

A Radically Pragmatic Vision for Universal Health Care



When it comes to health care, Americans could not face a clearer choice. Progressives believe all Americans should have access to affordable, high-quality health coverage. Republicans want to kill the Affordable Care Act – thereby depriving an additional 17 million Americans of insurance – and have no credible plan to replace it.

Too often, however, the health care debate focuses on how to pay for health insurance rather than how to deliver better health care. PPI believes producing better outcomes at lower prices must be the first principle of health care reform.

Instead, activists are trying to force Democrats to embrace “Medicare-for-all” as a magic pill for all that ails our health care system. PPI urges progressives to push instead for less disruptive and costly ways to align incentives to spur innovation and improve health care delivery in both the private and public sectors.

We favor a distinctly American architecture for health care reform that combines public and private insurance. Our approach would reward value rather than the volume of medical services provided, expand health coverage to those who have no protection against disease or accident, and modernize our public health programs, Medicaid and Medicare. Here’s how our approach would work:

Reward value not volume

The problem is prices: Over the next decade, the federal government predicts that half of the estimated 5.5 percent average annual growth in health care spending will come from price increases while just a third of the spending growth will come from greater utilization as the huge baby boomer generation ages.¹

Americans pay a lot more for health care that on average isn’t any better and is sometimes worse than what people in other advanced countries get. To push costs down, PPI urges policymakers to set a ceiling on what any out-of-network provider could charge for medical services. Price caps pegged to Medicare payment rates would give all health insurers and providers an incentive to compete on the basis of higher quality rather than more services. It would move private health markets away from fee-for-service medicine to plans that promote prevention and healthier lifestyles.

¹ <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05499>

Get everyone covered

Today, there are **28 million Americans who remain uninsured** and millions more who still cannot afford needed care.

The ACA was a big step toward universal coverage, but health insurance still remains out of reach for millions of Americans. Even if you have insurance, out-of-pocket costs have soared from \$601 in 1970 to \$1,124 per person on average in 2017.²



Out-of-pocket costs are too high

Out-of-pocket costs for those with employer-sponsored coverage have grown from \$601 per person in 1970 to \$1,124 per person on average in 2017.¹ This is in addition to the \$5,547 families pay toward their employer sponsored coverage, on average.³



Those in the individual market are hurting

Those at 400 percent of the federal poverty level (roughly \$49,000 for an individual) pay the full price of the premiums. On average, this means that a 40-year-old making \$50,000 would pay \$340 a month (8 percent of their income) for a low-tiered bronze plan.



Particularly hurt are older Americans

Older enrollees would pay even more: a 60-year-old making \$50,000 would pay 17 percent of their income toward premiums for the average lowest cost plan.⁴

Our plan would:

- Expand public subsidies for middle-income Americans so they can afford coverage
- Insure health plans against the risk of having too many high-cost patients
- Encourage uninsured people to enroll in coverage
- Create a “midlife Medicare buy-in” for Americans aged 55-64.

² In 2017 dollars. https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-health-insurance-represents-a-growing-share-of-total-health-expenditures-particularly-public-programs_2017

³ <https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/>
⁴ <https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/>

Modernize and Simplify Medicaid and Medicare

State Medicaid programs should follow Oregon's promising example and seek federal waivers to experiment with new ways of delivering better care. The state contracted with Coordinated Care Organizations (CCOs), a network of health care providers that includes social services agencies, hospitals, and dentists, to actively manage care for its roughly one million Medicaid beneficiaries. Instead of reimbursing providers for each service rendered to patients, as Medicaid normally does, Oregon's CCOs received a set dollar amount for each patient (risk adjusted). They were encouraged to coordinate with care providers and social service or community organizations to address the patients' needs. PPI's plan would make it easier for states to adopt these accountable care models with capitated growth rates.

CCOs reduced Medicaid cost inflation by two percentage points—from 5.4 percent to 3.4 percent per-member per-month, saving \$1 billion over 5 years.

Additionally, PPI's health reform blueprint would dramatically streamline Medicare by combining Part A (hospital and inpatient) care with Part B (physician and outpatient) and Part D (prescription drug) programs. Beneficiaries would be subject to one set of rules for premiums, deductibles, and co-pays. This would vastly simplify the system for users, while sharpening Medicare's incentives to move away from the antiquated fee-for-service model and deliver better outcomes for patients. Combining Part D plans with Parts A and B allows plans to better manage benefits which improves care. For example, if covering insulin with no co-pays reduces hospitalizations, an integrated health plan would have financial incentive to cover the life-saving drug.⁵ Aligning incentives and allowing for shared savings would reduce patients' likelihood of expensive hospitalizations down the road.

⁵ <https://www.ptcommunity.com/journal/article/full/2012/1/45/how-patient-cost-sharing-trends-affect-adherence-and-outcomes>