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HEALTH CARE FOR AMERICA

A proposal for guaranteed, affordable health care for all Americans building on Medicare and employment-based insurance

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America's $2.2-trillion-a-year medical complex is enormously wasteful, ill-targeted, inefficient, and unfair. The best medical care is extremely good, but the Rube Goldberg system through which that care is financed is extremely bad—and falling apart. One out of three non-elderly Americans spend some time without health insurance every two years, and the majority of those remain uninsured for more than nine months.[1] Meanwhile, runaway health costs have become an increasingly grave threat, not just to the security of family finances, but also to corporate America's bottom line. The United States spends much more as a share of its economy on health care than any other nation, and yet all this spending has failed to buy Americans the one thing that health insurance is supposed to provide: health security.

Health insecurity is not confined to one part of the population. It is experienced by all Americans: those without insurance as well as those who risk losing coverage; those who are impoverished as well as those with higher incomes who experience catastrophic costs; those who are sick or injured as well as those who are just one sickness or injury away from financial calamity. As health care costs have skyrocketed and the proportion of Americans with stable benefits has eroded, health insecurity has become a shared American experience, felt by those who thought they had it made as well as those just struggling to get by.

This growing problem is pushing health care reform back onto the agenda of American politics after more than a decade of neglect. And yet, nothing guarantees that this debate will end differently than previous battles. Again and again in the 20th century—most recently, in the early 1990s—efforts to make health insurance an integral piece of the American social fabric were stymied. The stakes are too high to allow reform to be blocked again. America's economy,

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the finances of its middle class, the quality of its medical care, and the health of its citizens all hang in the balance.

To avoid the dismal fate of previous reform campaigns, a successful agenda must take seriously the political constraints and organizational realities that have hamstrung reform efforts in the past. Limits on public budgets, resistance to measures that might be seen as taking away what Americans already have, and the embedded realities of the present system all stand squarely in the path of grand policy redesigns—from single-payer national health insurance, to individual mandates requiring that everyone purchase private coverage, to a universe of individualized Health Savings Accounts. Instead, the most promising route forward is to build on the most popular elements of the present structure—Medicare and employment-based health insurance for well-compensated workers—through a series of large-scale changes that are straightforward, politically doable, self-reinforcing, and guaranteed to produce expanded health security.

A true guarantee of affordable health care

Health Care for America embodies this strategy.[2] It would extend insurance to all non-elderly Americans through a new Medicare-like program and workplace health insurance, while creating an effective framework for controlling medical costs and improving health outcomes to guarantee affordable, quality care to all. It is at once comprehensive, realistic, consistent with American values and beliefs, and grounded in the best elements of the present system. It combines employer and personal responsibility with a strong public commitment to ensuring that American workers and their families and American employers can afford coverage. It promises better care, lower costs, more choice, healthier citizens, and immensely stronger guarantees for workers and their families. And it promises real savings for employers and state governments—without unraveling existing sources of health security, without forcing workers to obtain coverage on their own, and without pressuring patients into Health Savings Accounts or tightly managed health maintenance organizations (HMOs).

What Health Care for America would do is simple: every legal resident of the United States who lacks access to Medicare or good workplace coverage would be able to buy into the "Health Care for America Plan," a new public insurance pool modeled after Medicare. This new program would team up with Medicare to bargain for lower prices and upgrade the quality of care so that every enrollee would have access to either an affordable Medicare-like plan with free choice of providers or to a selection of comprehensive private plans.

At the same time, employers would be asked to either provide coverage as good as this new plan or, failing that, make a relatively modest payroll-based contribution to the Health Care for America Plan to help finance coverage for their workers. At a stroke, then, no one with a direct or family tie to the workforce would remain uninsured. The self-employed could buy into the plan by paying the same payroll-based contribution; those without workplace ties would be able to buy into Health Care for America by paying an income-related premium. The states would be given powerful incentives to enroll any remaining uninsured.

Equally important is what Health Care for America would *not* do. It would not eliminate private employment-based insurance. It would not allow employers to retreat from the financing of a reasonable share of the cost of health insurance. It would not leave Americans coping with ever-higher private insurance premiums with an inadequate voucher, or pressure them to enroll in HMOs that do not cover care from the doctors they know and trust. It would not break up the large insurance groups in the public and private sectors that are best capable of pooling risks today. And it certainly would not encourage individualized Health Savings Accounts that threaten to further fragment the insurance market and leave Americans even less protected against medical costs. Instead, Health Care for America would preserve what works in American health financing and replace what does not—through a simple yet comprehensive strategy that holds out the best promise of controlling costs, improving quality, and guaranteeing health security.

Health Care for America is not single payer—a vision that, for both political and budgetary reasons, is unlikely to be achieved in the near future. Nonetheless, Health Care for America does embody many of the key virtues of a universal Medicare-like program. At heart, it rests on the time-tested idea of social insurance, the notion that major financial risks should be pooled as widely as possible across rich and poor, healthy and sick, young and old. Health Care for America

would create a large publicly overseen insurance pool that would bargain for lower prices, capitalize on the vast administrative efficiencies of a single insurer, and use its reach and purchasing power to spearhead improvements in the quality and cost-effectiveness of medical care.

Health Care for America also rests on the conviction that the Medicare model has a proven track record—and a huge amount of untapped potential—when it comes to controlling costs and improving care. Sustaining Medicare's vital promise to the aged and disabled does not require abandoning the Medicare model, as critics of the program frequently claim. It requires extending the model to those without secure workplace coverage, filling some of the glaring gaps that remain in Medicare, and allowing the two programs to work jointly to hold down costs and improve the quality of care.

Health Care for America would be good not just for American families, but also for American corporations. It would make it easier for firms to provide coverage on their own by reducing the burden of uncompensated care and the cost to employers of covering workers' employed dependents (because all employers would be required to contribute to the cost of covering their own workers). It would also offer substantial savings to employers that decided to buy into the Health Care for America Plan—an option that many small and low-wage employers would likely seize. Employers that chose to enroll their workers would be free to supplement Health Care for America benefits, allowing them to provide better coverage at a lower cost. Yet, unlike many other approaches promising business savings, this approach would guarantee that every employer either provided good private coverage or enrolled its workers in a broad insurance pool and contributed to its cost.

If one word captures the essence of Health Care for America, it is "guaranteed." Health Care for America would guarantee coverage; it would guarantee a generous package of benefits; it would guarantee greater choice; and it would guarantee real savings and improved quality. The lack of such guarantees is at the heart of health insecurity in the United States today. To fulfill these guarantees, Health Care for America would create a new public–private partnership with powerful built-in incentives to control costs while improving quality. The stakeholders in our crumbling system would forge a new and stronger social contract for the 21st century.

How Health Care for America would provide affordable coverage to all

Health Care for America has just three central elements:

- the new Health Care for America Plan, which would be open to any legal U.S. resident without good workplace coverage;[3]
- a requirement that employers (and the self-employed) either purchase coverage comparable to Health Care for America for all their workers or pay a relatively modest payroll contribution (6% of payroll) to fund Health Care for America coverage for all their employees;
- a requirement that Americans who remain without insurance take responsibility for their and their families' health by purchasing private coverage or buying into the Health Care for America Plan.[4]

The benefits of the Health Care for America Plan would be comprehensive. Besides Medicare benefits, the plan would cover mental health and maternal and child health and include strict limits on total out-of-pocket spending. (Medicare currently lacks such limits, and Health Care for America would authorize a study of how best to incorporate cost-sharing limits into Medicare in the future.) Health Care for America would also provide drug coverage directly, rather than solely through private plans. And it would allow Medicare to provide drug coverage directly on behalf of the elderly and disabled as well. In addition, a new independent Benefits Advisory Commission would be created to determine what both the Health Care for America Plan and Medicare should cover going forward, allowing the harmonization of the two programs' benefits over time. To encourage better health, preventive and well-child care and covered screenings would be provided to all beneficiaries at no out-of-pocket charge.

The Health Care for America Plan would provide extensive assistance to enrollees to help them afford coverage. For those enrolled in the plan at their place of work, anyone whose income was below 200% of the poverty level would pay no additional premiums. (The poverty line in 2006 was roughly $10,000 for an individual and $20,000 for a family of four.) The maximum monthly premium—phased in between 200% and 300% of the poverty level—would be $70 for an individual, $140 for a couple, $130 for a single-parent family, and $200 for all other families.

In sum, every American with a direct or family tie to the workforce—a group that includes more than 80% of the currently uninsured and more than 90% of all non-elderly Americans—would be automatically covered by either private insurance or the Health Care for America Plan.[5] Employers, in turn, would contribute a share of earnings on behalf of every individual or family enrolled in Health Care for America. And Americans with family incomes above 200% of the poverty level who enrolled in Health Care for America through their place of work would pay a monthly premium based on family income, as just detailed.

Non-elderly beneficiaries of Medicaid and S-CHIP (the State Children's Health Insurance Program) would be enrolled in the Health Care for America Plan, either through their employers if working or individually if not. Enrollment in the plan would relieve the states of a significant share of the burden of these programs, providing states with strong incentives to streamline enrollment. To ensure that former Medicaid and S-CHIP beneficiaries received coverage at least as generous as that which they had enjoyed previously, the states would be required to provide wraparound benefits. (States could also elect to pay Health Care for America to provide such wraparound coverage.) Moreover, all low-income enrollees in the Health Care for America Plan would receive cost-sharing subsidies to ensure that co-payments or deductibles did not deter them from seeking necessary care.

For the small share of people without direct or family ties to the workforce and ineligible for Medicaid, S-CHIP, or Medicare, the Health Care for America Plan would be available as an attractive new coverage option. Premiums would again be based on income, ranging from no premium in the case of those with incomes below the poverty line to the average actuarial cost of coverage for all enrollees in Health Care for America in the case of those with incomes above 400% of the poverty level. In other words, Health Care for America would allow higher-income individuals without workplace ties to buy into the program for a premium that did not vary with age, region, or health status (a so-called community-rated premium).

Coverage under the Health Care for America Plan would be continuous and guaranteed. Once an individual or family was enrolled, they would remain covered unless they gained qualified private workplace coverage.

Building on the best aspects of workplace insurance while filling the gaps

Health Care for America capitalizes on the untapped potential of workplace insurance to ensure that virtually everyone has coverage. But while employers would play an important role in making Health Care for America work, they would not be asked to make an open-ended commitment. Most, in fact, would save money under the plan, and employers as a whole would reap substantial savings, especially over time.

While the workplace would be the main conduit of coverage, employers would no longer need to take on the administrative burden of providing insurance themselves. For a relatively modest cost, they could simply enroll their workers in the Health Care for America Plan. Employers enrolling their workers for the first time would be eligible for transitional subsidies that would ensure that no firm faced a substantial new burden.

Even employers that did not take advantage of this cost-saving option would gain immensely. Uncompensated care would all but disappear, bringing down private premiums. (In 2005, annual premium costs for family health insurance provided by private employers were $922 higher due to the cost of care for the uninsured, while premiums for individual coverage were $341 higher.[6]) Health Care for America would also spearhead quality improvement measures that would spill over into private practice, as Medicare's technology standards do now. And since all employers would be required

to contribute to the cost of covering their workers, firms that now cover their workers' employed spouses or domestic partners—a common expense for larger firms—would see their costs drop.[7]

For most workers with good coverage, Health Care for America would change little—besides eliminating the very real threat of *losing* coverage. Employers that provide generous insurance are largely big corporations with high wages, precisely the employers most likely to continue to sponsor tax-favored coverage, rather than pay the payroll-based contribution to enroll their workers in the Health Care for America Plan. Thus, enrollees in the Health Care for America Plan would mostly be current beneficiaries of Medicaid and S-CHIP, low-wage employees, and the working uninsured, as well as early retirees, contingent workers, and the self-employed. All these groups have weak access to employment-based insurance and insecure access to *any* insurance, and all would be vastly better off because of Health Care for America.

To be sure, some employers would be required to upgrade their plans to make them comparable to the Health Care for America Plan. Others might find it cheaper to provide current levels of coverage by enrolling their workers in the Health Care for America Plan and providing supplemental benefits. Nonetheless, detailed estimates based on economic simulations of the plan suggest that roughly half of non-elderly Americans would remain in workplace health insurance, with nearly all of the other half enrolling in the Health Care for America Plan.[8] (A small share of non-elderly Americans covered under TRICARE, the Department of Defense's health care program for members of the uniformed services, their families, and survivors, would be enrolled in neither.) Thus, among working-age Americans and their families, there would be a roughly 50/50 division of enrollment in employment-based coverage and the Health Care for America Plan.

For non-workers ineligible for Medicaid, S-CHIP, or Medicare—including early retirees—states would be required to set up effective enrollment and outreach systems that enrolled people when they sought state assistance or obtained hospital care. States would also be encouraged to subsidize the (community-rated) premiums paid by higher-income non-workers, especially those that were temporarily unemployed. In the case of early retirees, employers could contribute to the cost of the Health Care for American Plan on a tax-free basis. Most employers would find this a much less expensive way of providing retiree coverage, which is currently unraveling due to rising costs.

In sum, Health Care for America would level the playing field, ensuring that every firm made at least a modest contribution to the cost of coverage for every worker. Meanwhile, Americans without ties to the workforce would be enrolled in the Health Care for America Plan through an individual buy-in, through state antipoverty and unemployment insurance programs, or through new efforts to reach the uninsured when they sought medical care without insurance.

Using the Medicare model to contain costs and improve quality

The other side of Health Care for America's pragmatic approach is its commitment to build on the success and potential of Medicare, America's most popular and familiar health program. For millions of Americans who are now uninsured or lack secure or affordable workplace coverage, the Health Care for America Plan would be an extremely attractive option. Through it, roughly half of non-elderly Americans would have access to a good public insurance plan with free choice of providers. At the same time, the Health Care for America Plan would give enrollees access to a range of high-quality comprehensive health plans that would offer broad, easily comparable benefits.

A single national insurance pool covering nearly half the population would create huge administrative efficiencies. Medicare's administrative costs amount to roughly 2% of total program spending, compared with 14%, on average, in the private sector.[9]

Because Medicare and the Health Care for America Plan would bargain jointly for lower prices and join forces to improve quality, they would have enormous combined leverage to hold down costs. Cross-national evidence and the historical experience of Medicare show conclusively that concentrated purchasing power is by far the most effective means by which to restrain the price of medical services (see the accompanying box on the cost-control advantages of Medi-

EVIDENCE ON THE COST CONTROL ADVANTAGES OF A SIZABLE MEDICARE-LIKE PLAN

Despite Medicare's older and less healthy population, "Medicare's per enrollee spending has grown at a rate that is about 1 percentage point lower than for private insurance over the 1970-2002 period," and these "[d]ifferences have been more pronounced since 1985." (Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington, D.C.: MedPAC, 2005.)

The United States has not contained costs (public and private) as effectively as nations with broader public coverage. As the *OECD Observer* notes (March 6, 2004): "U.S. health expenditure grew 2.3 times faster than GDP, rising from 13% in 1997 to 14.6% in 2002. Across other OECD countries, health expenditure outpaced economic growth by 1.7 times." According to *OECD Health Data 2006* (Paris: OECD, October 2006), between 1985 and 2004 health spending as a share of the economy increased by more than 51% in the United States—from 10.1% of GDP to 15.3%—compared with an average increase of 34% in the other affluent OECD nations to 9.4% of GDP. The same report also shows that the United States continues to have the highest per capita health care spending among industrialized countries. In 2004, U.S. spending per capita ($6,102, adjusted for purchasing power parity) was more than two times the median for affluent OECD countries ($2,961). (These calculations exclude Korea, Mexico, Hungary, Poland, Turkey, and the Czech and Slovak republics.)

What accounts for these stark differences? According to a study published in the May/June 2006 issue of *Health Affairs* (Anderson et al., "Health Care Spending and Use of Information Technology in OECD Countries," as summarized at www.cmwf.org/usr_doc/Anderson_hltcarespendinfotechOECD_itl.pdf), "Higher prices, not higher utilization or resources, appear to be the main driver [of higher U.S. spending]. More spending does not translate into more services. In 2003, the U.S. had fewer physicians, nurses, and hospital beds than the median OECD country. And while the U.S. adopts many clinical technologies earlier than other nations, ultimately it does not make them more widely available, nor does it always provide the most sophisticated procedures compared with other countries."

Indeed, in a recent report ("U.S. Health System Performance: A National Scorecard" (Schoen et al., *Health Affairs*, web exclusive, 2006)), the United States comes up short on key health indicators, including "deaths before age seventy-five from conditions that are at least partially preventable or modifiable with timely and effective health care. The United States ranked fifteenth out of nineteen countries on this indicator as of 1998….The United States ranked last on infant mortality out of twenty-three industrialized countries as of 2002." In 2002, the Institute of Medicine estimated that lack of health insurance causes roughly 18,000 unnecessary deaths each year among working-age adults in the United States. (*Care Without Coverage: Too Little, Too Late*, Washington, D.C.: The National Academies Press).

However, according to *OECD Health Data 2006*, the United States is slightly above the OECD average when it comes to life expectancy at age 65—which may reflect in part the universal, guaranteed coverage provided by Medicare to America's elderly.

care-like plans). Other nations spend much less for the same medical services than we do because their insurance systems bargain for lower prices. And though Medicare covers less than a seventh of the U.S. population, it has still controlled costs substantially better than the private sector, especially since the introduction of payment controls in the mid-1980s.

To ensure that bargaining for lower prices does not come at the expense of high-quality care, Medicare and Health Care for America would also team up to monitor and improve the quality of care by applying the positive models already

developed or under development within Medicare and in the increasingly successful Military Health System. Using the extensive database of patient experiences it could amass, Medicare and Health Care for America would come up with guidelines for best practices, create new funding streams for the coordinated treatment of chronic medical conditions, provide comparative quality information about individual providers and medical institutions, encourage prevention and screening, and carefully assess the effectiveness of new medical technology. These innovations would be made available to private payers, and, as they do today, many would likely follow the lead of the public insurance pool in its coverage and payment decisions.

The Health Care for America proposal promises to restrain costs not just because it creates a large public insurance pool. The structure of the proposal also ensures that the sector best able to control costs is rewarded with additional patients over time. Because employers covering approximately half of workers would continue to provide private insurance, employers and insurers would be free to experiment with their own cost-control strategies, so long as these strategies did not involve cutting benefits or shifting more costs onto workers. And if employers and insurers effectively held down costs, then private insurance would become increasingly attractive in comparison with the Health Care for America Plan. If, by contrast, private premiums were not kept in line, an increasing share of employers would enroll their workers in the Health Care for America Plan.

Thus, rather than a constant tug of war, Health Care for America would create a constructive public–private dynamic that would reward the sector best able to control costs—and without holding the health security of ordinary Americans in the balance.

Health Care for America's realistic financing

Health Care for America would require new federal spending. But because the majority of workers who now have employment-based coverage would retain private workplace insurance when the new Health Care for America Plan was in place, federal spending would be much lower than it would be under a universal Medicare plan. Furthermore, most of the necessary financing would come from those benefiting directly from the new Health Care for America Plan—namely, from employers that make the payroll-based contribution for guaranteed health insurance for their workers and from higher-income individuals who pay income-related premiums when enrolling in the Health Care for America Plan.

A good deal of the additional financing would come from the reduction of federal spending for S-CHIP and Medicaid, and from the redirection of current state spending on these programs. (Despite requiring that the states continue to contribute to the cost of public health insurance, this proposal would still provide substantial savings to the states.) In addition, the movement of workers from tax-favored private coverage into Health Care for America would reduce federal tax subsidies for employment-based insurance. And payroll and income tax receipts would rise due to the substitution of wages for health benefits among firms that pay less for insurance than they would have without reform.

The remaining federal costs could be financed by various combinations of liquor and tobacco taxes and other dedicated levies and general revenues. Past estimates suggest that this approach has a relatively modest net federal cost compared with other comprehensive proposals, many of which would cover fewer Americans.[10] Moreover, Health Care for America requires much less new tax financing (even including the payroll-based contribution) than a single-payer proposal.

The main reason why Health Care for America is comparatively inexpensive is that higher-wage and larger employers would continue to offer qualified coverage privately. For large employers with higher payrolls, private employment-based coverage would remain a good deal—especially since this proposal would not eliminate the tax-favored status of private coverage. For employers not enjoying the administrative economies of large-group purchase or with lower payrolls, the Health Care for America Plan would be the better option. Thus, most of the new federal spending would be targeted on those firms and workers least capable of providing or obtaining insurance today.

Because an employer's size and payroll would be the main determinants of whether firms would benefit from enrolling their workers in the Health Care for America Plan, there is limited reason to worry about "adverse selection"—that

is, the disproportionate enrollment of high-risk workforces in the Health Care for America Plan. Lower-wage workers and the currently uninsured—the two main groups enrolled in the Health Care for America Plan—differ little from the rest of the population in their basic health characteristics overall.[11] While some degree of adverse selection is unavoidable, the Health Care for America Plan would be such a large pool enrolling such a substantial share of the population that it should have little problem spreading this small amount of extra risk.

Finally, and most important, Health Care for America promises substantial cost savings over time for employers, individuals, states, and the federal government. By bargaining for lower prices and encouraging cost-effective care, the Health Care for America Plan—working with Medicare—provides the best realistic hope for finally bringing American health spending under control.

Not only would the Health Care for America Plan reap the rewards of these efforts, so too would Medicare. The serious cost pressures on Medicare—driven overwhelmingly by general medical inflation rather than the aging of the population—have led to calls for restructuring the program in ways that would leave its beneficiaries ever more at risk. Health Care for America represents a different bargain: Medicare beneficiaries and younger workers would be united through a new social compact that extends Medicare-like coverage across the generational divide to ensure health security, improve medical quality, and better control costs.

Why Health Care for America is what Americans want

Americans are ready for a bold proposal for change like Health Care for America. Most believe the present system is broken, and most are willing to support fundamental change even if it means new taxes or an enhanced government role. Americans do not believe they should be on their own when it comes to health care. They want employers to remain in the game, and they are skeptical of measures, such as Health Savings Accounts, that would shift more costs and risks onto them. Overwhelming majorities of *insured* Americans worry that they won't be able to afford care in the future, and a substantial majority of those who currently have insurance fear losing coverage altogether.[12]

An innovative public opinion project sponsored by the Herndon Alliance has examined Americans' core values with regard to health reform (for more, see the box on public opinion and health reform). It finds that Americans want a proposal that guarantees standard health benefits from a choice of public or private coverage. Guaranteed coverage, good standard benefits, shared responsibility and risk, and a choice between public and private plans are all key elements of the Health Care for America Plan.

Other surveys indicate that a Medicare-like program covering all Americans beats the current system hands down. However, Americans are even more receptive to a mandate on employers to provide coverage—the most popular reform option in most polls.[13] In a poll done after the 2006 election, among those wanting to expand health care coverage the two most popular options were an employer mandate (44%) and an expansion of existing public programs (32%)—the twin foundations of Health Care for America.[14]

Health Care for America respects these longstanding views. It requires that employers insure their workers, but provides employers with the Health Care for America Plan as a modestly priced option through which their workers can obtain insurance, thus ensuring that this requirement is not unduly burdensome.

Health Care for America also responds directly to two other key elements of public opinion. First, most Americans do not recognize the full extent to which they pay for health care through forgone cash wages and the revenue cost of health care tax breaks. Rather than suddenly confront Americans with these huge hidden costs (a political nonstarter proposed by both Medicare for All plans and individual mandate initiatives), Health Care for America would largely preserve the current division of employer and individual responsibility, while nonetheless delivering major savings to business.

Second, and no less important, Americans remain extremely wary of tightly managed health plans like HMOs, which have not only lost out in the market but have also been the target of political backlashes nationwide.[15] And yet, nearly all proposals relying on private plan competition rely for much of their savings on the rapid further movement

PUBLIC OPINION AND HEALTH REFORM: THE HERNDON ALLIANCE'S FINDINGS

Over the past year, an innovative research project has examined American public opinion about health care reform, with a particular focus on the Health Care for America approach. The goal of the project, coordinated by a consortium of organizations called the Herndon Alliance, is to develop new strategic initiatives that can attract the enthusiasm of voters who traditionally support reform as well as the swing constituencies whose support will be most contested in any political battle. Combining the distinctive approaches of two established firms, American Environics and Lake Research Partners, the effort marries sophisticated social values research and the more traditional tools of focus groups and public opinion polls.

The Herndon process developed and tested a strategic initiative that includes the core elements of the Health Care for America proposal. The research found that this approach had very strong support from all voters: 8 on a scale of 10. "Base" voters, defined as those who strongly support the value of universal health care, gave it a 9.1, while three key swing constituencies rated it from 7.8 to 8.0. The study found that this approach was sturdy when voters were presented with some of the expected attacks on it. For example, each swing voter group favored access to a guaranteed affordable health plan and the choice to use a private plan, despite the argument that requiring such a choice will push people into inferior public plans. In addition, respondents expressed only mild concern that choice and quality of health care would decline, less than usually seen with universal health care proposals.

The Herndon Alliance expects to launch a more in-depth look at public opinion about various policy options congruent with the Health Care for America proposal in the coming year.

of Americans into HMO-style plans, with restricted choice of providers. To get this movement underway, these plans would impose substantial penalties on those who want to have a free-choice, comprehensive plan.

Health Care for America does not need to rely on pushing Americans into HMOs. Its savings instead come principally from the ability of Medicare and Health Care for America to bargain jointly for lower prices while upgrading the quality of care. Though the Health Care for America insurance pool would allow Americans to purchase good private plans, all Americans enrolled in the program would be guaranteed a reasonably priced fee-for-service health plan with free choice of providers at no extra cost to them.

To pass the test of public opinion, a reform proposal should be simple, rest on familiar foundations, and not be threatening to those Americans relatively happy with their coverage today. Health Care for America is such a proposal. It contains no complex purchasing pools or complicated new tax credits, no tough new incentives for HMO enrollment, and no unpopular changes in the tax treatment of health benefits. Instead, it builds on the most popular elements of the present system, changing little for most Americans with secure insurance today, except to promise them true health security at last.

A time for vision

Over the last generation, Americans have grown more economically insecure even as the nation's economy has expanded handsomely. In nearly every facet of our economic lives—our jobs, our family finances, our pension plans, and above all our health insurance—risk and responsibility have shifted from the broad shoulders of employers and government onto the fragile backs of American workers and their families. This great risk shift must end, and the place to push back first is health care, the epicenter of economic insecurity in the United States today.[16]

Health Care for America would provide the health security that is sorely lacking, guaranteeing affordable, quality health care to all. Without upending our system, it would create a new framework ensuring that everyone is covered, that risk is spread broadly, and that costs are controlled and quality improved.

Health Care for America is consistent with American values, politically realistic, and based on real-world successes. It draws on the best elements of existing ideas for reform—combining a requirement on employers to insure their workers, a new Medicare-like plan covering tens of millions of Americans, and an individual coverage requirement on those without workplace ties—to create a flexible framework for affordable, quality universal health care that can evolve over time in the right direction for Americans.

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Endnotes

1. Families USA, *One in Three: Nonelderly Americans Without Health Insurance, 2002-2003* (Washington, D.C.: Families USA, 2005), available online at www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf
2. This proposal builds on a plan developed in 2001 for the "Covering America" project sponsored by the Robert Wood Johnson Foundation. Although key features of the proposal have not changed, a number of provisions have been altered or updated. Readers interested in the earlier proposal ("Medicare Plus") and the cost and coverage estimates for this earlier proposal that were produced by the Lewin Group can find them at www.greatriskshift.com/ideas.html.
3. For simplicity, legal U.S. residents are hereafter referred to as "Americans."
4. All Americans would eventually be required to show proof of coverage by attaching a standard insurance verification form to their federal income tax return. Because all workers and their families would be enrolled automatically in either Health Care for America or employer-sponsored plans, the individual mandate would have true significance only for the small share of Americans who both lack ties to the workforce and are currently ineligible for Medicaid or S-CHIP (the State Children's Health Insurance Program). To reach those in this population who do not file tax returns, states would be given powerful incentives to enroll non-workers in Health Care for America. They would also be encouraged to subsidize Health Care for America coverage for the temporarily unemployed, and to establish mechanisms for enrolling the uninsured in Health Care for America when they sought care.
5. The estimate of the share of the non-elderly population with ties to the workforce is drawn from the 2006 Current Population Survey and represents the proportion of non-elderly individuals living in households with positive earnings. The exact share is 94%.
6. Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington, D.C.: Families USA, 2005), available online at www.familiesusa.org/resources/publications/reports/paying-a-premium.html.
7. Firms that do not cover all their workers would be required to pay 6% of payroll for health insurance (with transitional rate reductions available to newly insuring firms). Usually, this payment would fund coverage under the Health Care for America Plan. However, if a firm's worker was insured by another firm, the share of payroll contributed on behalf of that worker would be remitted to the firm sponsoring coverage. The contribution rate would be the same whether workers were full time or part time.
8. These estimates, prepared by the Lewin Group in response to an earlier version of this proposal, are available at http://www.esresearch.org/publications/SheilsLewinall/E-Hacker.pdf.
9. Private administrative costs are taken from National Health Expenditure data, available at www.cms.hhs.gov/NationalHealthExpendData/downloads/nhe2004.zip. Administrative and net costs of private health insurance (including profits) were 14.4% of private insurance payments in 2004. Medicare's administrative costs are calculated from tables II.B1 and III.B1 of the 2006 Medicare Trustees Report, available at www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf. The estimate includes "administrative expenses" from table II.B1 ($6.1 billion) and "fraud and abuse control" costs from table III.B1 ($1.1 billion)—which sum to administrative costs of 2.1% of expenditures ($336.4 billion).
10. As part of the Agenda for Shared Prosperity project, the Economic Policy Institute plans to commission independent estimates of the cost and coverage impact of the Health Care for America proposal.

11. Although some of the uninsured are in poor health (in part because they lack insurance), many are young and inexpensive to insure. Past estimates suggest that the overall costs of uninsured Americans should be about equal to the rest of the population once they are covered. See Alice M. Rivlin, David M. Cutler, and Len M. Nichols, "Cost Estimates: Authors Respond," *Health Affairs Supplement* (Spring 1994), p. 55; P. Anthony Hammond, "Actuarial Memorandum: Premiums in Regional Health Alliances under the Clinton Administration's Proposed Health Security Act," Health Insurance Market Reform, Hearing before the Committee on Finance, United States Senate, 103rd Congress, 2nd Session, 1 February 1994, Washington: U.S. GPO, 1994, pp. 102-4. The same is true of lower-wage workers. They are more likely to have a work-limiting health condition than higher-wage workers but also younger. And the overall incidence of work-limiting health problems even among low-wage workers is less than 10 percent. See Peter Schochet and Anu Rangarajan, *Characteristics of Low-Wage Workers and Their Labor Market Experiences: Evidence from the Mid- to Late 1990s*, Report Prepared by Mathematica Policy Research, Inc., for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, D.C., 2004), available at http://aspe.hhs.gov/hsp/low-wage-workers04/.
12. For a good recent compendium of polls, see Ruy Teixeira, "What the Public Really Wants on Health Care," The Century Foundation, December 4, 2006, available online at http://tcf.org/publications/healthcare/wtprw.healthcare.pdf.
13. In a December 2003 Harvard School of Public Health/Robert Wood Johnson/ICR poll, 76% of respondents supported employers being required to offer a health plan, while 54% supported an individual coverage mandate. See Teixeira (ibid.).
14. Kaiser Family Foundation/Harvard School of Public Health, "The Public's Health Care Agenda for the New Congress and Presidential Campaign," December 2006, available online at www.kff.org/kaiserpolls/upload/7597.pdf. The third option, new tax credits for private insurance, garnered support from 24% of those favoring action.
15. HMO enrollment as a share of all health plan enrollment nearly doubled between 1988 and 1996, but has since fallen dramatically—and in 2005 was only around a third higher than it had been in 1988. Moreover, HMO coverage has shifted away from more tightly managed group and staff model plans toward mixed and open models. See Kaiser Family Foundation, "Trends and Indicators in a Changing Health Care Marketplace," available online at www.kff.org/insurance/7031/index.cfm (visited January 2, 2007).
16. See Jacob S. Hacker, *The Great Risk Shift: The Assault on American Jobs, Families, Health Care, and Retirement—And How You Can Fight Back* (New York: Oxford University Press, 2006).

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