A Social Insurance Solution To Health Care Finance

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12/10/2016

Six years after the passage of the Affordable Care Act (ACA), there is widespread agreement that changes are still needed to the health care financing system in the United States to improve coverage and ensure that affordable health care is available to all. But there is little agreement as to the direction these changes should take. Although there are many nuances in individual positions, the essential divide is between those who think government interference in health care is the problem, and those who think private sector involvement in health care is the problem. The proposal set forth below attempts to achieve a compromise that addresses the priorities of both sides. Undoubtedly it will alienate those with the most extreme positions on either side. I hope it can appeal to enough people in the broad middle to become a viable alternative to the ACA.

The proposal uses a social insurance model. Under this model, the government and the covered population now share the financing of health care, while the provision of health care and most program administration remain in the private sector. This combination accommodates the sought-after goal of universal coverage, while providing plausible mechanisms for cost control missing from government-only proposals.

What Is Social Insurance?

Insurance involves the sharing, or pooling, of financial risk. In commercial insurance, this is accomplished through a contract between the insurer and the insured - the insured agrees to pay a premium to the insurer in return for receiving a benefit from the insurer to cover part or all of the financial loss due to the occurrence of the insured event. The premium, benefit, and insured event are all defined in the contract. Because many insureds agree to be covered under similar contracts, their collective premiums fund a pool of assets from which the insurer can pay benefits if and when the insured event occurs to a particular insured. For this arrangement to work, the premium must be sufficient to pay the expected benefits and administrative expenses associated with each contract with an allowance for adverse experience and, in some cases, profits for the insurer. However, the premium cannot exceed the expected benefits to a degree that makes the potential insureds unwilling to enter into the contract. Thus, as in all commercial transactions, the terms of the insurance contract are subject to market forces.

Social insurance, like commercial insurance, involves the pooling of financial risk. Social insurance differs from commercial insurance in several ways:

- In social insurance, the funding mechanisms, benefits, and insured events are defined by law rather than by contract, and the program is usually administered either directly by the government or under government supervision. Unlike commercial insurance contracts, the laws governing social insurance can be changed unilaterally by the government, even if the changes reduce benefits or raise contributions.

- In social insurance, coverage is mandatory for the insured population defined by law, which generally includes all, or nearly all, residents.

- In social insurance, while overall funding is intended to cover the cost of benefits, the benefits of individuals may not be closely related to the funding provided by them or on their behalf. In other words, some groups of insureds may subsidize the benefits of other groups. This could not occur to the same degree in commercial insurance, because a contract whose expected benefits are significantly less than the premiums would have difficulty attracting enough policy holders to be commercially viable.

It is important to distinguish social insurance programs from welfare programs. Welfare programs do not involve the pooling of financial risk. Rather, welfare programs cover only those who already experience financial need, as defined under the particular program, and money is appropriated as necessary to pay benefits. However, this distinction is not always clear cut: some programs may have characteristics of both social insurance and welfare. For example, in the United States health care for the poor is currently provided through Medicaid, which is set up as a welfare program; whereas in most other developed countries, health care for the poor is provided through the same social insurance program that covers all residents.

Around the world, social insurance programs have been developed to cover a wide variety of financial risks, including: retirement; premature death and disability; health care; unemployment; work-related sickness and disability; child care; and, more recently, elder care. The United States has two primary national social insurance programs:

1. Old Age, Survivors, and Disability Insurance, commonly known as Social Security, provides benefits for retirement, premature death, and disability.

2. Medicare provides health care benefits, specifically hospitalization (Part A), physician care (Part B), and prescription drug benefits (Part D), to the elderly and disabled. The optional Medicare Advantage program (Part C), underwritten by private insurers operating under government standards and regulation, combines the benefits in Parts A and B.

The United States has other social insurance programs, including Unemployment Insurance and Workmen's Compensation, but these programs are much smaller measured by the amount of benefits currently paid. Except for child and elder care, the United States provides a full range of social insurance programs, although some of these programs are not as comprehensive or generous as their counterparts in other developed countries. Adopting a social insurance model for health care reform would bring practice in the United States more into line with that in other developed countries.

Coverage and Finance

The program covers all legal residents of the United States. This includes emergency care for foreign tourists under a separate program administered by the State Department. However, it does not include care for foreign residents who come to the United States for the purpose of obtaining medical care. Current Medicare beneficiaries will have a one-time opportunity to elect either to remain covered by Medicare or join the new program. Based on past experience, such as the transition from the Civil Service Retirement System to the Federal Employees Retirement System, it is expected that most will remain in Medicare, even among those for whom it would financially advantageous to switch.

Like Social Security and Medicare, program benefits are paid from a trust fund, the Health Care Trust Fund (HCTF), financed by a payroll tax shared equally by employers and their employees, with self-employed persons paying both the employer and employee share. The tax is a flat percentage of wages, defined the same as for Social Security and Medicare, *i.e.*, FICA wages, with no minimum or cap. Expenses for foreign tourists and certain expenses for low-income participants and veterans, as described below, are reimbursed from general revenues. The HCTF is administered by the Center for Health Care Services (CHCS), the renamed Center for Medicare and Medicaid Services.

The trust fund will receive an initial infusion of funds sufficient for six months' expenses from the Medicare Trust Fund (MTF). Thereafter, the HCTF will reimburse the MTF for all benefits of Medicare enrollees that would otherwise be payable from the HCTF. This bookkeeping scheme means that, even though initially some people will remain in Medicare, the HCTF will be financed from the start as if all Medicare enrollees were covered. Thus, the HCTF tax rate will not depend on the elections of current Medicare beneficiaries to switch coverage or not.

The initial HCTF tax rate will be based on best estimate actuarial assumptions, but with a margin for adverse experience sufficient to minimize the chance that the rate will prove insufficient over a ten-year time horizon. As experience emerges, the rate can be fine-tuned and the solvency horizon extended, with the ultimate goal of establishing a long-term stable tax rate. The Medicare tax will remain until that program winds down, but at a much lower rate than at present since there will be no new Medicare enrollees, and some MTF expenses will be reimbursed by the HCTF.

Benefits

The program provides comprehensive health care coverage, including doctor visits, diagnostic tests, hospitalization, prescription drugs, mental health, dental care and eye care. However, the program will not cover any medical product, device or procedure that has been advertised in any medium not addressed specifically to health care professionals during the immediately preceding the calendar year. This proviso is not intended to infringe in any way on the freedom to advertise any medical product, device or procedure in any medium. Benefits are divided into three categories: preventive care, routine care and catastrophic care.

Preventive Care

Eligible preventive care is paid for entirely by the HCTF, *i.e.*, it is free to the patient. The CHCS will determine what constitutes eligible preventive care, based on the recommendations of an ongoing panel of medical experts. The panel will continuously revise its recommendations to incorporate advances in medical knowledge. Eligible preventive care will take into account such parameters as a patient's age, sex, personal and family medical history, genetic profile and the results of previous medical testing. The panel may draw on machine learning algorithms to fine tune its recommendations. Thus, eligible preventive care will not be a one-size-fits-all battery of tests, but rather a testing regime that takes into account the specific needs of covered individuals based on the best available medical knowledge.

Preventive care will be provided by special clinics set up specifically for this purpose. The clinics will be privately run, and may be set up within existing medical facilities, but must be financially independent. The clinics will have no discretion regarding the preventive care provided, but must follow the CHCS schedule. It is expected that preventive care clinics will be staffed primarily by nurses and medical technicians, with perhaps a supervisory physician. Test results will be made available to the patient and his/her primary care physician. An annual consultation with the primary care physician is included as part of eligible preventive care. Providers basing preventive care on the CHCS schedule will have a non-rebuttable defense against any malpractice claim based on inadequate preventive services. Providers recommending additional preventive care services will lose this immunity. Patients themselves, however, may obtain additional preventive care outside the system at their own expense.

Providing free preventive care at dedicated clinics encourages universal utilization of preventive care services, assures that such services meet high standards of medical efficacy, and provides these services in the most economical and efficient manner.

Routine Care

Routine care, except as noted below, is paid for entirely by the patient. This seems reasonable, since most people pay for the other routine necessities of life, such as food, clothing and shelter. The problem is coming up with a suitable definition for routine care. We define it as a series of negatives: it is not preventive care; it is not due to a condition for which the patient has been in treatment for at least two years; and it does not exceed in cost 7.5 percent of yearly family income.

Income, for this purpose, includes FICA wages, cash income from other social insurance programs and from needs-based government programs, and income from savings whose source was not subject to FICA taxation, such as employer-financed retirement plans (other than salary-reduction plans). Retirement benefits received in a lump sum are spread over the recipient's remaining lifetime by the same method used by IRS for determining the non-taxable portion of retirement annuities. Income is determined once a year when income tax is filed. Each income tax return defines a family for health care purposes, including those persons for whom deductions are claimed. The return for a given calendar year determines the deductible, *i.e.*, the dollar limit on routine care, for the second following calendar year.

Although routine care is paid for by the patient, all provider fees are paid directly by the administrators (see below), drawing on the HCTF. The administrators, in turn, bill patients monthly, like a credit card company. Patients pay no interest on their outstanding charges provided they make a minimum payment each month of the lesser of the entire outstanding balance or one tenth of the deductible for the year. This ensures that routine health care payments are spread out over time even if large routine expenses are incurred in a short period.

This still leaves the problem of decreasing income due, for example, to job loss. Currently, employers must report wages quarterly for FICA purposes. To accommodate the new health care program, all providers of income used for determining the health care deductible must report such income monthly. This should be feasible, since technology has advanced greatly in the decades since the quarterly reporting requirement went into effect. Then, a new constraint is placed on the minimum payment described above: that it not exceed 10 percent of one twelfth the previous month's annualized reported income. (Annualization is necessary to smooth out predictable fluctuations in monthly income for those paid on a basis other than monthly.) This ensures that the payment burden on patients responds quickly to sudden decreases in income. Further, if a charge remains unpaid for a year, determined on a first-incurred first-paid basis, even though the patient makes all required minimum payments, the charge is converted from routine to catastrophic, and no payment is required. This prevents the build-up of large charge balances during extended periods of reduced income. The program has additional features described below to help low-income families.

This payment regime makes patients aware of the true costs of routine medical care while still keeping routine medical costs manageable regardless of the level of family income.

Catastrophic Care

Catastrophic care, like preventive care, is paid for entirely by the HCTF. Catastrophic care is care that is neither preventive nor routine; specifically, care that either exceeds in cost 7.5 percent of family income or is due to a condition for which the patient has been in treatment for at least two years, provided the patient is enrolled in and follows a registered medical condition management program and/or a registered experimental treatment program. The CHCS is responsible for registering medical condition management and experimental treatment programs, following protocols laid down by panels of medical experts. These panels will operate much like the National Transportation Safety Board, continuously monitoring medical outcomes, evaluating experimental treatments, maintaining a dialogue with health care professionals, and updating protocols as necessary to ensure optimal outcomes based on the best available medical evidence. Providers following such a program will have a non-rebuttable defense against any malpractice claim based on improper treatment. Providers without access to such a program for a particular condition are required to transfer patients to a facility with a program at the provider's expense.

Full payment for catastrophic care prevents recurring high medical bills from causing financial distress. Medical condition management and experimental treatment programs assure that treatment for severe or chronic conditions meets high standards of medical efficacy and encourage advances in treatment through carefully monitored experimental programs. The program provides incentives for both providers and patients to follow such programs.

Program Administration

The program is administered by private companies competing with each other to enroll covered families. The services provided by such companies include claims administration, paying providers and billing patients, and negotiating fees with providers.

The administrators would work out among themselves, subject to approval by the CHCS, standard procedures for receiving claims and paying providers. Since the administrators pay all provider fees, providers are assured of prompt payment in full for their services without the need for issuing bills. To the providers, the system will look little different from a single-payer system. The result is a greatly reduced administrative burden on providers and an overall reduction in health care costs.

Administrators are required to negotiate fees with all willing providers. In turn, providers are required to respond to administrators' requests to negotiate fees. Thus, administrators cannot maintain networks of preferred providers. Nevertheless, it is to be expected that providers will negotiate different fees with different administrators, so that patients will encounter different fees depending on which administrator they enroll with. Administrators must make available to the public the fees they have negotiated with all providers. This will enable participants to compare fees before choosing an administrator. Thus, not only will patients be aware of the cost of their care under this program, but they will have a practical means for reducing that cost. This will prove a powerful mechanism for controlling health care costs.

Administrators market their services directly to families, either individually or in groups, competing on the basis of negotiated provider fees and the quality of their service. Because they are not assuming any insurance risk, they are free to operate across state lines without running afoul of the state-based insurance regulatory system. Enrollment is strictly on a family basis. For example, if a family member enrolled with administrator A goes to work for a company with a marketing agreement with B, the family may retain A or switch to B, or for that matter switch to C. To accommodate switching, the administrators would work out among themselves, subject to the approval by the CHCS, standard systems for patient billing. Although health insurers will lose their underwriting business, they will gain from a market for administrative services expanded both in scope and number of participants.

Administrators are paid capitation fees from the HCTF. Fees would be equalized to take into account variance in expected administration costs among participants. The equalization regime would be worked out among the administration companies themselves, subject to approval by the CHCS. The cost variance will be small, reflecting differences in the frequency and complexity of claims, but not differences in the cost of care.

This method for program administration provides incentives for administrators to provide efficient, high quality service and to negotiate lower prices from health care providers. Because the administrators bear none of the health care cost risk, they have no financial incentive for denying claims.

Low-Income Families

While it is all well and good to talk about limiting health care expenses to 7.5 percent of family income, we recognize that for families at the low end of the income spectrum almost any health care cost is catastrophic. To meet the needs of low-income families, the program includes a needs-based mechanism, called Health Stamps, for paying all or a portion of their otherwise required routine care costs. As the name implies, this mechanism is inspired by Food Stamps (known today as the Supplemental Nutrition Assistance Program, or SNAP). Eligibility requirements for Health Stamps are the same as for Food Stamps, and in fact any application for Food Stamps will also be an application for Health Stamps and *vice versa*. Health Stamps pay all or a portion of routine care expenses for eligible families according to a sliding scale similar to Food Stamps. Families will never see any physical manifestation of the stamps other than the resulting credit on their monthly health care bill. The Health Stamp subsidy is financed from general revenues.

Veterans

Veterans are treated the same as non-veterans, except that health care for injury or disease suffered as a result of military service is automatically treated as catastrophic care. Veterans can receive health care, whether or not related to their service, at a VA or non-VA facility without financial effect. Costs to the HCTF for veterans in excess of the costs for similarly situated non-veterans as a result of this provision are reimbursed to the HCTF by the VA.

Transition

The most important features of the ACA became effective less than three years after the law's passage, and experience shows this was insufficient lead time to ensure a smooth transition to the new program. If the proposal herein described is adopted, we believe a transition period of five years would be prudent. Tasks to be accomplished during this period include: writing regulations, developing administrative systems, establishing standards for preventive care and medical condition treatment programs, setting up preventive care clinics and medical condition treatment programs, increasing the frequency of income reporting, renegotiating compensation packages for both bargaining and non-bargaining workers, negotiating provider fees, setting the tax rate, and enrolling all families with an administrator. It may also become necessary for the federal government to assume some health insurance risk during the transition period if too many insurers withdraw from the health insurance marketplace as it nears its demise.

Once the new program becomes effective, ERISA will no longer cover employer-sponsored health benefit plans. An employer may sponsor a group health insurance plan that covers the out-of-pocket health care expenses of some or all of its employees, but the value of such insurance would be taxable to covered employees as ordinary income. Likewise, no portion of the cost of health insurance obtained by individuals would be tax deductible. Tax-favored accounts for pre-funding health care expenses, both for individuals and employers, will be eliminated. Accounts for individuals, such as health spending accounts and medical savings accounts, will be automatically converted to IRAs. Accounts for employers, such as VEBAs, may be used to fund other tax-qualified plans or drawn down into ordinary income over a period of up to five years without penalty.

The "T" Word

The perceptive reader will have noticed that the program includes a new universal payroll tax. For some, this alone eliminates the program from consideration. In defense of this new tax, it is useful to look at the Social Security program. The new payroll tax is similar to, and likely to be of roughly the same magnitude as, the OASDI payroll tax. Under Social Security, the elderly have gone from having the highest to the lowest poverty rate among population age segments. More than half of Social Security beneficiaries receive at least 90 percent of their income from Social Security. Suppose Social Security and its payroll tax did not exist. The elderly who depend on Social Security would still survive. The income they would otherwise get from Social Security would be made up by a combination of greater personal savings, higher benefits from their employers, needs-based government programs, help from family and friends, and just plain doing without. Not coincidentally, these are the current sources of health care financing outside of Medicare. The Social Security payroll tax has successfully supplanted this hodgepodge of sources for financing retiree income, and most people would agree the country is better off for this. The proposed health care payroll tax can do the same for health care financing. The burden of health care financing is the cost of health care, which is not directly related to the financing mechanism. Nevertheless, introduction of the new program will have complex and, to some extent, unpredictable effects on income distribution. No major system overhaul can hold everyone harmless in the short term. By controlling health care costs, the proposed program will reduce this burden over time for everyone.

The financial burden of the program will fall most heavily on high income families, due to both higher taxes and the higher dollar limit on routine care. It may be desirable to mitigate this burden somewhat. High income families spend more than low income families on most things, but they usually get more in return - bigger houses, more luxurious cars, designer clothes and haute cuisine. However, we are all issued the same model body, and when we get sick, there are no high-priced and low-priced treatment options. While it can be argued that it is fair for high income families to spend more on health care because they can afford it, it can also be argued that this is unfair since they get nothing more in return. This conundrum explains why we cannot leave health care finance to market forces alone. Past efforts to manipulate the market to provide universal affordable care, notably the ACA, have proven unwieldy and inadequate, and no plausible alternative has yet emerged. Social insurance currently provides a solution for financing a basic level of income for retired and disabled workers and their dependents and health care for the elderly and disabled. Social insurance can provide the solution for financing health care for all.

Summary of the Program

Coverage

The program provides universal coverage for legal residents.

Simplicity

While some aspects of the program may seem complex, overall the program is far simpler than the ACA, which runs to 2,000 pages in the law alone.

Cost Control

The program has concrete and viable mechanisms for controlling the health care cost spiral in preventive care, routine care and catastrophic care, as well as in program administration.

Shared Burden

Under the program, the burden of the added cost controls is shared among patients, providers and administrators.

Affordability

The program has three separate mechanisms to ensure that required participant payments do not exceed ability to pay.

Reduced Government Role

Under the program, the government has three roles: collecting the payroll tax and maintaining the HCTF; assuming the health care insurance risk; and providing regulatory oversight of program administration. All other roles fall to the private sector. Despite the new payroll tax, the government's role is greatly reduced, since bureaucracies overseeing the health care marketplaces, Medicaid and, ultimately, Medicare would disappear.

Medical Practice

The program includes several mechanisms for integrating new or experimental treatments into medical practice and for encouraging consistent, high quality medical practice.

Malpractice Reform

The program does not directly limit malpractice lawsuits against health care providers, but provides important new defenses against such lawsuits that should reduce the volume of litigation against providers.