurance in the United States.

First pathway: Medicare (not Medicaid) - expansion. The reason for federal *vs.* state financing 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 which, as of September 2023, 10 states did. Without full compliance by all states for an additional Medicaid-expansion and in the absence of federal laws mandating it, Universal Health Insurance cannot be accomplished under the joint federal-state Medicaid program. Thus, federal Medicare - expansion is the only option for the public sector.

What about financeability? If the presumed 27 million uninsured Americans would be enrolled in this proposed Medicare-expansion program at an annual cost of $7,000 per enrolled (comparable to adult per capita ACA Medicaid expansion [7]) 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.

Funding/financing of Medicare-expansion for this Universal Health Insurance proposal will be provided through the following mechanisms:

- A $30-50 billion (2.5%) cut in U.S. household discretionary funds.
- A small(!) increase in federal taxes (each 0.25% increase generates about $12 billion in revenue).
- Increase in the pharmaceutical industry's contribution ($20-30 billion) through savings from the Biden administration's- Medicare drug negotiations program and higher corporate taxation.
- Close monitoring of medical services by Medicare case managers (each 5%-decrease of the proposed adult per capita Medicare-expansion cost saves about $20 billion); and
- Creation of a workforce (re-)integration program which would save Medicare-expansion per each 100,000 formerly uninsured $0.7 billion.

Second pathway: creation of a national, 2-tier healthcare system with mandatory enrolment. This is a more complex pathway than the Medicare-expansion model because it does not retain some components of the current health system. However, it does retain all existing government programs with their federal (Medicare, Veterans Health Administration, Military Health System, Indian Health Service) and joint federal-state (Medicaid and CHIP) components.

The 2-tier system as outlined herein 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. The argument against has always been that in a traditional 2-tier system patients with private insurance enjoy faster healthcare access and better quality of care. Hence, the 2-tier system is considered by some as a system that discerns the "the haves and have nots" because it supposedly discriminates against the poor. However, in this

proposal, most Americans (80%+) will (to save additional premiums) or will have to (due to lack of funds) be insured through Medicare. Access to care and treatment options based on medical necessity are the same for the two insurance choices.

If the public (Medicare) option is chosen, employers will continue to pay about 70% (for employees with families) and 80% (for single employees). If the private option is chosen, 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, single hospital room accommodation, and treatment options not dictated by medical necessity (e.g., cosmetic surgery). Private health insurers must comply with ACA requirements such as inclusion of preexisting conditions, guaranteed renewability, and absence of lifetime and annual dollar limits. This proposed 2-tier Universal Health Insurance system will render the current and opaque system of HMOs, PPOs, POSs, EPOs etc. superfluous in Favor of traditional private insurance coverage. 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.

What about financeability? Funding/financing of this 2-tier Universal Health Insurance system will be provided through the following mechanisms:

- 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.
- Funding for the Medicare-expansion of the 27 million uninsured Americans will be provided as described above.
- Mandatory health insurance for employed Americans is paid directly 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%; private insurance companies must disclose premiums and services on standardized forms for transparency, comparability, and auditing; since hospital and physician providers may receive higher reimbursements for their services from private insurance payers (*vs.* Medicare), they may be taxed at a higher rate to disincentivize them from exclusively treating privately insured patients.

From the author's perspective as a practicing physician, these two proposed pathways comprise a levelled solution through Medicare-expansion for the uninsured only and a more complex solution through a national, 2-tier healthcare system for all Americans. The political prospects of the smaller approach (Medicare expansion) are higher to gain political and public support. In contrast to the much more sweeping 2-tier system, it would also not require incremental implementation. Under both scenarios, the uninsured would benefit the most from either pathway; resistance would be greatest from established providers. Importantly, both pathways are based on solid and partly novel financing plans without major tax increases by using existing and yet untapped funding sources. Although short-term finances are on solid ground, projections for long- term costs warrant further investigation. Neither system would deviate from current standards of patient care quality and equity. For the sake of forming a more perfect union as stated in the Constitution, Universal Health Insurance in the United States must no longer be an illusion.

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