VIEWPOINT

Achieving Universal Coverage Without Turning to a Single Payer
Lessons From 3 Other Countries

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The most popular parts of the Affordable Care Act (ACA) are the most expensive. Universal coverage is a top priority not only for Democrats but also for President Trump. Both Republicans and Democrats want to preserve many costly coverage features of the ACA, including those that prevent insurers from precluding people with preexisting conditions and those that eliminate lifetime or annual coverage limits. The challenge is how to preserve these features and make insurance affordable.

A primary obstacle to achieving affordable universal coverage is the high costs of those with diseases or costly traumatic events—approximately 20% of individuals accounting for approximately 80% of health care spending.[1] So, a key question is how to pay for their care.

Some nations in the Organisation for Economic Co-operation and Development (OECD) rely on a governmental single-payer model to achieve universal coverage, but this approach is politically infeasible in the United States. As the United States relies on private-sector insurance, 3 other countries that use private-sector insurance to offer affordable universal coverage provide some potentially helpful lessons.

Paying for Costly Patients

Some advocate creating risk pools for enrollees with preexisting conditions. This strategy removes individuals with high health care costs from the broad pool of enrollees and uses government funds to subsidize their insurance premiums. In turn, the cost of insurance is substantially reduced for the rest of those who are insured.

This strategy, however, requires substantial infusions of funds. In 2016, the costliest 5% of patients younger than 65 years (the age before Medicare begins) accounted for nearly 50% of all expenditures for that age group,[2] yet their insurance premiums can realistically cover only a small fraction of their costs. Accordingly, when states experimented with high-risk pools before the ACA, the costs proved to be unsustainable: net losses for 35 state high-risk pools combined were more than $1.2 billion, or $5510 per enrollee, in 2011.[3] The expenses forced states to limit enrollment in these high-risk pools, leaving out many costly patients. By the time the ACA was implemented, the combined enrollment in 35 state high-risk pools included only about 2% of non–group health insurance participants. By comparison, a recent report estimated that 27% of individuals in the United States younger than 65 years have health conditions "that would likely leave them uninsurable if they applied for individual market coverage under pre-ACA underwriting practices."[4]

If high-risk pools are part of the solution to attaining universal coverage, federal funding is essential. But federal policy makers are unlikely to commit a sufficient amount of funds to make this approach successful. One plan proposes $25 billion in state grants over 10 years to fund high-risk pools, but this sum is likely insufficient considering that insurance companies received $8 billion from the federal government through the ACA in 2014 and 2015 in reinsurance payouts for their costliest ACA patients.[5]

Another strategy to pool costly patients would channel them into Medicare and rely on the federal government as the ultimate risk bearer. But Medicare premiums are artificially controlled by passing some present spending onto future generations. Trustees project Medicare's 75-year total spending in excess of dedicated revenues at $27.9 trillion, and the Centers for Medicare & Medicaid Services Office of the Actuary projects this amount at $36.8 trillion.[6] Adding costly individuals to Medicare would only exacerbate these intergenerational problems.

This leaves a third strategy: the individual mandate—or as the Supreme Court characterized it, an annual tax assessed against individuals who have not purchased qualified health insurance within the calendar year. Although vilified by some, the mandate is attractive for several reasons. It is relatively easy to implement, is effective in pooling risk, and reflects the values of individual responsibility. Coverage is primarily funded by the enrollees rather than by general taxation. For these reasons, some nations that are committed to a private health insurance sector have achieved universal coverage and effective risk pooling by mandating the purchase of insurance.

Examples of the Individual Mandate and Penalties

Switzerland, Singapore, and Germany have achieved universal coverage and made insurance affordable even for their citizens with highest health care costs by instituting an individual mandate. One major difference, however, is that unlike the ACA, the mandates instituted by these countries are reinforced with effective penalties for nonparticipation, thus ensuring that lower-cost enrollees—generally healthier individuals—balance out the costs of the others who require more medical resources.

- In Switzerland, citizens must purchase health insurance. If they do not, government authorities automatically enroll them, selecting the insurance provider on the individuals' behalf. Moreover, insurers can implement debt enforcement proceedings against anyone failing to pay their premiums and collect a penalty in addition to back premiums. The Swiss government subsidizes premium payments for more than a quarter of the population, including retirees who purchase the same insurance as workers.

- Singapore institutes compulsory contributions from employers on behalf of their employees to create medical savings accounts. Employees maintain these accounts for health care expenses such as health and disability insurance premiums, hospitalization, surgery, rehabilitation, end-of-life care, and outpatient services. Those failing to pay their premiums are subject to garnished wages and other legal actions that can force payment of back premiums, penalties, and interest. Unemployed or low-income individuals are eligible for government subsidies that enable them to pay for the premiums.
- In Germany, insurance is funded by compulsory contributions to private insurers levied as 7.3% of income. Unemployed individuals have their contribution taken out of their unemployment benefits coupled with means-based sliding-scale subsidies, and uninsured self-employed persons who later attempt to purchase insurance face payment of back premiums for the period in which they were uninsured.

To be sure, these health care systems differ from that in the United States in other important ways. For instance, all allow individual tax deductions for health insurance expenditures and thus have evolved from an employer-based to a consumer-based system, whereas the United States limits the individual market with constraints on such deductions. In addition, these countries have many more insurers than the United States, and consumers benefit from vigorous competition among them.[7] Germany in 2015, for example, had 124 sickness funds and 42 private health insurance companies, and the average resident of Switzerland in 2011 could choose from 59 health insurers offering coverage, with the 5 largest insurers covering 43% of the population. By comparison, in California, a state with approximately half Germany's population, only 7 firms covered more than 95% of privately insured individuals in 2011, with the 3 largest firms covering 75%. In Massachusetts, with a population slightly smaller than Switzerland's, 3 insurance companies enrolled 79% of individuals with private insurance.

As with the ACA, these nations provide financial support for insurance mandate purchases. Singaporean employers contribute to their employees' medical savings accounts, and German employers match their employees' payroll contributions to insurance premiums.

In sum, health insurance models in Switzerland, Singapore, and Germany suggest that an individual mandate, with adequate subsidies, can achieve affordable universal coverage. But the recipe for their success also includes firm penalties. They also suggest that the ACA's individual mandate failed to pool risk adequately, in large part because its penalties were too weak. In 2014, approximately 7.5 million individuals paid the penalty rather than purchasing insurance, and of the approximately 15 million uninsured people who were ineligible for Medicaid, an estimated 7.1 million would pay a penalty lower than the cost of the least expensive plan.[8] The Internal Revenue Service's recent announcement that, to comply with President Trump's January 20, 2017, executive order rolling back the ACA, it might not pursue individuals who fail to provide evidence of health insurance will further dilute the current individual mandate.[9] Achieving universal coverage, like these 3 nations, requires a more forceful approach.

Conclusions

Although insurance mandates and penalties may seem unattractive, policies that induce citizens to purchase insurance are as old as the republic and as common as the most popular programs. In 1790, President George Washington required that ship owners purchase medical insurance for their seamen, and Medicare has long assessed penalties on healthy people who do not enroll by age 65 years. If the goal is universal health coverage that provides care even for patients with the highest health care costs without relying on public insurance programs, the financial burden must be spread across the whole population. This requires either massive government spending, whether through high-risk pools or Medicare, or requiring individuals to purchase insurance.

It is time to stabilize the premiums of the universal insurance market by neutralizing the political disagreements surrounding the ACA's mandate and penalties. As these 3 countries demonstrate, maintaining the popular aspects of the ACA requires keeping its less popular part, and achieving the stated goal of universal coverage requires a serious commitment to individual responsibility.

ARTICLE INFORMATION

Published Online: February 27, 2017. doi:10.1001/jama.2017.1475

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Herzlinger reported owning shares in some health care firms as part of broad diversified investment portfolios. No other disclosures were reported.

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