Healthcare for All Americans

NaCCRA wants a nonpartisan approach to healthcare to reduce costs and to provide better outcomes and well-being for all Americans. We actively pursue practical approaches toward that vision.

Where we stand. American healthcare is dramatically costlier than elsewhere with outcomes that are no better. Moreover, population health has deteriorated with neglect of lifestyle factors leading to obesity, drug dependence, inactivity, and widespread non-specific malaise.

What's to be Done. We need to unleash all the creative resources of our society to address the healthcare cost/results challenge. That includes the ingenuity, flexibility and adaptability of private initiative alongside the governmental capacity for inclusion. While this hybrid private/public approach is easily stated, the details of transition from today's imperfect healthcare to tomorrow's better vision are complex.

Dealing with complexity. Healthcare is complex, so even simple concepts for universal coverage may initially seem complex. But we shouldn't allow complexity to mask ineptitude or dilatory performance.

(1) The proposal we have been developing allows private enterprise to prove itself more effective than a government monopoly solution by allowing comprehensive, integrated healthcare providers to enroll people as an alternative to the government default program.

(2) The government default program need not be solely at the Federal level. It might be a state program subject to Federal constraints not unlike today's healthcare exchanges. It must be universal and all-inclusive.

(3) With the proposal, all Americans are enrolled in the default program (or a private alternative) at birth and enrollment continues through death. The existing Social Security Administration collection mechanism can be used to collect enrollment fees. Like Social Security, healthcare will be individual and portable.

(4) Fees will be payable from all productive activity just as with today's FICA taxes. Foreign visitors will pay a healthcare fee for the duration of their visit. Undocumented immigrants can be treated the same as they are today for Social Security.

(5) Payments by individual enrollees will be set to be the same as what would be required if healthcare cost in the United States were, say, at the average of the ten costliest OECD (Organisation for Economic Cooperation and Development) nations. Although alternative benchmarks can be used, the aim is to set the cost at a level that makes the United States globally competitive and that provides incentives for the American political system to bring U. S. costs in line with competitor nations.

    The following table shows per capita healthcare costs in decreasing cost sequence based on 2015 costs.

	Country	2012	2013	2014	2015
35	United States	$8,423	$8,617	$9,024	$9,451
21	Luxembourg	$6,423	$6,629	$6,682	$7,765
32	Switzerland	$6,289	$6,635	$6,787	$6,935
25	Norway	$5,738	$5,967	$6,081	$6,567
23	Netherlands	$5,044	$5,250	$5,277	$5,343
11	Germany	$4,695	$4,922	$5,119	$5,267
31	Sweden	$4,860	$5,003	$5,065	$5,228
15	Ireland	$4,658	$4,980	$5,001	$5,131
2	Austria	$4,646	$4,806	$4,896	$5,016
7	Denmark	$4,545	$4,708	$4,857	$4,943
3	Belgium	$4,286	$4,485	$4,522	$4,611
4	Canada	$4,320	$4,503	$4,492	$4,608
1	Australia	$3,808	$4,177	$4,207	$4,420
10	France	$4,063	$4,292	$4,367	$4,407
18	Japan	$4,017	$4,152	$4,152	$4,150
14	Iceland	$3,506	$3,739	$3,897	$4,012
34	United Kingdom	$3,192	$3,881	$3,971	$4,003
9	Finland	$3,759	$3,891	$3,870	$3,984
24	New Zealand	$3,199	$3,486	$3,537	$3,590
17	Italy	$3,174	$3,142	$3,207	$3,272
30	Spain	$2,929	$2,952	$3,053	$3,153
29	Slovenia	$2,487	$2,549	$2,599	$2,644
27	Portugal	$2,536	$2,539	$2,584	$2,631
16	Israel	$2,273	$2,473	$2,547	$2,533
19	Korea	$2,132	$2,225	$2,361	$2,488
6	Czech Republic	$2,028	$2,330	$2,386	$2,464
12	Greece	$2,324	$2,340	$2,220	$2,245
28	Slovak Republic	$2,000	$2,073	$1,971	$2,064
13	Hungary	$1,704	$1,756	$1,797	$1,845
8	Estonia	$1,503	$1,623	$1,725	$1,824
5	Chile	$1,485	$1,558	$1,689	$1,728
26	Poland	$1,464	$1,580	$1,625	$1,677
20	Latvia	$1,149	$1,219	$1,295	$1,370
33	Turkey	$911	$969	$990	$1,064
22	Mexico	$1,006	$1,021	$1,035	$1,052

(6) Employers will pay an amount proportionate to the enrollee payment (just as now with FICA taxes) with the proportion set to be sufficient to make up the difference between the competitive benchmark and the current actual cost for any year. The employer share of healthcare costs will decrease or increase as U. S. healthcare cost falls more in or out of line with the cost in other nations, with the employer subsidy determined on the basis of the individual enrollment, i.e. if an enrollee participates in a private plan with more favorable cost, the employer also benefits. The employer share cannot be less than zero. This will provide an incentive for the business community to use its influence and expertise to seek to better manage healthcare costs.

(7) Whether to determine rates by age will be up to the managers of the default and private programs. Gender, health status, and other conceivable determinants will not be permitted. All people must be enrolled in a plan so the preexisting issue is moot. Actuarial risk adjustment factors, certified as program neutral by the Chief Actuary of the Centers for Medicare and Medicaid (CMS), if developed with unbiased professional integrity, can maintain a level playing field between private programs and the government default program. Incidentally, CMS data show that healthcare cost for those 85 and older is more than 7 times the cost for people age 19 to 44. The question, therefore, is the extent to which younger people should subsidize older people, and whether people should prefund the costs of aging (level premium actuarially reserved program).

(8) Benefit adequacy is more important for the health of the American population than is cost control so benefits for the government default program will be the greatest of the benefits that are payable under any of the existing government programs (Medicare, Medicaid, Affordable Care Act, Veterans Benefits, Tri-Care, or the Federal Employees health program). All people in the United States will be eligible for the same benefits. The existing divergent portfolio of government provided healthcare programs will be replaced by a single program for all.

(9) Current programs to incentivize innovation and to encourage value based healthcare will continue, though remedial actions will be substituted for financial penalties for underperforming programs. Presumptive waivers will allow healthcare providers to move quickly to implement creative changes requiring regulatory waivers subject to review after implementation.

Unlike many of the political discussions now taking place in Washington, this proposal is actuarially sound, meaning that it can be made to work on a sustainable basis that preserves intergenerational equity with steady improvement in healthcare outcomes. This differs from a special interest approach in which a group, say, who benefit from legislated reimbursement and payment distortions, lobby the government to receive higher payments at the expense of the taxpayers and the debt position of the United States.

Summation. Reflecting the thinking of one political polarity, this approach calls for universal coverage for every person within the United States. Our military defense protects all U.S. residents and we need comparable defenses against contagion. This proposal calls for a unified government run default option.

Reflecting the thinking of the other polarity, this approach allows private enterprise to demonstrate better performance than the government option. Entrepreneurial competitiveness and American ingenuity would be freed to work to improve quality and accessibility of healthcare while controlling cost. People could opt out of the government program if they find private alternatives giving better value.

The program envisioned here is challenge program and Americans have always been up for a challenge.

NaCCRA Research