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Not the Last Word

Not the Last Word: JoeCare: Free Health Insurance Coverage for All

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About 3 years ago, Quicken Loans sponsored The Billion Dollar Bracket Challenge [5]—a contest that promised to award that sum to anyone who could pick all of the winners for every round of the NCAA basketball tournament. Although the probability of accurately predicting the outcome of all 63 games is about one in 9 quintillion—that is to say, the prize had an expected cash value of approximately zero—Quicken needed to assure the public that the winners would be paid. Warren Buffett, America's third richest man, duly provided this guarantee.

I need similar help from Mr. Buffett. I have a plan to give free health insurance to all Americans, but without an underwriter famous for his deep pockets, it won't seem plausible enough to get off the ground. (Don't worry, Mr. Buffett, it won't cost you a penny).

My plan, JoeCare, is simple. It is free and it covers everything, with only one catch: It kicks in only after a USD 20 million annual out-of-pocket deductible is met.

It's not impossible that somebody could make a legitimate claim against this policy—just as somebody might pick the NCAA bracket perfectly. But the odds are about the same.

Mr. Buffett, a staunch Democrat, is not apt to help me here. After all, with JoeCare in place, the loudest defense of the Affordable Care Act (ACA or Obamacare)—namely, that it cut in half the number of uninsured—is instantly silenced. JoeCare, at no cost, reduces the number of uninsured Americans to zero.

Of course JoeCare is preposterous, but if you are unwilling to tag Obamacare with the same label at least with regard to how its supporters count the uninsured, you have not been paying attention.

Consider a person of ordinary means holding a health insurance policy with a USD 3000 deductible. That person is, of course, counted as insured. Nonetheless, because of the high deductible, this person might decline to go to the emergency room after an ankle injury, or try to manage an infected finger at home with hot soaks. In other words, despite being nominally insured, this person might opt to forgo timely care that can prevent a fracture from displacing or an infection from spreading. Even with coverage, the costs may be too daunting. For that reason, JoeCare and Obamacare are awfully alike in terms of the access to healthcare they provide.

Yet JoeCare can do more than help score rhetorical points in a debate about how to count the uninsured. In a less-ludicrous, but only slightly more-expensive form, it could be the basis

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of real progress. Imagine if JoeCare were rechristened, to say, Trumpcare, and the deductible were reduced from USD 20 million to 20% of a person's income. That would provide protection against financial ruin for Americans with some wealth, and provide a grant of free or low-cost healthcare for those without.

The 20% threshold was not chosen randomly: The United States spends about 20% of its gross domestic product on healthcare [4]. The arrangement proposed here is that nobody is asked to pay more than an average share out of pocket; if more is needed, the government will step in.

A new approach to health insurance like this would likely affect providers. In orthopaedics, collections for trauma care would likely rise. On the other hand, it's hard to imagine that people would pay much for treatments (viscosupplementation [13], say) that offer scant benefits. Further, if people are spending their own money, market competition might drive down prices for even highly effective treatments (as was witnessed with laser eye surgery [16], for instance).

I predict that the greatest benefit of having people pay for smaller expenses themselves (with insurance reserved for the big-ticket items) is that it would substantially reduce unnecessary testing. Even if market pressures were to reduce the out-of-pocket expense of an MRI to evaluate back pain to "only" a few hundred dollars, most people, in my view, would still prefer to spend their money on other things. And because the unnecessary MRIs are the gateway to unnecessary treatments, avoiding these scans may offer substantial savings far beyond the cost of the study itself.

Transforming JoeCare into a real program with a realistic deductible couldn't be done for free, of course. Nevertheless, because so many people are already covered by Medicare, and because the current tax preferences given to employer-sponsored health insurance [6] consume USD 260 billion that can be redirected, the additional cost would be small—about what is currently devoted to supporting ObamaCare, I estimate.

It is time now to move the discussion from the meaningless (how many people are insured) to the meaningful (how to improve the quality of healthcare and broaden access to it). My plan will do that. And if Mr. Buffett won't help, perhaps the president, another man of means, might be interested.

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Dr. Bernstein begins his discussion about health insurance with a discussion about gambling, and indeed, his ideas are tantamount to gambling with the lives of the citizens of the United States. The ACA carefully defined what health insurance is and what it isn't. Many would say its definition was too stringent and comprehensive. JoeCare would lead to a higher number of patients being insured, however a large percentage would be underinsured. The rise in underinsured patients will cause delayed healthcare for many, less preventive care, and larger financial challenges for most patients.

It is clear that Dr. Bernstein would like to leave much of America underinsured in order to create a market. The problem is that what he is proposing is only for insurance offered through the exchanges, and it does not change insurance offered through employers or the government (and these two provide most of health insurance in the United States). So even with this change, there would not be a market for healthcare in the true economic sense of a free market. Lastly, the 20% of income co-pay that he envisions would be enough to cause most patients extreme financial hardship.

I agree we need to talk about quality and broad access to the best healthcare. That will not be achieved by eliminating health insurance for 24 million patients, according to the

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Congressional Budget Office. I also agree that a free market would provide better incentives and lower costs, and that the costs of regulation have become too high. The ACA did not effectively deal with these issues, but unfortunately the present Republican Plan does not, either. Orthopaedic surgeons should support the best access to care, and incentives that lead to higher quality with lower costs.

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In 2015, the United States spent USD 3.2 trillion on healthcare—equating to roughly 18% of the nation's Gross Domestic Product (GDP). Dr. Bernstein proposes a new approach for providing universal coverage, arguing that all Americans should have coverage with a deductible that is set at a proportion of income equal to the proportion of GDP the United States spends on healthcare (about 20%).

The proposal has some intuitive appeal; it seems grounded in the idea that everyone should pay a fair share based on his or her income. That idea makes sense—healthcare costs have grown far faster than wages for most Americans—and lower- and middle-income workers have been steadily priced out of our relatively high cost healthcare system. The idea that a family earning USD 50,000 (median household income in the United States) could afford a typical family health insurance plan (roughly USD 17,000 in 2015) is absurd [20]. Therefore, income-based assistance is necessary to make health insurance affordable.

Though the details are scant, Dr. Bernstein proposes that Americans receive free insurance (presumably from the government or with a premium fully paid by the government). However, for the family described above (earning USD 50,000), their insurance plan would have a deductible of USD 10,000 (20% of income). After meeting the deductible, the consumer would have full coverage for all additional medical expenses.

The main benefit of this approach is that it would represent a clear path toward universal coverage if provided to all Americans. However, the approach raises some thorny questions. First, the deductible for many low- and middle-income consumers would represent such a large share of their discretionary income that it would create enormous financial barriers to accessing care. Dr. Bernstein refers in passing to grants for free or low-cost healthcare for consumers without adequate financial resources. But without details, it is hard to know how this might be structured, who would be eligible, and how much help would be provided. The details would matter a great deal. Though he critiques the high deductibles of the ACA, it would seem that the proposed deductibles under his plan would be just as high, if not higher. The discussion also overlooks the cost-sharing assistance lower income consumers receive under the current law.

Second, though high deductibles seem like an appealing idea to reduce the growth of healthcare spending, the reality is that they may not have much of an effect. Most spending in our healthcare system is concentrated on patients who have high cost-acute illnesses and injuries or those with multiple chronic conditions that are simply expensive to manage. Each year, approximately 5% of the population accounts for roughly half of all healthcare spending and 25% account for more than 85% of all healthcare spending. The healthiest 50% account for less than 3% of all healthcare spending [7]. Just one or two exacerbations of a chronic illness leading to hospitalization will result in spending that far exceeds the typical deductible—and the idea of consumerism in this context evaporates.

Third, few families are in a position to withstand a financial shock equivalent to 20 percent of their income [17, 23]. A deductible of this magnitude exceeds most definitions of underinsurance [1]. Even a family earning

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USD 100,000 is likely to struggle a great deal to absorb USD 20,000 in new healthcare expenses in their household budget, particularly if these expenses begin to recur beyond a single year. It's important to not overlook an important role for all types of insurance—financial security.

Dr. Bernstein should be commended for advancing ideas on how our nation can move toward the goal of broader coverage. However, the focus on increased cost-sharing as the primary strategy to address health care spending has its limits and will face stiff opposition from an American public that is looking for less (not more) out-of-pocket spending [10].

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Insurance is not equivalent to access to care. Some insurance plans are not widely accepted by physicians [14], wait times for appointments can be long [19], and as Dr. Bernstein shows, out-of-pocket payments are high enough that they might as well be USD 20 million for many families.

Rising out-of-pocket costs are not limited to Obamacare plans purchased from the insurance marketplaces. In 2016, 83% of employer-sponsored health plans also included a deductible, up from 55% in 2006, and the average deductible increased from USD 584 to USD 1478 over the same period [22]. In comparison, of the four marketplace plans (bronze, silver, gold, and platinum) 97.5% of silver marketplace plans include a deductible, which averaged USD 3064 in 2016 [18]. Silver plans, the most common choice for marketplace shoppers, qualify for both tax credits and cost-sharing subsidies.

We've known for some time that making patients pay for a portion of their healthcare causes them to use less of it [2]. Unfortunately, patients lack the medical training required to know when they can wait and when they should seek care. This is why Obamacare, borrowing from behavioral economics, excluded preventive care from any out-of-pocket costs; doing so makes it less likely that a patient will make a cost calculation that could result in worsening health. Every person has a different threshold for what amount of money is prohibitively expensive and would cause him or her to delay care. A physician might balk, but could probably afford a USD 3064 deductible, while some patients cannot afford even the USD 4 prescriptions at Walmart, which is why JoeCare's plan to limit out-of-pocket costs to 20% of patient income makes sense.

Obamacare did something similar. People earning less than 400% of the federal poverty level (USD 47,550 for an individual in 2017) receive subsidies that decrease their insurance premiums. In addition, people earning up to 250% of the federal poverty level (USD 29,700 for an individual in 2017) receive "cost-sharing reductions," which decrease their deductibles and copayments relative to their income. Approximately 56% of people enrolled in silver marketplace plans received these cost-sharing reductions in 2016 [11].

However, Obamacare did more than just establish a marketplace for high-deductible insurance plans. A third of the decline in the uninsured rate came from Medicaid expansion [3], which does not have any deductibles and has only minimal copayments for individuals earning less than 150% of the federal poverty level [15]. Another quarter of the increase in the insured population came from an expansion of people enrolled in employer-sponsored plans, which have lower deductibles than marketplace plans [3]. Obamacare also mandated that nonprofit hospitals could not bill self-pay patients more than what they typically collect from insurers for the same services [9].

After Obamacare took effect in 2014, the percentage of Americans who were delaying needed healthcare because it was too expensive declined for the first time in over a decade. The rate peaked in 2012 at 43%, but in 2016 was down to 34% [8]. Still, a

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third of Americans today cannot afford all the healthcare they need. We need to continue to build on the trend Obamacare started to make sure everyone in the United States has timely access to affordable care.

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Dr. Bernstein has very astutely and accurately highlighted the paradox in our current healthcare system between coverage and access to healthcare. This has been one of the issues with the ACA—that coverage exists, but the access to care is lacking or insurmountable because of the high deductibles.

JoeCare provides everyone coverage, they just have no access to care unless they are billionaires. Coverage does not equal care. He correctly points out that the ACA, while providing more coverage to millions, has not provided any increased access to care for these millions for several reasons.

The ACA has reduced the number of uninsured Americans by primarily increasing substantially those in the Medicaid program. However, as journalist and policy advisor Avik Roy has pointed out [20], Medicaid is failing those low-income children and adults covered by it. Medicaid provides virtually no access to outpatient specialty care, including in specialties like orthopaedics. Orthopaedists in private practice are challenged caring for Medicaid patients when the reimbursement from the state does not cover the overhead cost of seeing the patient. Furthermore, medical studies point out that Medicaid patients have health status and outcome measures that are no better than uninsured patients.

Our state, which has a USD 1.7 billion deficit for this budget cycle [21], has recently cut hospitals USD 500 million in Medicaid reimbursements, while at the same time, increasing the number of people on Medicaid. This is untenable. Medicaid is not only bankrupting our states, it is bankrupting our country. Boston University economist Laurence J. Kotlikoff [12] testified before Congress in 2015 that our true national debt is over USD 200 trillion, based on the unfunded mandates going forward for Medicaid, Medicare, and Social Security.

Why did the State and US Government become health insurers, covering every encounter, medication, and procedure? Two big failings of the ACA: (1) It doubled down on a failed entitlement program, Medicaid, and (2) it did not lower costs nor provide "affordable" insurance. One reason these failings occurred is the essential requirements of each ACA policy such as pediatric care including dental and vision care. Why should a single person pay for pediatric care as a mandatory part of their insurance policy?

What the American Health Care Act needed was mandatory 1% withholding of payroll into a health savings account for each working American. Someone making USD 25,000 would then have USD 250 in a health savings account. A patient would then have some money to see a physician for that infected finger in the outpatient office. All office encounters with a physician should be a cash transaction, with the cash available in personal health savings accounts. Let doctors compete on the basis of quality care and efficiency. In this way, health insurance becomes catastrophic, more for major health issues like cancer care or myocardial infarction with lower overall costs both for insurance and healthcare.

Americans are a kind and generous people and would want those of limited means to have access to healthcare. This could be achieved through a voucher program (supported by the federal government) that limits the government's liability to cover every encounter. The ideal healthcare system empowers patients to make choices with their own money about the insurance plan and the medical care they actually want.

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