

# Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform

**Ed Dolan**  
Senior Fellow  
Niskanen Center

June 2019

---

## Key Takeaways

- ▶ Universal Catastrophic Coverage (UCC) is an approach to health care reform that offers universal, affordable access to care and protection against financially ruinous medical expenses.
- ▶ UCC would cover medical expenses in full for people below a low-income threshold while asking those who can afford it to pay their fair share of the costs of services they use through income-based premiums, deductibles, and coinsurance.
- ▶ The cost-sharing features of UCC provide ample scope for the use of market incentives to improve quality, transparency, and competition.
- ▶ UCC can be made more or less costly to the federal budget by adjusting premiums, deductibles, and other parameters. This paper outlines a baseline version that would maintain the current split between household and public health care spending.
- ▶ UCC offers the flexibility needed to ease the transition to a new mix of public and private coverage.

---

The Niskanen Center is a 501(c)3 issue advocacy organization that works to change public policy through direct engagement in the policymaking process.

**NISKANEN CENTER | 820 FIRST ST. NE, SUITE 675 | WASHINGTON, D.C. 20002**  
[www.niskanencenter.org](http://www.niskanencenter.org) | For inquiries, please contact [ltavlas@niskanencenter.org](mailto:ltavlas@niskanencenter.org)

# Contents

Introduction	3
Why Reform Is Needed	6
<i>High cost, disappointing performance</i> .....	6
<i>Uninsurable risks</i> .....	9
Universal Catastrophic Coverage: The Basics	12
Fine-Tuning the Parameters	14
<i>The low-income threshold</i> .....	15
<i>Deductibles</i> .....	15
<i>Coinsurance and copays</i> .....	18
<i>Preventive care</i> .....	19
<i>Premiums</i> .....	21
Alternatives to UCC	22
<i>High-risk pools</i> .....	23
<i>Reinsurance</i> .....	23
Could We Afford UCC?	25
Further Cost-savings Strategies	30
<i>Demand-side savings</i> .....	31
<i>Supply-side measures</i> .....	32
How Cost-savings Affect UCC Affordability	33
Transition Options	35
<i>Who should administer UCC?</i> .....	35
<i>Transition issues for Medicare</i> .....	37
<i>Transition issues for Medicaid</i> .....	38
<i>Employer-sponsored insurance</i> .....	39
The Intellectual Origins of UCC	41
Conclusion	43
<i>About the Author</i> .....	43

## Introduction

Health care is a top priority for reformers across the political spectrum, yet there is intense disagreement over how to characterize the failures of the current system and what to do about them. America needs health care reform, but what kind?

Many see the problem primarily as one of a broken health care payment system. Programs like Medicaid and CHIP that are intended to help the poor have gaps that still leave many people without access to quality care. The Affordable Care Act (ACA) offers insurance coverage, even for people with pre-existing conditions, but premiums and out of pocket costs strain the budgets of working-class families. Millions remain one serious illness or accident from medical bankruptcy. When the problem is viewed in this way, the obvious solution seems to be a policy guaranteeing that no one has to pay more than they can afford for the care they need. Proponents of such a guarantee often say they want “single-payer” health care like in other high-income countries, even though that term that is rarely an accurate description of those other systems.<sup>1</sup>

Others see the problem more as the lack of a working market for health care services. On the demand side, they argue the prevalence of third-party payments erodes incentives for health care consumers to shop for effective and reasonably priced services. On the supply side, regulations stifle competition, block entry by would-be innovators, and protect the interests of providers at the expense of consumers and taxpayers. When the problem is viewed in this way, the aim of reform seems to be to get the government out of the way let the market do its job.

Although single-payer advocates and market reformers often seem to talk past one another, they have more in common than it might at first appear. By and large, they agree that even under the most market-oriented reforms, there would still be a need for some kind of social insurance to assure that even the very poor and very sick have access to appropriate care. At the same time, everyone agrees that whatever is done about the payment system, there is a need for more transparency, more choice, and more innovation than the current system seems able to deliver.

---

<sup>1</sup> Dolan, Ed. “Please Stop Calling Sanders’ Health Care Plan ‘Single Payer’.” (September 2017) <https://niskanencenter.org/#/content/please-stop-calling-sanders-health-care-plan-single-payer>

This Policy Essay outlines an approach known as universal catastrophic coverage (UCC) that has the potential to achieve the goals share by both approaches to reform. Under UCC, everyone would be protected against financially ruinous medical expenses through insurance that is issued free to the poorest beneficiaries and requires income-based cost-sharing from those who can afford it. UCC posits a robust role for the government as a provider of social insurance where needed while creating room for market mechanisms where they have the best chance of working.

“Health care reform, whatever its guiding philosophy, will encounter tradeoffs.”

A few words of caution are in order before proceeding.

First, reformers should not overpromise. Health care is not the same as health. For most people most of the time, good health depends more on social factors and lifestyle choices than on services delivered by doctors and hospitals. Yes, it is important that people be able to get quality health care services when they need them, but no matter how accessible, health insurance can neither guarantee that people remain healthy nor restore health to everyone who is not.

Second, universal access to health care is not the same as universal, first-dollar insurance coverage. Under UCC, community health centers, cash-only clinics, health savings accounts, health sharing plans, and so on would provide supplementary avenues of access, with a universal catastrophic insurance policy serving as a backstop when needed.

Finally, it is important to recognize that any health care reform, whatever its guiding philosophy, will encounter tradeoffs, many of which have political as well as economic dimensions. What is the right way to balance the burden of health care costs between families and taxpayers? Should coverage be limited to basic services or extend more broadly to experimental treatments and alternative therapies? Will cost control initiatives enhance or undermine incentives for innovation?

UCC, as discussed in what follows, is a set of principles, not a set of answers to all possible questions. It is broad enough to allow for good faith political compromise. Above all, it is flexible enough to accommodate future advances in medicine. Looking back from a few decades hence, it will surely appear that the health care system of today offers only a fraction of what innovation will make possible.

— *Ed Dolan*

---

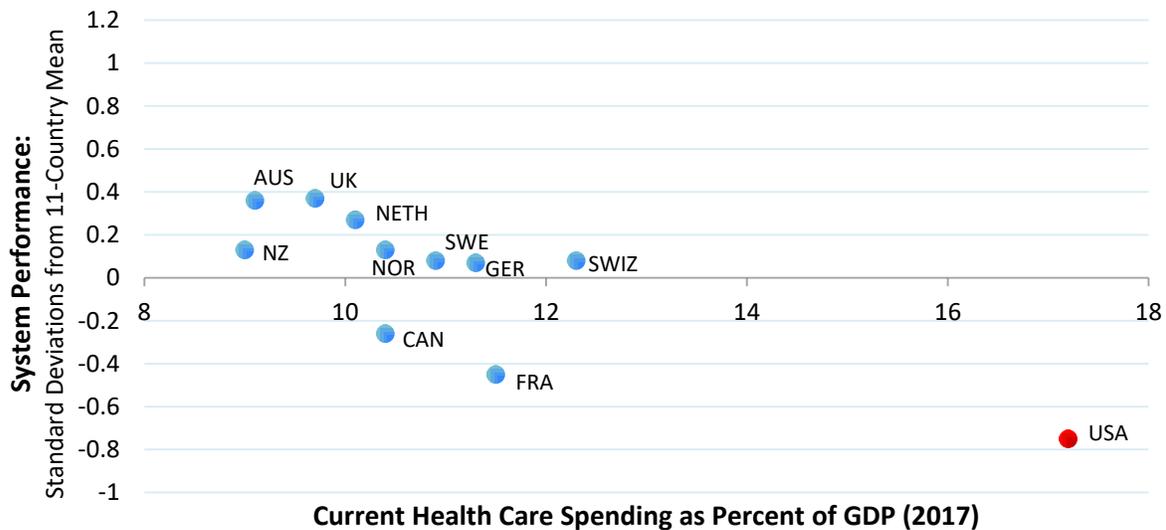
## Why Reform Is Needed

Before delving into the specifics of UCC, it will be helpful set the economic context of health care reform. Doing so will help make it clear why reform is so urgently needed.

### High cost, disappointing performance

We can begin with the high cost and disappointing performance of the U.S. health care system in comparison with other high-income countries. **Figure 1**, based on data from a widely cited Commonwealth Fund report, ranks the United States lowest among eleven comparable countries in system performance even though it spends the highest share of GDP on health care.<sup>2</sup> **Figure 2** shows that although increases in spending have accompanied better health outcomes everywhere, improvements in performance have come more slowly in the United States than in comparable countries, even though spending has risen almost as fast.<sup>3</sup>

Figure 1: Health Care Performance vs. Spending



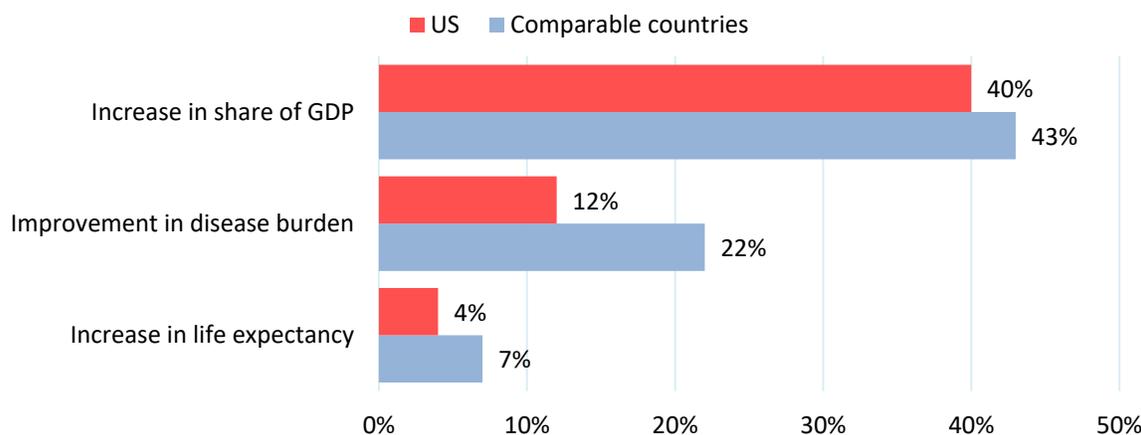
Data source: Commonwealth Fund, Mirror-Mirror 2017, OECD



<sup>2</sup> The performance data are taken from the table in Appendix 1. A similar chart in the Commonwealth report uses 2014 spending data from the OECD. The chart here uses 2017 data from the same source.

<sup>3</sup> Kaiser Family Foundation. Health System Tracker. (2018) <https://www.healthsystemtracker.org/brief/a-generation-of-healthcare-in-the-united-states-has-value-improved-in-the-last-25-years/#item-start>

Figure 2: Health Care Performance  
Percent Change, 1991-2016



Data source: Kaiser Family Foundation



U.S. health care spending is high, in part, because the demand for health care tends everywhere to increase more than in proportion to average income. The United States has a higher per capita GDP than most of the other countries in the Commonwealth study, and therefore higher levels of consumption of medical goods and services. Yet, even after adjustment for levels of income and consumption, U.S. health care spending is higher than expected.<sup>4</sup>

Many critics trace the excess spending primarily to higher prices, although there are some particular tests and procedures, such as MRIs and C-sections, for which the quantity of services used is also higher than elsewhere.<sup>5</sup> The observation that U.S. health care prices are unreasonably high is consistent with the narrative of market reformers, which highlights a lack of competition and innovation.

The reasons for low U.S. performance ratings are more complex. The Commonwealth study gives the United States high scores on some components of the composite performance score. For example, Americans who are hospitalized for heart attacks or strokes, or who are treated for breast

<sup>4</sup> For details, see Dolan, Ed. “Health Care Spending vs. Health System Performance.” (January 2018) <https://niskanencenter.org/blog/healthcare-spending-performance-reform-options/>

<sup>5</sup> Dolan, Ed. “Health Care Will Never Be Affordable Without Action on Prices.” (March 2017) <https://niskanencenter.org/blog/healthcare-prices/>

or colon cancer, have survival rates well above the eleven-country average. U.S. patients also report better than average engagement with their doctors in terms of discussing treatment options and following patient preferences. Preventive care is another area where the U.S. system gets high marks.

Unfortunately, those strong points are more than offset by problems with access and affordability. Many more American patients report cost-related problems with access to care than in other countries, and more say they have serious difficulties in paying medical bills. Differences in access and affordability between low- and high-income patients are also wider in the United States than elsewhere. Those differences, which show up in population health statistics like life expectancy at age 60 and the number of adults with chronic conditions, are consistent with the view of single payer proponents that lack of access to care is a key weakness of the U.S. system. At the same time, since high prices are a barrier to obtaining needed care, access issues can also be seen as consistent with market reformers' views.

Poor U.S. performance on population health indicators is not in every case traceable to flaws in the health care system. For example, relatively high U.S. infant mortality is partly due to international differences in reporting practices.<sup>6</sup> In some cases, poor health may stem from lifestyle, demographic or behavioral factors rather than deficiencies in health care. Nonetheless, the United States also scores poorly in terms of amenable mortality. Amenable mortality is a measure that controls for the imperfect comparability of international health indicators by focusing on premature deaths from conditions like diabetes and appendicitis, which are largely preventable given effective and timely health care.<sup>7</sup>

Finally, the U.S. score for administrative efficiency pushes the United States both lower and farther to the right on the Commonwealth chart, since it adds to costs and is scored as a component of performance. Only France has a worse score for administrative efficiency.

No package of reforms is going to solve U.S. problems of high health care costs and low performance overnight. Single payer proposals, including the

---

<sup>6</sup> See MacDorman, Marian F. and T. J. Mathews. "Behind International Rankings of Infant Mortality: How the United States Compares with Europe." (November 2009) <https://www.cdc.gov/nchs/products/databriefs/db23.htm>

<sup>7</sup> See Nolte, Ellen and C. Martin McKee. "In Amenable Mortality—Deaths Avoidable Through Health Care— Progress In The US Lags That Of Three European Countries." (September 2012) <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0851>

pending House and Senate Medicare for All bills, place a priority on improving access. Those plans would provide universal first-dollar coverage for a wide range of health care services while taking a regulatory approach to cost control.<sup>8</sup> If successful, they could move the United States sharply upward in Figure 1, with either a moderate increase or decrease in total public and private spending, depending on the balance between increased use of services and the success of cost control measures.

Market-based reforms instead aim to control costs by increasing competition and encouraging innovation. Their immediate effect would be to move the United States toward the left along the horizontal axis. To the extent that lower costs made care more affordable and innovation made it more effective, there would be upward movement, too. Brute force measures to reduce spending by limiting access would instead produce movement downward and to the left.

Universal catastrophic coverage lies somewhere between the single-payer and market approaches. It would allow for better cost control, both through regulation, where appropriate, and through transparency, competition and innovation, where feasible. At the same time, it would take a proactive approach to access and affordability. If successful, it would move the U.S. health care system up and to left in Figure 1, lowering cost *and* increasing performance, leaving the United States as less of an outlier.

### Uninsurable risks

Uninsurable risks are another important feature of the economic environment of health care reform. Of particular concern are risks that fail two traditional standards of insurability.

One standard is that an insurable risk must be the result of unpredictable chance. That is not the case, however, for the health risks of people who suffer from chronic conditions like diabetes and heart disease, which require costly lifetime care. It is also not the case for people with genetic markers that make them medical time bombs for insurers. In a study by the Kaiser Family Foundation, 53 percent of Americans reported that they, or someone else in their household, had a pre-existing condition that would cause a private

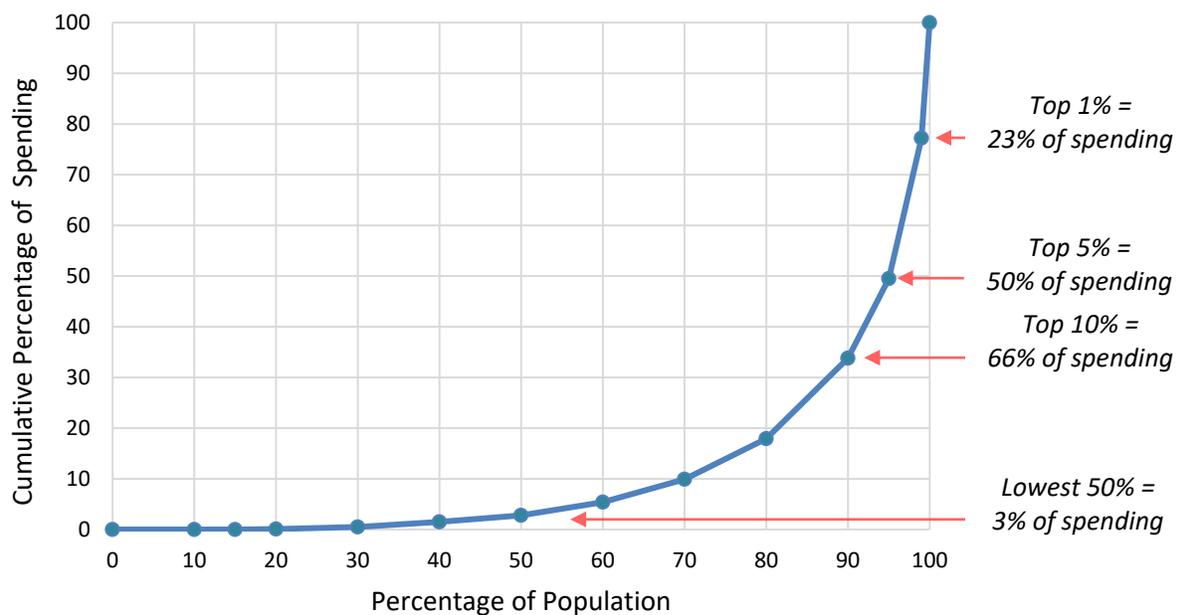
---

<sup>8</sup> “Medicare for All: Leaving No One Behind.” <https://live-berniesanders-com.pantheonsite.io/issues/medicare-for-all/>

insurance company to decline coverage under pre-ACA underwriting practices.<sup>9</sup>

A second standard for commercial insurability is that the actuarially fair premium — one high enough to cover the expected value of claims — must be affordable. That might be true if health care expenses were distributed evenly among the population, but they are not. As **Figure 3** shows, the healthiest half of the population accounts for just 3 percent of all personal health care spending.<sup>10</sup> At the other end of the curve, 5 percent of the population account for half of all spending and just 1 percent for more than a fifth of all spending.

**Figure 3: Population Share of Health Spending**



Data source: NIHCM Foundation July 2017



Because medical expenses are distributed so unevenly, an actuarially fair premium for health insurance would exceed the entire income of many people with pre-existing conditions. Projected forward to 2018 levels of total spending, the data on which Figure 2 are based imply average annual health

<sup>9</sup> Claxton, Gary et. al. “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA.” (December 2016) <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>

<sup>10</sup> National Institute for Health Care Management. “The Concentration of Health Care Spending.” (July 2017). <https://www.nihcm.org/categories/concentration-of-us-health-care-spending>

care spending per person of nearly \$60,000 for those in the top 5 percent of spenders, and more than \$130,000 for the top 1 percent. Furthermore, the higher up the curve, the more predictable the risk. The same data source indicates that only about a quarter of all people in the top half of the spending distribution move to the bottom half in the following year, and nearly half of those in the top 10 percent stay there in the next year.

Several regulatory mechanisms exist to mitigate the problem of uninsurability, at least to a degree.

- ▶ *Guaranteed renewal* requires insurers to continue to issue policies to those who become ill, provided there is no break in coverage.
- ▶ *Guaranteed issue* requires insurers to accept all applicants, regardless of pre-existing health conditions, is another step in the same direction, although people in poor health would still face high premiums.
- ▶ *Community rating* is a still stronger step that requires insurers to charge the same premium, based on average claims, to everyone in a general category regardless of their health status.

The ACA uses a combination of these mechanisms to make it possible for people to buy health insurance for a premium that is fixed regardless of pre-existing conditions. However, doing so creates problems of its own. One of the biggest is that the system becomes vulnerable to *adverse selection*. Adverse selection is the temptation for healthy people to remain uninsured and to buy into the system only when they become ill. As more healthy people drop out, premiums for those who remain in the pool rise higher and higher. If adverse selection goes unchecked, premiums can become unaffordable for many people, even with community rating.

Some market reformers reject the ACA's regulatory approach to the problem of insurability. Instead, they attribute uninsurability largely to overregulation. In their view, an unregulated market would see the emergence of forms of insurance that would protect policyholders from changes in health status. People would be able to buy policies that extended over their full lifetime with guaranteed renewability, and encouraged competition by

making coverage transferable from one company to another.<sup>11</sup> Perhaps some of these ideas are worth pursuing. However, it is likely that in any purely commercial insurance market, gaps in coverage would remain, due to factors such as the ability to detect genetic susceptibility to risk before birth, chronic conditions that develop during lapses in coverage, changes in family status, and other reasons.

Universal catastrophic coverage is designed to fill those gaps. It would go beyond guaranteed issue and community rating by guaranteeing affordable access to health care for everyone, regardless of health status. The next section explains the basic principles of UCC.

## Universal Catastrophic Coverage: The Basics

The objective of UCC is to relieve the threat of financially ruinous medical bills for the very poor and very sick while requiring those who can to pay an affordable share of the cost of their own non-catastrophic care. To accomplish that, UCC sets an income-based cap on each household's health care spending. The cap is defined by a number of parameters.

The simplest version of UCC would have just two parameters, a **low-income threshold** and, for those above the threshold, a **deductible** that varies with household income.

The low-income threshold is a level of household income below which even moderate medical expenditures would threaten serious financial distress. Under UCC, people whose incomes are at or below the threshold would have their health care costs covered in full. The dollar value of the threshold would vary with family size. For example, the threshold could be set equal to the federal poverty level (FPL) or a fixed percentage of it. As of 2019, the FPL stood at approximately \$12,500 for an individual and \$25,000 for a family of four.

A household's **eligible income** is defined as the amount by which household income exceeds the low-income threshold. In a simple version of UCC, the deductible could be set at, say, 10 percent of eligible income and the low-

---

<sup>11</sup> See, for example, Cochrane, John H. "After the ACA: Freeing the Market for Health Care." (September 2014) [https://faculty.chicagobooth.edu/john.cochrane/research/papers/after\\_aca.pdf](https://faculty.chicagobooth.edu/john.cochrane/research/papers/after_aca.pdf). Footnote 25 of that paper gives links to several of Cochrane's other writings on this subject.

income threshold at the FPL. A family of four with total income of \$50,000 would then have eligible income of \$25,000 and a deductible of \$2,500. A family with total income of \$100,000 (approximately the upper limit of eligibility for premium subsidies on the ACA exchanges) would have a deductible of \$7,500. A family with total income of \$1 million would have a deductible of \$97,500, and so on. Income could be defined as adjusted gross income reported on the previous year's tax return, with some form of averaging for people with highly variable incomes.

In addition, a UCC plan could include additional **cost sharing** in the form of **coinsurance** and **copayments**. For example, suppose the low-income threshold were set to the FPL and the deductible at 10 percent of eligible income. Coinsurance of 20 percent could then be assessed for health care expenses from 10 percent to 35 percent of eligible income. A family of four with eligible income of \$50,000 would then face a deductible of \$5,000 and 20 percent coinsurance on expenditures from \$5,000 to \$17,500. The family's **out-of-pocket maximum** would then be \$7,500, consisting of the \$5,000 deductible plus \$2,500 in coinsurance.

Some UCC proposals also include a **premium**, which would be paid whether or not a household had any health care expenses in a given year. The premium, too, could vary with income, starting at zero for families below the low-income threshold and following a sliding scale for those with higher incomes. A household's total **contribution to the cost of care** would then be the sum of its out-of-pocket spending and its premium.

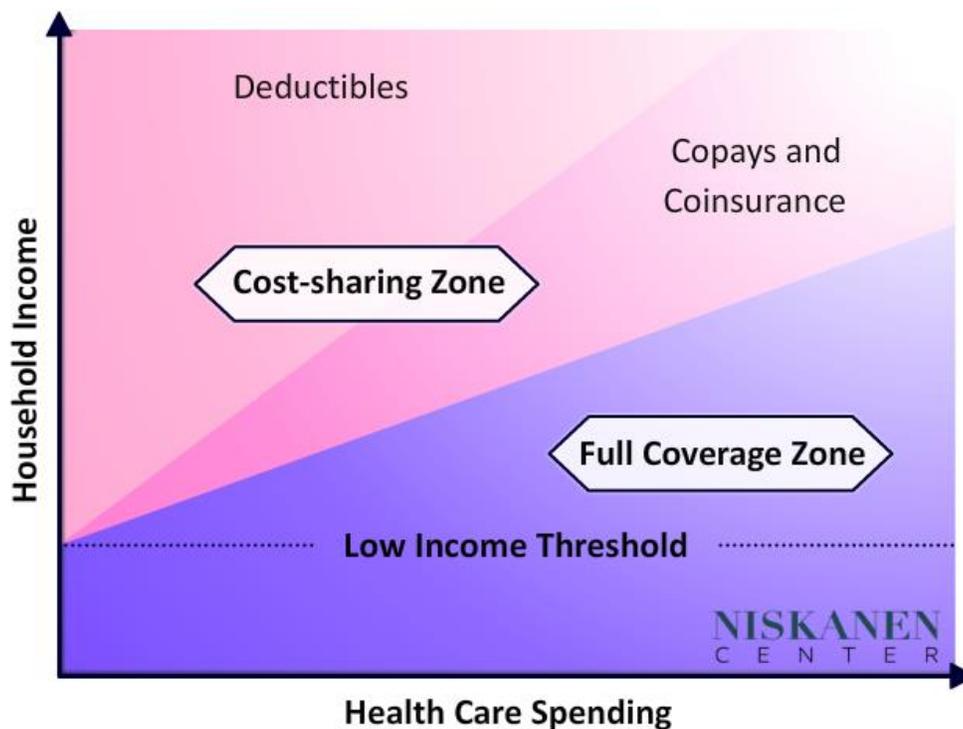
Finally, many versions of UCC include a package of preventive services that would be exempt from cost sharing to avoid discouraging their use.

Taken together, these UCC parameters define two zones, shown schematically in **Figure 4**. Households fall into one zone or the other according to income and health care spending.

The *full coverage zone* includes those whose incomes are so low or whose health care needs are so great that any additional medical expenses would threaten financial catastrophe. They get full, first-dollar coverage of their health care expenses, at the margin, although those who are above the low-income cutoff must first satisfy their deductible, copay, and coinsurance requirements. Access to care for people who fall into the full-coverage zone is a key concern of reformers who favor a single-payer approach.

The *cost-sharing zone* comprises people who are healthy and/or wealthy enough that they do not fully meet their cost-sharing requirements. People in this zone face immediate economic incentives to shop carefully for health care services and to manage their expenses in a prudent manner. Some of them may do so by paying out of pocket, others may pay from health savings accounts, and still others may buy supplemental insurance or join health care sharing organizations. These incentives and mechanisms play an important role in market-based reform strategies.

Figure 4: Coverage Zones



The relative sizes of the two zones and the location of the borders between them depend on the values assigned to the various UCC parameters. The next section examines some of the considerations that go into deciding how those parameters should be set.

## Fine-Tuning the Parameters

Each of the five parameters of a UCC plan — the low-income threshold, the deductible, the coinsurance or copay, the premium, and the preventive

package — serves a particular objective. Tightening or relaxing any one parameter would lower or raise the cost of a UCC plan to the government budget. By trading off one parameter against the others, it is possible to emphasize one objective and de-emphasize others while holding the overall cost of the plan constant. Here are some of the most important considerations in setting the parameters.

### **The low-income threshold**

Conceptually, the low-income threshold represents a level of income just high enough to allow a household to pay for non-medical necessities. For the sake of discussion, it is convenient to set the low-income threshold equal to the federal poverty level, but in practice, the FPL is not especially well-suited for that purpose.

Historically, the FPL, which dates from the 1950s, assumed that a family with income equal to three times the cost of the minimum needed for food would have enough left over for other necessities.<sup>12</sup> At that time, however, health care costs were much lower than they are now relative to those of food, shelter, and clothing. The government's cash and non-cash poverty programs were also much less extensive.

Those considerations might justify setting the low-income threshold at more than 100 percent of the FPL, for example, at the current Medicaid eligibility threshold of 138 percent of the FPL. Instead, other measures of poverty could be used that apply different treatments to items like non-cash benefits, housing expenses, and medical expenses. The Census Bureau's Supplemental Poverty Measure may offer a more useful benchmark in that regard.<sup>13</sup>

### **Deductibles**

Under UCC, deductibles have three effects. First, they limit the cost to the government budget in comparison to plans such as Medicare for All, which extend first-dollar coverage to everyone. Second, they serve the goal of fairness by requiring that people who can afford it to assume responsibility for their own non-catastrophic health care expenses. Third, together with

---

<sup>12</sup> Fisher, Gordon M. "The Development and History of the U.S. Poverty Thresholds." (1997) <https://aspe.hhs.gov/history-poverty-thresholds>

<sup>13</sup> For further information, see Fox, Liana. "The Supplemental Poverty Measure: 2017." (September 2018) <https://www.census.gov/library/publications/2018/demo/p60-265.html>

coinsurance and copays, they define the cost-sharing zone of Figure 4, within which people face a direct tradeoff between spending on health care or on other goods and services.

The third effect is the most controversial. The issue is whether the tradeoff created by deductibles induces people not just to spend less (which they do), but also to spend more wisely. According to many advocates of market-based health care, giving consumers “skin in the game” encourages them to compare the cost and quality of services from various providers, avoid excessive and inappropriate tests and procedures, and budget prudently to meet foreseeable medical expenses. However, numerous studies cast doubt on the idea that high deductible health plans (HDHPs) automatically make people better shoppers.

For example, an NBER Working Paper by Zarek C. Brot-Goldberg et al. found “no evidence of consumers learning to price shop after two years in high-deductible coverage.”<sup>14</sup> The authors noted that consumers reduced quantities consumed across the board, including potentially valuable preventive care as well as potentially wasteful care such as unnecessary imaging. Similarly, a recent review of the literature in *Health Affairs* concluded, “Current evidence suggests that HDHPs are associated with lower health care costs as a result of a reduction in the use of health services, including appropriate services.”<sup>15</sup> And a research letter by Jeffrey Kullgren and colleagues published by *JAMA Network* found that HDHPs were ineffective in inducing enrollees to set up health savings accounts, compare prices or quality of services across providers, discuss prices with their physicians, or negotiate prices.<sup>16</sup>

Studies such as these, which cast doubt on the most facile versions of the “skin in the game” argument, raise both technical and political issues for policymakers.

The technical issues concern the extent to which the negative effects of high deductibles can be mitigated through better policy design. For example,

---

<sup>14</sup> Brot-Goldberg, Zarek C., et al. “What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics. (November 2015) <https://www.nber.org/papers/w21632>

<sup>15</sup> Agarwal, Rajender, Olena Mazurenko, and Nir Menachemi. “High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services.” (October 2017) <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0610>

<sup>16</sup> Kullgren, Jeffrey, et al. “Consumer Behaviors Among Individuals Enrolled in High-Deductible Health Plans in the United States.” (March 2018) <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2664065>

although some consumers are reported to make no effort to obtain or act on price information, others who attempt to do so are frustrated by a lack of pricing transparency. Measures to make price and quality information more readily available to consumers could help. So could changes in training and incentives that encouraged physicians to discuss the relative cost-effectiveness of treatment options.

“Numerous studies cast doubt on the idea that high deductible health plans automatically make people better shoppers.”

The political issues turn on attitudes toward health care paternalism. If the objective of reform is simply to make sure that everyone has affordable access to care, then it can be argued that consumers have only themselves to blame if they neglect appropriate services that they can afford to pay for. On the other hand, if the policy objective is actually to improve health outcomes, rather than just to provide access to services, then high deductibles are more problematic.

Finally, before leaving the topic of high deductibles, we should note that not all families would choose to pay all of their out-of-pocket costs from current income over the full range of their UCC deductibles. Higher-income families, for whom deductibles could run to the tens of thousands of dollars or more, would be likely to make use of various mechanisms to manage their medical expenses.

One obvious possibility would be to purchase private supplemental insurance, similar to the “Medigap” coverage now purchased by many Medicare beneficiaries. For example, a wealthy family with a \$100,000 UCC deductible might buy a supplemental policy to cover expenses from \$10,000 to \$100,000. Their maximum out-of-pocket exposure would then be the \$10,000 deductible on the supplemental policy, not the full \$100,000 on the UCC policy.

Some market reformers might look askance on low-deductible supplemental policies, since they could potentially undermine incentives for careful health care shopping within the cost-sharing zone. However, simple supplemental

insurance is not the only means by which middle- and high-income families could manage their UCC deductibles. Some of the alternatives would have less deleterious incentive effects.

Health savings accounts (HSAs) are one example. A family could smooth the financial shock of an unexpected illness or accident by accumulating a substantial balance in an HSA, perhaps with tax incentives to do so. Since the funds in the HSA are their own, which they would want to replace over time, such a family would have an incentive to spend them wisely.

Families with high UCC deductibles could also take advantage of health sharing plans. Health sharing plans are not technically insurance, but rather function more like a cooperative. As under insurance, members pay into a pool from which those who are sick can draw to cover medical expenses. Health sharing plans include a variety of features that encourage prudent shopping for services, such as advice on where to find the lowest prices for imaging services or prescription drugs. Such plans are already permitted under the ACA. Some of them are affiliated with religious groups while others are secular. Together, they enroll more than a million consumers.<sup>17</sup>

### Coinsurance and copays

Coinsurance and copays serve the same three fundamental objectives as deductibles, but with advantages and disadvantages of their own. For any given out-of-pocket maximum, adding coinsurance and copays to a UCC plan, while reducing the deductible, enlarges the cost-sharing zone, as shown in Figure 4. That is a plus from the perspective of market reformers without detracting from overall affordability.

Furthermore, coinsurance and copays are a potentially more flexible policy than simple deductibles. As noted in the previous section, high deductibles tend to affect health care spending in an indiscriminate way, reducing use of both appropriate and inappropriate care. Advocates of an approach called Value-Based Insurance Design (VBID) argue that coinsurance and copays, properly calibrated, can offer a way around that problem. Under VBID, coinsurance and copayments are set according to the clinical value of

---

<sup>17</sup> For an overview of health sharing plans, see Goodman, John C. "Alternatives to Obamacare." (January 2019) <https://www.forbes.com/sites/johngoodman/2019/01/30/alternatives-to-obamacare/#6c82f88a61ff>

treatments.<sup>18</sup> Those known to be highly beneficial are assigned a low coinsurance rate or low copays while the out-of-pocket burden is set higher for treatments of lower clinical value.

### Preventive care

If an ounce of prevention were reliably worth a pound of cure, as many people believe, the case for exempting preventive care from cost sharing would be open and shut. In practice, things are not so simple. A few preventive measures are so cheap and effective that they clearly reduce total health care spending, but more typically, prevention increases total spending even when it improves outcomes.<sup>19</sup>

Childhood vaccinations, or at least many of them, reliably reduce total costs, since they not only avoid treatment costs for those who are vaccinated but also reduce contagion. Intervention to discourage smoking is often cited as another example of cost-saving preventive care. One study identified twenty preventive measures that could reduce total spending if more widely used as a package, although not all would save costs individually.<sup>20</sup>

More commonly, however, providing preventive care improves health while increasing total spending. For example, colonoscopies can detect cancer at an early stage and improve the chance of a cure, but are expensive. Many people are tested who turn out to be cancer-free, and occasionally the tests themselves cause costly complications. On balance, colonoscopies are a cost-effective way of improving quality of life and preventing premature deaths, but the more widely their use is expanded to parts of the population at lower risk, the more likely they are to increase, rather than decrease, total spending.

Colonoscopies also illustrate the importance of price variations in determining the cost effectiveness of preventive care. Prices for common preventative procedures vary widely. For example, a 2014 study by Alexis Jane Pozen observed colonoscopy prices varying from \$374 to \$2749, with a mean

---

<sup>18</sup> For an introduction to VBID, see Chernew, Michael E. and A. Mark Fendrick. "Value Based Insurance Design: Restoring Health To The Health Care Cost Debate." (2009) <http://vbidcenter.org/wp-content/uploads/2014/08/health-essay-2009-chernew.pdf>

<sup>19</sup> For a more detailed discussion of the points summarized in this section, see Dolan, Ed. "The Role of Prevention in Health Care Reform." (May 2018) <https://niskanencenter.org/blog/the-role-of-prevention-in-health-care-reform/>

<sup>20</sup> Maciosek, Michael V. et al. "Greater Use of Preventive Services In U.S. Health Care Could Save Lives At Little Or No Cost." (September 2010) <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2008.0701>

of \$1,363.<sup>21</sup> Practices such as reference pricing, which provides reimbursement based on the rates of low-cost providers (screened for acceptable quality), would make it possible to offer a broader package of preventive services while controlling costs.

“Most preventive measures fall in a middle category that increase total health care spending even though they produce benefits that exceed their costs.”

At the far end of the spectrum of cost-effectiveness, overzealous application of some preventive measures can both increase total health care costs and lead to worse health outcomes. Some studies have pointed to PSA tests to screen for prostate cancer as an example.<sup>22</sup>

A study by Joshua T. Cohen and colleagues, published in the *New England Journal of Medicine*, found that most preventive measures fall in a middle category that increase total health care spending even though they produce benefits that exceed their costs.<sup>23</sup> The study used *quality-adjusted life years*, or QALYs, to measure effectiveness. QALYs weight years of extended life according to their comfort and restrictions on activity. For example, a year spent in a hospital bed might count just half as much as one spent in perfect health.

Ultimately, the choice of which preventive measures to exempt from cost sharing depends on policymakers' objectives. An emphasis on minimizing health care costs would favor a narrow exemption covering only preventive care that is strictly cost reducing. A greater emphasis on improving health outcomes could, instead, set a limit for inclusion in the exempt package based on a benefit-cost metric such as QALYs per added dollar of spending. An article published in *Health Affairs*, Mark V. Pauly, Frank A. Sloan, and Sean D.

---

<sup>21</sup> Pozen, Alexis Jane. “Price Variation for Colonoscopy in a Commercially Insured Population.” (2014)  
<https://escholarship.org/uc/item/5wq5d390>

<sup>22</sup> Prasad, Vinay. “The new recommendations for prostate cancer screenings are a bad deal.” (April 2017)  
<https://www.statnews.com/2017/04/11/psa-screening-prostate-cancer/>

<sup>23</sup> Cohen, Joshua T. “Does Preventive Care Save Money?” (March 2018)  
<https://www.nejm.org/doi/full/10.1056/nejmp0708558>

Sullivan discusses some of the economic and clinical issues involved in drawing up a list of cost-effective preventive services.<sup>24</sup>

### Premiums

The final parameter of a UCC plan is the premium, if any, to be paid by policyholders. Premiums are motivated by the idea that those who can afford to do so should pay for the benefit of being insured. Within a given budgetary cost, adding premiums to a UCC plan would make it possible to reduce the required amount of cost sharing. For a given level of cost sharing, adding a premium would reduce the total budgetary cost.

To be consistent with the goal of making coverage affordable to everyone, premiums should vary with income and be waived for households below the low-income threshold. For that reason, adding premiums to a UCC plan would not have much effect on the distribution of health care costs among income classes. Instead, their main effect would be to redistribute health care costs toward people who are healthy and away from those who are ill within any given range of eligible income. When UCC is viewed as a form of social insurance, this might be seen as an increase in fairness.

Yet premiums have their drawbacks. One is that simultaneously adding a premium to a UCC plan while reducing deductibles shrinks the size of the cost-sharing zone, thereby reducing incentives for more careful choice by health care consumers. A premium, once paid, is a sunk cost that has no effect on consumers' decisions to lead a healthy lifestyle, to seek medical care in cases they view as optional, or to shop for the best price rather than simply visiting the most convenient provider. Reasonable people will differ as to how serious of a drawback this is according to their assessment of the "skin in the game" effect discussed earlier.

Premiums also raise difficult issues regarding the universality of coverage. There would be minimal barriers to automatically enrolling everyone in a UCC plan that had no premium. Some people might decline to use their policies, perhaps on religious grounds or because of misinformation about the risks and effectiveness of medical care, but that would be their own choice.

---

<sup>24</sup> Pauly, Mark V., Frank A. Sloan, and Sean D. Sullivan. "An Economic Framework For Preventive Care Advice." (November 2014.) <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0873>

Adding a premium raises the issue of what to do about people who chose not to pay it, even though they can afford to do so. For example, what should be done with people who show up at an emergency department (ED) without a paid-up UCC policy? It seems likely that EDs would be required at least to stabilize their condition, as they are under current law. If so, that would open the door to the problems of overuse of EDs and uncompensated care that hospitals now face. Since low-income people would be fully covered under UCC without required premiums, the severity of those problems would presumably be reduced, but they would not be eliminated.

“Premiums raise difficult issues regarding the universality of coverage.”

Finally, premiums raise an issue of adverse selection, since healthy people would be the most likely to choose not to purchase insurance. If that reduced the number and average health of the pool of UCC participants, it would drive up premiums for those who did participate.

One way to deal with adverse selection would be to require people who had never been covered, or whose coverage had lapsed, to pay a penalty if they decided to join the insurance plan later. However, the penalty would have to be quite substantial to induce healthy people with good incomes to join the system. The modest penalties for noncoverage under the ACA and some proposed replacements are widely regarded as inadequate to deter adverse selection.

Alternatively, payment of premiums could be made compulsory for everyone above the low-income threshold. However, a compulsory premium is no longer a premium, but simply a tax. To the extent UCC would be financed with taxes, it is arguably better to do so out of general revenue than through a special health care tax that is euphemistically called a “premium.”

## Alternatives to UCC

UCC, however the parameters are set, is not the only possible way to deal with the financially ruinous but commercially uninsurable tip of the distribution of

medical expenses. The two most important alternatives to UCC are high risk pools and reinsurance.

### High-risk pools

In a high-risk pool, people whose health conditions make them uninsurable are placed in a separate pool for which claims are paid by government. According to a summary by Karen Pollitz of the Kaiser Family Foundation, 35 states had some type of high-risk pool prior to passage of the ACA.<sup>25</sup> All of the pools, by design, paid out more in claims than they brought in as premiums. The shortfall was made up, directly or indirectly, from general tax revenue.

The hope was that if insurance companies were relieved of the obligation to cover the highest-risk patients, they would lower premiums for the patients they continued to cover. But because the pools were often underfunded, that hope was not always realized. In many states, high premiums, high deductibles, and waiting periods discouraged enrollment. As a result, the pools covered only 1 to 10 percent of the population that had insurance in the individual market — well below the 27 percent that Pollitz estimated should theoretically have been eligible. The state-run high-risk pools have now been made redundant by the guaranteed issue and community rating requirements of the ACA.

### Reinsurance

Reinsurance takes a different approach. Instead of segregating high-risk consumers, reinsurance leaves everyone in the general risk pool, while a government reinsurance fund reimburses insurers for claims above an *attachment point* and up to a *cap*. For example, suppose the attachment point is \$50,000 in annual claims and the cap is \$1 million. An insurance company would then get a reimbursement of \$40,000 for a patient with \$90,000 in claims and a maximum reimbursement of \$950,000 for patients with claims of \$1 million or more.

Under reinsurance, private insurers continue to cover the high-risk consumers, but the reimbursements make it possible for them to offer lower premiums to all their customers. As in the case of high-risk pools, the actual

---

<sup>25</sup> Pollitz, Karen. "High Risk Pools for Uninsurable Individuals." (2017) <https://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/>

reduction in premiums would depend on the level of funding for the reinsurance program.

The traditional form of reinsurance is *retrospective*, with no effort made to identify high-risk consumers in advance. Under retrospective reinsurance, a large share of reimbursements would represent the claims of people with identifiable chronic conditions or genetic predispositions, but those claims would be treated no differently from those of healthy individuals who experienced high expenses because of unforeseeable accidents or illnesses.

A newer variant, *prospective* reinsurance, operates somewhat differently. Private insurers continue to issue policies to all applicants, regardless of health condition. However, when particular applicants are identified as being at high risk, the primary insurer “cedes” a part of the risk to the reinsurer, along with part of the premium. For example, the primary insurer might cede risks over \$50,000 per year to the reinsurer in exchange for 90 percent of the premium. The reinsurer would then cover claims above the \$50,000 attachment point, while the primary insurer would cover lesser claims in return for the remaining 10 percent of the premium.

Prospective reinsurance is, in effect, a hybrid. It resembles a high-risk pool in that it places consumers who are most likely to have high claims in a separate pool, where they are covered with government funds. However, the whole process goes on out of sight. Because consumers do not know when a particular claim is being reimbursed by the government, prospective reinsurance schemes are sometimes called *invisible high-risk pools*.

The American Health Care Act of 2017, which passed the House but failed in the Senate, included a provision for prospective reinsurance, although it was probably underfunded. The AHCA failed to pass, but since then, several states have been experimenting with invisible risk-pools or are considering doing so. Even if adequately funded, however, high-risk pools and reinsurance have some practical drawbacks.

One problem is that high-risk pools and the prospective form of reinsurance require advance screening for health risks. Even if everyone is ultimately guaranteed coverage in one form or another, screening raises administrative costs. After the experience of guaranteed issue under the ACA, with no intrusive questionnaires, health histories, or physicals, a return to widespread screening for pre-existing conditions or genetic predispositions would

probably encounter consumer resistance. Only the retrospective form of reinsurance avoids screening.

“High-risk pools and the prospective form of reinsurance require advance screening for health risks.”

A more serious problem is that high-risk pools and reinsurance treat all households equally, regardless of income. As a result, even if such programs succeeded in lowering average premiums, many low- and middle-income consumers would likely find that coverage was still unaffordable.

For example, if high-risk pools or reinsurance absorbed half of all personal health care expenditures, the remainder would still work out to an average close to \$20,000 per year for a family of four. Families would have to pay those costs through a combination of premiums, deductibles, and copays. Health care expenses of \$20,000 per year would be equivalent to some 40 percent of median household income — affordable for some, but by no means for all.

UCC addresses both of these problems. Because payments for catastrophic expenses are made retrospectively, UCC would avoid the need to screen for health risks. Everyone would be issued a UCC policy automatically. Furthermore, because premiums and out-of-pocket costs would be scaled to income, UCC would be affordable for everyone. In effect, UCC can be described as a form of retrospective reinsurance with an attachment point scaled to household income and without a cap. As such, it offers the best combination of access, affordability, and social insurance of any method for dealing with the problem of uninsurable medical risk.

## Could We Afford UCC?

Skeptics often greet proposals for greater access to health care with the question, “Yes, but could we afford it?” Since this is not an examination of a specific UCC proposal, however, that is the wrong question. For present purposes, it is more appropriate to begin by asking how generous a UCC plan we could buy with the money we already spend on health care.

Accordingly, this section outlines a baseline case in which the parameters of a UCC plan are set to fit within current U.S. levels of health care spending from public and private sources. As of 2017, the most recent year for which full data are available, U.S. health care spending came to about \$10,700 per capita, or about 18 percent of GDP, funded as follows:

- ▶ About 50 percent came from federal, state, and local government spending on Medicaid, Medicare, ACA subsidies, and other programs.
- ▶ About 30 percent was contributed by households in the form of insurance premiums and out-of-pocket spending.
- ▶ About 20 percent came from employer spending on health care benefits for workers.

Of those three funding sources, employer-sponsored health insurance (ESHI) is the most problematic. International comparisons, such as those published by the OECD, classify employer health care spending as private.<sup>26</sup> By that reckoning, the public share of health care spending in the United States is the lowest of all OECD countries. In practice, however, the prevalence of ESHI is as much a product of public policy as of private decisions. Without the exemption of employee health benefits from personal income taxes, ESHI would never have become so widely established to begin with. In addition, although the number of companies offering ESHI is gradually decreasing, it would be falling more rapidly without the ACA's employer mandate, which requires all but the smallest employers to provide coverage for their full-time workers. It is therefore reasonable to group ESHI expenditures with other on-budget programs. Doing so makes the nonhousehold share of health care spending in the United States about 70 percent, only slightly below the OECD average of 72 percent.

A detailed estimate of the cost of any given UCC plan would require actuarial calculations that lie beyond the scope of this report. However, it is possible to make a reasonable approximation of the cost of various UCC plans based on a stylized population with the following characteristics, which are similar to those of the actual U.S. population:

---

<sup>26</sup> OECD, Health Statistics 2018. (November 2018) <http://www.oecd.org/health/health-systems/health-data.htm>

- ▶ The default value for average health care spending is \$10,700 per person, approximately the 2017 U.S. level.
- ▶ Individual health care spending is distributed by population decile as shown in Figure 3.
- ▶ The stylized population consists entirely of two-person households. (The actual average size of U.S. households is 2.5 persons. The two-person household of the stylized population is close to the average equivalence-adjusted number of members per household in the actual population, using OECD equivalence weights of 1 for the first adult in a household, 0.7 for each additional adult, and 0.5 for each child.<sup>27</sup>)
- ▶ The levels and distribution of household incomes by decile follow 2017 census data, adjusted for the assumed two-person household size.<sup>28</sup>
- ▶ Health status and income level of households are assumed to be uncorrelated, as are the health status of members within each household.

Call this the *stylized population model*. The cost of any particular configuration of UCC parameters can be derived from the model. For example, here are two basic UCC variants, one without and one with a premium, both of which would maintain the current level of total health care spending and the 30/70 division of spending between household and nonhousehold sources:

- ▶ **V1:** No premium. Low-income threshold equals \$16,240, the federal poverty level for a family of two in 2017. Out-of-pocket maximum equals 25 percent of eligible income (income in excess of low-income threshold).
- ▶ **V2:** Premium equals 4 percent of eligible income. Low-income threshold equals \$16,240, no premium for those below the threshold. Out-of-pocket maximum equals 15 percent of eligible income.

---

<sup>27</sup> OECD. "What are Equivalence Scales?" <http://www.oecd.org/els/soc/OECD-Note-EquivalenceScales.pdf>

<sup>28</sup> DQYDJ. "United States Income Brackets and Percentiles." (December 2018) <https://dqydj.com/united-states-household-income-brackets-percentiles/>

Both of these variants protect all families from the most financially catastrophic medical expenses. However, they differ substantially in the way household contributions are distributed according to income and health status.

Under V1, which has no premium, approximately 65 percent of the population would have health care expenses of no more than 15 percent of total household income, including all households with incomes below 250 percent of the poverty level. More than 95 percent of households would have expenses of less than 20 percent of total income. Under V2, which includes a premium, 95 percent of households, including all of those below 400 percent of the poverty line, would have expenses of less than 15 percent of income.

Compared to V1, the premium and lower out-of-pocket maximum of V2 redistribute health care spending toward relatively healthy households. The extent of the redistribution differs according to the level of income. Within the first income decile, which starts at about 150 percent of the poverty level, monthly premiums average a modest \$25 a month under V2. As a result, only the healthiest 20 percent of households experience higher total costs than under V1. For the top income decile, premiums average \$575 a month, with the result that all but the 20 percent of households with the highest medical expenses pay more under V2.

The stylized population model can also be used to calculate the approximate size of the cost-sharing and full coverage zones shown in Figure 4. For example, consider a plan — call it V1a — that has no premium, a deductible equal to 25 percent of eligible income, and no other cost sharing. Under that plan, about 43 percent of all households, accounting for about 29 percent of all health care spending, would fall into the cost-sharing zone in any given year. Alternatively, consider a variant V1b that reduced the deductible to 20 percent of eligible income and added coinsurance at a rate of 20 percent over a range from 20 to 45 percent of eligible income. V1b would have the same out-of-pocket maximum as V1a, but it would enlarge the cost-sharing zone to encompass 54 percent of households accounting for 40 percent of all health care spending.

The above calculations, based on the stylized population model, support the feasibility of a baseline UCC plan that would protect households against financially ruinous medical expenses while maintaining, at least approximately, the existing pattern of cost-sharing between household and

nonhousehold sources. Another study by Jodi L. Liu of the RAND Corporation has reached the same conclusion using a completely different methodology.<sup>29</sup>

Liu uses a more detailed cost model that includes population data, estimates of demand elasticities, and other parameters drawn from reviews of existing literature. She applies the model to two different national health care plans: a 2013 version of Sen. Bernie Sanders' Medicare for All proposal and a UCC plan outlined in 2012 in *National Affairs* by Kip Hagopian and Dana Goldman.<sup>30</sup>

In estimating the cost of the UCC plan, Liu assumes a low-income threshold equal to the federal poverty level and an out-of-pocket maximum equal to 14.5 percent of eligible income. She also includes a fixed annual charge, waived for incomes below the poverty threshold and assessed on a sliding linear scale up to a maximum of \$3,350 at 300 percent of the poverty level. She calls this charge a "tax," although Hagopian and Goldman themselves refer to it as a "premium." These parameters are similar to those of our own "V2" UCC plan discussed above.

The basic version of UCC that Liu considers leaves Medicaid and Medicare intact and covers everyone who does not participate in either of those programs. It completely replaces all employer-sponsored insurance. The share of health care costs not borne by employers is recaptured through premiums and taxes.

Liu estimates that under her basic UCC plan, total federal expenditures on health care would be \$648 billion higher in 2017 than expenditures under the ACA. Of that increase, \$524 billion would be covered by revenue from the dedicated tax/premium. The remainder would be slightly more than offset by increased revenue from income and payroll taxes due to the elimination of the deduction for employer-sponsored insurance. As a result, the net impact of the basic UCC plan on the federal budget would be a saving of \$40 billion.

The UCC plans described in this section offer protection against the most ruinous medical bills, but they still leave health care as a major expense for middle-class families who experience medical bills high enough to put them at the out-of-pocket maximum. Consider a married couple with total income

---

<sup>29</sup> Liu, Jodi L. "Exploring Single Payer Alternatives for Health Care Reform." (2016) [https://www.rand.org/pubs/rgs\\_dissertations/RGSD375.html](https://www.rand.org/pubs/rgs_dissertations/RGSD375.html)

<sup>30</sup> Hagopian, Kip and Dana Goldman. "The Health Insurance Solution." (Fall 2012) <https://www.nationalaffairs.com/publications/detail/the-health-insurance-solution>

of \$64,000, roughly 400 percent of the federal poverty level. UCC plan V1, described above, would require the family to pay up to \$12,000, or 19 percent of their total income, in out-of-pocket costs. Their expenses under plan V2 would be about the same, although more of that would be in the form of a premium and less would be out of pocket. Under Liu's version of UCC, total health care costs for the same family would come to about 16 percent of household income.

Even those expenses seem moderate compared with what the same family, who would not be eligible for subsidies, would face under the ACA. For 2017, the average family premium was over \$8,000 a year,<sup>31</sup> with an out-of-pocket maximum of more than \$14,000.<sup>32</sup> The total, \$22,000, would come to 34 percent of household income.

The preceding discussion focuses on a baseline version of UCC that holds the household share of healthcare spending at its current level of 30 percent. In practice, the plan could be made more or less generous. For example, the household share could be reduced by raising taxes in order to increase the government share. However, households would still bear the same costs indirectly, since all taxes are, in one way or another, ultimately borne by real people.

Fortunately, there is a better way to make health care more affordable to households: Attack excessive health care spending directly, as explained in the next section.

## Further Cost-savings Strategies

The large gap between per capita health care spending in the United States and that of other high-income countries, shown above in Figure 1, leads many reformers to argue that there is room to cut costs while maintaining or improving performance.<sup>33</sup> This section looks at the potential for reducing per

---

<sup>31</sup> eHealthServices, Inc. "How Much Does Obamacare Cost in 2017?" (2017) <https://www.ehealthinsurance.com/resources/affordable-care-act/much-obamacare-cost-2017>

<sup>32</sup> HealthCare.gov. "Out-of-Pocket Maximum/Limit." (2017) <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>

<sup>33</sup> Some observers think that the gap is not as large as it appears to be. For example, the anonymous author of the blog Random Critical Analysis argues that all or at least most of the gap can be explained by high U.S. levels of income and consumption. For a summary of that argument, see Random Critical Analysis, "Why everything you have said about the determinants of health expenditure is wrong in one million charts: a response to Noah Smith." (November 2018)

capita health care costs and the effects of such reductions on the affordability of universal catastrophic coverage.

The discussion is divided into two parts, according to whether the cost-saving measures operate primarily on the demand side or on the supply side of the market. To a large extent, the demand-side measures operate within the cost-sharing zone; that is, the parts of the health care market within which consumers face deductibles, coinsurance, or copays. Those that operate on the supply side, by and large, affect the entire market for health care services.

### **Demand-side savings**

The cost-sharing zone includes everyone except the very poor and the very sick, who receive first-dollar coverage, at the margin, for their medical expenses. As discussed previously, cost-sharing creates an incentive to spend less on health care, but economic incentives alone are not enough to ensure that consumers will choose wisely. Instead, studies indicate that many of them indiscriminately reduce spending on both appropriate and inappropriate care. The challenge for market reformers, then, is to create an environment in which consumers will not only choose to spend less, but to demand better quality for their money.

Properly designed supplemental insurance could be part of the solution, but not just any kind of insurance. Policies that simply covered UCC deductibles, coinsurance, and copays in full would actually undermine incentives for cost-saving consumer behavior. However, a competitive market for supplemental coverage could favor innovative policies that discouraged wasteful spending and incentivized better consumer choice. For example, insurers might offer features like value-based insurance design, concierge services to help consumers identify the best providers, or reference pricing. Policies that induced better choices for the money spent should ultimately attract more customers and prove both more effective and more profitable.

To produce that result, the supplemental insurance market should be lightly regulated. Obviously, a combination of regulations and common-law remedies should be in place to discourage fraud, false advertising, and failure to meet contractual obligations, but there would be little need to regulate

---

<https://randomcriticalanalysis.com/2018/11/19/why-everything-you-know-about-healthcare-is-wrong-in-one-million-charts-a-response-to-noah-smith/>

things like specific procedures or conditions to be covered, caps on coverage, renewability, and the like. After all, even consumers who chose to spend their money on unsatisfactory supplemental policies would face neither financial nor medical catastrophe. If their supplemental insurance did not pay for needed services, their underlying catastrophic coverage would do so once their income-based cost-sharing obligations were met. The remedy for consumers who purchased unsatisfactory supplemental policies would be to try something different in the future.

Supplemental insurance is not the only option that would emerge to help consumers manage their deductibles, coinsurance, and copays. Health savings accounts and health sharing organizations would also be available, not to mention the possibility that entirely new forms of protection might emerge.

### Supply-side measures

Other cost-saving measures are not specific to the market zone. They would apply to all consumers, whether they have reached their out-of-pocket maximums or not. A systematic treatment of the full range of potential cost-saving measures is beyond the scope of this report, but here are some frequently proposed examples:

*Supply of practitioners:* Education of physicians in the United States is dominated by professional associations that are seen by many as defending the interests of practitioners at the expense of consumers. Problems include inadequate numbers of places in medical schools, excessively long courses of training, and the wrong mix of specialists and generalists. More flexibility in substituting services of nurse practitioners and physician assistants for those of M.D.s is another possible way of easing supply restrictions.<sup>34</sup> Making it easier to attract foreign-trained doctors is still another proposal.<sup>35</sup>

*Provider incentives:* Many reformers see the traditional fee-for-service system as biased toward overuse of tests, procedures, and medications that are unnecessary or not cost-effective. Alternatives include bundled payments, value-based care that pays providers according to outcomes rather than inputs, and independent panels to screen treatments for cost-effectiveness.

---

<sup>34</sup> Flier, Jeffrey, and Jared Rhoads. "The U.S. Health Provider Workforce." (Feb. 2018)  
<https://www.mercatus.org/publications/us-health-provider-workforce>

<sup>35</sup> Peak, Sam. "Foreign Doctors Will Heal America, If Congress Lets Them." (Nov. 2018)  
<https://niskanencenter.org/blog/foreign-doctors-will-heal-america-if-congress-lets-them/>

*Reform of patent law:* The application of patent law to the pharmaceutical industry is another potential area for reform. Patent law is supposed to strike a balance between temporary monopoly as an incentive for innovation and the need for competition to keep prices at a reasonable level. Critics see the current U.S. patent system as excessively biased toward the former objective.<sup>36</sup>

*Administrative expenses:* As noted earlier, administrative expenses are higher in the U.S. health system than in most other high-income countries. Excessive fragmentation of the payments system is a big part of the problem. Even without going all the way to a single-payer system, a move to UCC could greatly reduce this problem.

## How Cost-savings Affect UCC Affordability

The overall affordability of UCC is highly sensitive to assumptions about cost-saving. The preceding section discussed two variants of a baseline UCC plan without a premium (V1) and with a premium (V2). The stylized population model was used to estimate the parameters for those two plans subject to the constraint that total nonhousehold costs would be no greater than the 70 percent of total health care spending now paid by government and employer-sponsored insurance. The same approach can be used to estimate how the parameters would change for given assumptions regarding cost-saving. For example:

- ▶ If total spending could be cut by 10 percent, maximum out-of-pocket spending for a no-premium baseline plan could be set at 15 percent of eligible income, rather than the 25 percent of eligible income plan for the V1 variant discussed earlier.
- ▶ For a plan with a premium, a 10 percent spending reduction would make it possible to lower the out-of-pocket maximum to 10 percent of eligible income while reducing the premium to 2 percent, compared to a 15 percent out-of-pocket maximum and a 4 percent premium based the 2017 cost of care.

---

<sup>36</sup> Amin, Tahir. "Patent Abuse is Driving Up Drug Prices." (Dec. 2018) <https://www.statnews.com/2018/12/07/patent-abuse-rising-drug-prices-lantus/>

- ▶ If total spending could be cut by 15 percent, it would be possible to lower the out-of-pocket maximum of a UCC plan to 10 percent of eligible income without requiring any premium.

Such changes would have the effect of narrowing the cost-sharing zone and correspondingly increasing the zone within which household medical costs were covered in full. Market reformers might view such a change as potentially threatening the very market incentives that they see as playing a key role in reducing costs in the first place.

Accordingly, market reformers might advocate using any cost-savings to reduce the budgetary cost of a UCC program without changing the out-of-pocket maximum or premium (if any). Instead of preserving the baseline 30/70 division of health care spending between household and nonhousehold sources, the percentage share (but not a greater absolute total) of spending would shift toward households as overall health care costs declined.

“With a robust cost-saving package, UCC could both reduce consumer outlays on health care and realize savings for the federal budget.”

For illustration, suppose we begin with a V1-type program with no premium and an out-of-pocket maximum of 25 percent of eligible household income. If we then applied a 10 percent saving in overall health care costs entirely to the nonhousehold share, nonhousehold costs would fall by the ratio of  $(70-10)/70$ , or by a little over 14 percent. The cost-sharing zone would increase as a proportion of total spending, but not in absolute terms.

Finally, any cost-savings could be applied in a way that maintained the relative sizes of the cost-sharing and full coverage zones. That would make it possible both to reduce the out-of-pocket maximum borne by households and at the same time reduce the government share of total medical expenses.

Liu’s study for RAND confirms the importance of additional cost-savings for the affordability of UCC. She estimates that the inherent features of UCC, such as changes in demand induced by higher deductibles, would cut \$211 billion, or almost 9 percent, from estimated 2017 health care spending of \$2,438

billion. She then explores further potential savings, including lower administrative costs for insurers and providers and negotiation of lower prices. Based on the midpoint of a range of cost-savings estimates, those measures could cut an additional \$556 billion, or 23 percent, from national spending.

Liu's analysis allocates all of those savings to the federal budget. As a result, net federal health care outlays, taking into account both changes in federal spending and revenue from premiums and taxes, would decrease by \$596 billion relative to their estimated levels under the ACA.

Alternatively, we can rework Liu's results to reflect the assumption, made in our earlier estimates that all cost-savings accrue to households. It turns out that Liu's estimate of \$556 billion in cost-savings is very close to the estimated \$524 billion of revenue that would be raised by the premium included in her version of UCC. Consequently, the projected cost-savings could be moved from the budget to the household sector simply by eliminating the premium. Doing so would still leave a \$32 billion reduction in government spending.

In summary, both our estimates from the stylized population model and the different methodology used by Liu in her RAND study suggest that, even in the absence of additional cost-saving measures, a baseline version of UCC could be implemented without increasing total spending by households, government, or employers. With a robust cost-saving package, UCC could both reduce consumer outlays on health care and realize savings for the federal budget.

## Transition Options

Up to this point, we have discussed the characteristics of a fully implemented UCC plan that would replace many of the interlocking parts of the current health care payment system. This section turns briefly to some of the economic and political choices regarding in the transition from here to there.

### **Who should administer UCC?**

In principle, UCC could be administered in a variety of ways, with more or less centralization and with a smaller or greater role for the private sector.

A centralized variant could be administered by an entirely new federal agency, but it would make more sense to build UCC on the framework of the largest component of the current system, the Centers for Medicare and Medicaid Services (CMS). Conceptually, Medicare could be converted to a UCC system simply by removing age limitations and adjusting the schedule of premiums, out-of-pocket costs, and other parameters as appropriate.

In that case, UCC policies could be issued automatically by CMS to everyone eligible for the program at the time of its inception and, after that, to children at birth. It would be up to Congress to decide how to treat noncitizens. (In practice, even countries that offer free universal coverage to citizens usually only offer a restricted range of services to visitors and migrants.)

Even with automatic enrollment, it would be possible to offer the right to opt out of UCC. Opt-outs based on religious belief could be allowed, as they are, for example, in The Netherlands, but it is likely that relatively few people would take that choice. A more general issue is whether consumers and providers should be allowed to opt out because they prefer purely private health insurance rather than a public payer.

One possibility would be to allow the emergence of a separate, private health care system but to segregate it from governmental UCC both with regards to consumers and providers. The British system provides such a model. Private providers are allowed to offer services and consumers to purchase them, but consumers are not entirely free to mix and match, taking what they like from National Health Care and supplementing that with private services.

Sec. 303 of Sanders' Senate version of Medicare for All, "Use of Private Contracts," takes such an approach.<sup>37</sup> It gives providers the choice of entering into private contracts with patients, but those contracts must be all or nothing. A provider cannot accept the standard reimbursement for a treatment from the government and then collect an additional fee from the patient for the same treatment. Under either the British or the Sanders version, no subsidies would be offered for private care. In the UK, private medicine reportedly accounts for about 8 percent of the market, so something similar might be expected in the United States.

---

<sup>37</sup> U.S. Congress. S-1804 "Medicare for All Act of 2017". (Sept. 2017) <https://www.congress.gov/bill/115th-congress/senate-bill/1804/text>

A broader form of opt-out could follow the example of the existing Medicare Advantage program. Under a hypothetical UCC Advantage option, consumers could choose to purchase coverage from a private insurance company rather than take the CMS version. Purchase of such coverage would be subsidized in an actuarially fair manner. UCC Advantage policies would be more tightly regulated than private supplemental policies to ensure that companies do not enter the market with the intent of offering coverage advertised as equivalent to basic UCC but without delivering on that promise. In view of the fact that about half of all seniors currently choose Medicare Advantage, a UCC Advantage option might be taken up rather widely.

### **Transition issues for Medicare**

Regardless of whether UCC is administered by CMS or some other agency, the transition will create issues for at least some current Medicare beneficiaries. In particular, high-income seniors would face higher out-of-pocket maximums than at present. One way to deal with that would be to specify a separate out-of-pocket maximum, regardless of income, for everyone above a certain age.

Another possibility would be to allow current beneficiaries to choose to remain on traditional Medicare or their current Medicare Advantage policies, while specifying that everyone born after a certain date would be moved immediately to UCC and continue on it as they aged.

Conceptually, it would be possible to leave the current version of Medicare permanently in place for all seniors and introduce UCC only for those below the age of eligibility. In practice, however, such a proposal would probably meet resistance. Although out-of-pocket costs would rise under UCC for some high-income beneficiaries, the sum of premiums and out-of-pocket costs would be lower under UCC for many with moderate incomes. Also, UCC would have no lifetime caps on hospital stays, so there would be no need to buy supplemental insurance to cover that particular risk.

Finally, UCC would simplify coverage by unifying Medicare Parts A (hospitalization), B (outpatient services), and D (prescription drugs). The idea of putting large numbers of people in a position such that their cost of health care suddenly increased on reaching the Medicare age limit, rather than decreasing, as it does now, seems both politically and economically unattractive.

### Transition issues for Medicaid

From a conceptual point of view, replacing Medicaid with UCC might seem like the easiest part of the transition, since both provide full first-dollar coverage, without a premium, to households below a low-income threshold. In practice, though, there are major differences between the two programs.

One challenge would be dealing with the role that states now play in the administration and funding of Medicaid. Some formula would have to be devised so that neither state nor federal budgets experienced unreasonable windfalls or additional burdens. It is possible that states might be allowed, at their own expense, to offer improvements on the national UCC package, for example, by raising the low-income threshold or enlarging the package of exempt preventative care. However, any such variations should be kept under control in the interests of maintaining full state-to-state portability of coverage.

Another issue is that Medicaid, as it now exists, is not universal. Some people, despite low incomes, are excluded from coverage by work requirements, lock-out periods, and other administrative. Such restrictions on coverage would be inconsistent with UCC's promise of universality.

A third issue concerns coverage of long-term care. Although UCC could, in principle, be extended to cover long-term care, this Policy Essay has assumed long-term care would be left to a separate program. In that case, the part of Medicaid devoted to long-term care would need to remain, in place, at least for the time being. It is possible that federalizing Medicaid for the poor while leaving states responsible for long-term care would be a way of disentangling federal and state financial responsibilities.

The switch from Medicaid to UCC should also disentangle health care coverage from Social Security disability payments. With UCC in place, there would no longer be a need for the disabled to submit to the administrative hassles and work restrictions of SSI disability for the sole reason of obtaining health care coverage under Medicaid. The disabled would receive UCC just like everyone else.

The potential political and administrative difficulties of making the switch to UCC might tempt some to leave Medicaid as it is for low-income households while enacting UCC only for households who are above the low-income

threshold. However, such a policy would have serious disadvantages. The kind of UCC described in this brief would clearly be more attractive to many beneficiaries than the current version of Medicaid. In addition to work requirements, lock-out periods, and other administrative restrictions, there is the problem that low Medicaid reimbursement rates often make it harder for beneficiaries to find willing providers than it is for those covered by other forms of private and public health insurance.

Today, Medicaid recipients notoriously face an “earnings cliff,” as a result of which the good fortune of an increase in earnings can result in termination of coverage. Introducing UCC for those above the threshold while leaving those below it on Medicaid would produce a “reverse cliff” in which the misfortune of a decrease in earnings would be compounded by the switch to an inferior form of coverage, or none at all in states where work requirements, lock-out periods, or other penalties are in force. The existing Medicaid cliff is already problem enough for the many people whose earnings cycle back and forth across the eligibility threshold from season to season or year to year. A reverse cliff would create an even greater problem for households with incomes that are both low and irregular.

### **Employer-sponsored insurance**

Close to half of all Americans receive health insurance coverage through their jobs. In no other major country is health care coverage tied as closely to employment as in the United States. American-style ESHI has several major unintended consequences.<sup>38</sup>

One problem is “job-lock” — the reluctance of many workers to move to a more suitable job, to become self-employed, or to start one’s own business for fear of losing insurance coverage. Even in other countries like Germany where employers play a role in health insurance, special measures exist to ensure that transition from job to job; from a job to self-employment; or from work to nonemployment does not interrupt coverage.

The severe inequity of ESHI is a second problem. Health insurance benefits are tax-deductible, but the deduction is of greater value to people in higher tax brackets. The inequity is amplified by the fact that higher-paid workers are

---

<sup>38</sup> For a full discussion of the problems of employer-sponsored health insurance, see Dolan, Ed. “What’s Wrong with Employer-Sponsored Health Insurance.” (November 2018) <https://niskanencenter.org/blog/whats-wrong-with-employer-sponsored-health-insurance/>

far more likely to get health benefits to begin with. According to data from the Social Security Administration, fewer than 20 percent of workers in the lowest quintile of the wage distribution get health benefits compared to more than 80 percent in the highest quintile.<sup>39</sup> Robert Kaestner and Darren Lubotsky, economists at the University of Illinois, Chicago, estimate that workers in the bottom fifth of the family income distribution get annual tax benefits of less than \$500 from ESHI, while those in the top fifth get benefits averaging \$4,500. What is more, their data show that the inequity has become worse over time.<sup>40</sup>

A third problem is that the existence of thousands of ESHI plans, some of them quite small, adds to the fragmentation of the U.S. health care system and contributes to high administrative costs.

As discussed earlier, although ESHI is nominally part of the private sector, it is by no means a creature of market forces. Inasmuch as it allows employers to pay a part of their labor cost as tax-deductible health benefits, the tax deductibility serves as an implicit wage subsidy. The benefits of the subsidy are presumably split between employers and employees according to the elasticity of demand for labor in various submarkets and according to the tax status of employees. However, the fact that the carrot of the deduction is backed up by the stick of the employer mandate clouds the picture. Although the mandate is apparently not binding on many employers, where it is binding, it is clear that the cost to employers of offering ESHI outweighs the value of the implicit subsidy. That possibility presumably lies behind the gradual decline in ESHI coverage.

Any way one looks at it, it is hard to see any overall public policy justification for a program that primarily benefits high-wage employees while undermining labor mobility and adding to the fragmentation of the health care payment system. Any serious health care reform proposal should aim to eliminate ESHI once and for all.

However desirable, the transition away from ESHI will not be easy. In part that is because a strong majority of beneficiaries who receive ESHI say they

---

<sup>39</sup>Burtless, Gary and Sveta Milusheva. "Effects of Employer-Sponsored Health Insurance Costs on Social Security Taxable Wages." (2013) <https://www.ssa.gov/policy/docs/ssb/v73n1/v73n1p83.html>

<sup>40</sup> Kaestner, Robert, and Darren Lubotsky. "Health Insurance and Inequality." (Spring 2016) <https://www.aeaweb.org/articles?id=10.1257/jep.30.2.53>

are satisfied with their coverage. In part, that is probably because many workers have little chance of getting other coverage, have no interest in changing jobs, or are on the favored end of the unequal distribution of tax benefits. In part also, it may be because workers do not understand that their cash wages would be likely to rise if EHSI were removed from the cost of labor.

“Workers in the bottom fifth of the family income distribution get annual tax benefits of less than \$500 from ESHI.”

The experience with the ACA shows that reformers need to act cautiously in demanding that people change their health plans. A transition that induced people to move voluntarily onto UCC because they find it attractive would presumably be more politically acceptable than one that pushed people from ESHI to UCC by fiat.

One way to make the transition from EHSI to UCC as voluntary as possible would be to lift the employer mandate, phase out the tax deductibility of EHSI, and allow employees to opt into UCC if they chose. Most lower-paid workers would probably take that option. Employers who wanted to use health care benefits to retain higher-paid employees could offer them supplemental policies to cover out-of-pocket costs, but without the tax deduction. That way many fewer people would be forced to make a change of plans against their will.

Whether voluntary or compulsory, any transition away from EHSI would also have to decide what to do about the 20 percent of national health care costs that are now paid by employers. If ESHI disappeared, to be replaced with UCC, much of what is now spent by employers on health care would be passed through to employees as increase in cash wages, and some, perhaps, to business owners as increased profits. In that case, the federal budget would recapture some of the 20 percent through an increase in income tax revenues.

## The Intellectual Origins of UCC

Universal catastrophic health care coverage is not a new idea. The concept can be traced back at least as far as a proposal made by Martin Feldstein in 1971

for something he called “Major Risk Insurance.”<sup>41</sup> Feldstein was concerned that the prevailing health care system posed risks both of underspending and of overspending on care.

In his view, the risk of underspending was greatest when expenses threatened to become financially ruinous, hence the maximum-liability feature. Overspending, on the other hand, was encouraged by excessively generous first-dollar coverage. His solution was to provide every family with a comprehensive insurance policy that had an annual limit on out-of-pocket expenses that that increased with family income.

Feldstein’s concept, renamed “Maximum Liability Health Insurance,” soon became part of a comprehensive reform of social insurance dubbed the “Mega Proposal.” That proposal was advanced by Elliot Richardson during his tenure as Secretary of Health, Education and Welfare under President Richard Nixon.<sup>42</sup> Richardson and his team added much practical detail to Feldstein’s concept, but their proposal became a casualty of the chaotic demise of the Nixon administration.

The idea of universal catastrophic coverage did not die with the Mega Proposal, however. Milton Friedman was one proponent.<sup>43</sup> Although his version of UCC did not get as much attention as his proposals for a negative income tax or school vouchers, it fit naturally with his support of other forms of market-friendly social insurance. More recently, Kip Hagopian and Dana Goldman have developed a more detailed version of UCC, including specific recommendations for its main parameters.

Looking abroad, the health care system of Singapore appears most closely to resemble UCC.<sup>44</sup> One element of the three-part Singaporean system, Medishield, provides universal coverage for catastrophic expenses. A second part, Medisave, mandates compulsory, income-based contributions to health savings accounts, which can be used to pay out-of-pocket costs not covered by Medishield. A third part, Medifund, pays for services to people whose

---

<sup>41</sup> Feldstein, Martin. “A New Approach to National Health Insurance.” (1971) [https://www.nationalaffairs.com/public\\_interest/detail/a-new-approach-to-national-health-insurance](https://www.nationalaffairs.com/public_interest/detail/a-new-approach-to-national-health-insurance)

<sup>42</sup> For a more detailed discussion of the Mega Proposal, see Dolan, Ed. “From the Nixon Era, a Health Care Proposal Ahead of Its Time.” (February 2018) <https://niskanencenter.org/blog/mega-proposal-maximum-liability-healthcare/>

<sup>43</sup> Friedman, Milton. “How to Cure Health Care.” (March 2001) <https://www.hoover.org/research/how-cure-health-care-0>

<sup>44</sup> Liu, Chang and William Haseltine, “The Singaporean Health Care System.” (nd) <https://international.commonwealthfund.org/countries/singapore/>

incomes are too low to generate significant balances in their Medisave accounts.

## Conclusion

This Policy Essay has sought to present universal catastrophic coverage as a pragmatic way forward for health care reform. Rather than a detailed legislative proposal, it offers a conceptual framework. That framework envisions a robust role for the government as a provider of social insurance to the very poor and very sick while creating a space for the operation of market mechanisms where they have the greatest potential to raise quality and reduce costs. UCC would guarantee universal, affordable access to care and protection against financially ruinous medical expenses while asking those who can afford to do so to pay a fair share of the cost of the services they use. It achieves those objectives by providing full first-dollar coverage to people with very low incomes while setting a scale of income-based premiums and cost sharing on middle- and upper-income households.

The rough cost estimates outlined here suggest that UCC would be affordable even at the current level of health care spending, which, on a per capita basis, is higher in the United States than in any other country. It should be possible to provide a baseline UCC package to the entire population without upsetting the current division of spending among payers — roughly 30 percent from households, 50 percent from government, and 20 percent from employers. UCC would be more affordable still if accompanied by a robust set of cost-saving measures. Implementation of a truly universal plan for affordable, accessible health care would put in place the single most important piece still missing from our system of social insurance.

---

## About the Author

**Edwin G. Dolan** holds a PhD in economics from Yale University. He has taught at Dartmouth College, the University of Chicago, and George Mason University in the United States and in Moscow, Budapest, Prague and Riga, in Europe. He is currently a Senior Fellow at the Niskanen Center.