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Equal Healthcare Act: A Brief Review of Health Insurance Programs and how Healthcare Vouchers Ameliorates many Endemic Issues

Miles Pollard
Pepperdine University, miles.pollard@yahoo.com

Equal Healthcare Act

Executive Summary

The US healthcare insurance market is in desperate need of reform. Currently, Americans face an insurance crisis as premiums skyrocket while private providers agglomerate into fewer private insurers. However, publicly run healthcare insurances are not excelling either. Government-run insurance schemes, such as Medicare and Medicaid, are rapidly becoming burdened with citizens either reaching retirement age or becoming unable to afford medical insurance. Current government spending for healthcare has eclipsed $1 trillion dollars a year but does not begin to cover all of the citizenry's medical needs. Therefore, systematic change is needed to address both the oligopolistic private market and the massive cost overruns for government-run healthcare.

When reforming the US healthcare system, the primary evaluative measures included within this paper are (1) fiscal sustainability, (2) equal access to healthcare, (3) addressing government failures, (4) addressing market failures, and (5) political feasibility. While many reform bills have been evaluated to address these concerns, many fail to satisfy all five of these requirements. Firstly, the bill must ensure the insurance schemes remain financially viable both upon immediate passage and well into the future. Secondly, any bill that does not address the unequal access to healthcare is unlikely to garner much support as most champions of reform are primarily concerned with increasing the citizenry's access to healthcare. Next, the bill must address both the inherent structural problems within both government and private markets. Government-run programs tend towards lethargic reactions to market conditions and fiscally unsustainable bloat, while private programs are susceptible to the profit motives and self-serving tendencies of private insurance at the expense of enrollees. Lastly, and perhaps most importantly, any reform bill will need bipartisan support to make it through the House, Senate, and finally past the Presidential Veto. The current inefficient system is best rectified by weaving a complex and systematic alteration of the current healthcare insurance programs that takes all five of these measures into account.

The alternative to the current system presented in this paper is the Equal Healthcare Act (EHA). The EHA creates universal healthcare vouchers that peg their endowment solely to FICA taxes, the taxes currently financing Medicare and Medicaid, for all citizens rather than just the elderly and the poor. These vouchers can be spent on private, nonprofit insurance with the excess held in a healthcare saving account to accrue interest over time. Compared to other reforms to the current healthcare market, the Equal Healthcare Act addresses both the massive cost overruns of the state and the significant proportion of the citizenry who cannot currently afford insurance. Additionally, it reforms the government and private market insurance schemes to realign incentives to serve the enrollees first. However, and perhaps most importantly, the EHA is the only proposal that assuages the concerns of both the political left and right, respectively, as the bill adjusts the private insurance market to serve the enrollee first while controlling government deficit spending on fiscally unsustainable programs.

Introduction to US Healthcare

Before evaluating the current state of US healthcare, an analysis of the earliest formations of US insurance programs will need to be introduced. Initially, itinerant religious practitioners, barber-surgeons, or town doctors provided care to people sometimes in exchange for bartered goods

such as food, precious metals, and occasionally for free if the sick could not pay. Often these early medical professionals had essential religious duties, and many of these healers would be sought out for their medical and religious expertise. As the medical profession became informed of empirical science and modern medical practices, the ability of these doctors to heal, as well as the complexity of the treatment, began to increase. As the 20th century dawned, medicine had become firmly entrenched in empirical testing, and medical marvels such as insulin and penicillin revolutionized the profession. However, the evolution in complexity and the subsequent rising expense of treatments demanded an evolution in payment. No longer would bartered bread or altruism be sufficient to pay for cutting-edge medical treatment. Therefore, the costs of modern medicine incentivized groups to come together to assuage the crippling financial burden an individual may face due to receiving modern medical care. Some nations, like the UK and France, nationalized their medical industry making doctors part of the bureaucracy while other nations, such as the US, left the costs and payment of medical treatment to be solved by smaller groups.

In the US, most of these smaller groups created insurance pools. These pools, either organized under a private company or as a nonprofit, would have enrollees pay a small premium into the pool for safekeeping and investment to be paid out when someone in the pool requires medical attention. Therefore, the risk to a single individual was minimized and prevented an enrollee or their family from becoming destitute due to medical debts. Often, these first pools were organized under large corporations pressured by labor unions for more substantial benefits. However, those who did not receive health insurance through a provider were left to join an insurance pool privately. These private pools were not cheap, and often the poor and elderly could not afford the premiums for coverage. Therefore, the federal government created public insurance pools called Medicare and Medicaid for the elderly and poor, respectively. These programs have provided healthcare to millions of at-risk Americans at the cost of billions of taxpayer dollars, though it still does not cover all citizens without private insurance. Some analysts, like Jackson Hammond and Gordon Gray at the American Action Forum, have projected that the Medicare insurance pool could become bankrupt by 2026 due to overly generous policies and insufficient revenues.[1]

Policy Problem: The Issues of Insurance

Since the backdrop of US healthcare has been introduced, the policy problems endemic to the private market will be evaluated to ascertain why the federal government felt compelled to address these failures. Additionally, this paper will analyze the governmental failure in providing health insurance as it has neither covered all who need it nor controlled costs to make the venture fiscally sustainable. First, however, some basic definitions need to be clarified. Market failure may be defined as when the basic assumptions of production and consumption create an inefficiency or unforeseen externalities. According to a theoretical understanding of the US's competitive economic structure, this should not occur when driven by private choice and informed by price signals. However, we will ascertain why there are glaring market failures

[1] Jackson Hammond et al., "The Future of America's Entitlements: What You Need to Know about the Medicare and Social Security Trustees Reports," AAF, September 1, 2021, https://www.americanactionforum.org/research/the-future-of-americas-entitlements-what-you-need-to-know-about-the-medicare-and-social-security-trustees-reports-4/.

specifically for insurance schemes. Broadly speaking, market failure occurs when a market creates externalities, is endowed with informational asymmetries, or when the market is distributing a non-private good. In this paper, private US healthcare is identified as having a market failure because of all of these factors. The first factor is the contradictory nature of being a private good forced into being a common good. The second factor describes the externalities of private and public insurance plans with an acknowledgment of some minor asymmetrical information issues.

When considering these two factors, further definitions need to be explored. What exactly is a common good compared to a private good, and why is healthcare commonly considered to be the former? Common goods are defined as goods or services whose nature is rivalrous yet unexcludable. A rivalrous good means that the "consumption or use of the good or service prevents another from consuming or using the good or service."[2] For example, when one patient occupies a good such as a hospital bed, another patient cannot use the bed. When a patient receives a service like surgery, the same surgeon cannot be giving surgery to another patient. Because both resources and manpower are finite, the ability of medical services to provide for patients is constrained. An excludable service is defined as one entity having "control over the consumption or use of the good or service."[3] Restated, the provider of a good or service can exclude those who do not pay for it. Before federal law prohibited denying service, doctors and hospitals could deny treatment if the individual could not pay for treatment. However, after the passage of the Emergency Medical Treatment and Labor Act, hospitals cannot deny medical service to anyone in an emergency situation. This act prevents healthcare from being a perfectly excludable service. Therefore, healthcare can no longer be considered a purely private good, rivalrous and excludable, or a purely public good, non-rivalrous and nonexcludable because it has aspects of both.

Therefore, healthcare is now considered a common good, rivalrous but nonexcludable, rather than a private or public good. Other examples of common goods include public parks and public libraries. Someone else's use of a campsite or book may conflict with one's own, but one cannot stop their use or deny them access to a campsite or book that one isn't currently using. However, in the case of healthcare, this nonexcludable aspect only applies to emergency use which is also the most expensive. Chronic conditions like lifelong heart disease or multiple sclerosis, however, are ineffectively managed if only acute symptoms are dealt with. With heart disease, restarting the cardiac muscles after a heart attack and putting stints in to restore blood flow only treats the immediate symptoms. Long-term healthcare, including regular checkups and prescription medication, is required to mitigate and treat the patient's contributing factors to affordably deal with these medical issues.

Now that healthcare is defined as a common good, rivalrous and nonexcludable, the second factor can be explored. What are the externalities of private and public plans, and what asymmetrical information issues need to be explored? To explain, a deep dive into the origins of public plans is required. The passage of the Social Security Amendments Act of 1965, popularly known as the Medicare Bill, established the insurance programs of Medicare and Medicaid for the elderly and poor, respectively. As mentioned previously, the programs were created to

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[2] David Leo Weimer and Aidan R. Vining, *Policy Analysis: Concepts and Practice*, 6th ed. (New York City, New York: Routledge, 2017), 74.

[3] Ibid.

supplement the private insurance market that developed around the common good of healthcare. While private healthcare insurers have an incentive to underserve insurees to maximize profit, a perfect example of a negative externality, government run insurance pools also come with their own externalities as well.

These externalities include Moral Hazard, Asymmetrical Information which occurs regardless of who insures the patient, and finally the immense cost overruns of financing the programs. Moral Hazard is defined as "the reduced incentive that insures have to prevent compensable losses."[4] Essentially, those who receive insurance are not paying for the full cost of the care they receive and are, therefore, unlikely to make proper financial decisions. As stated earlier for most market conditions, private choice and price signals usually govern decision; however, these signals are distorted by those who use insurance that are insulated from the cost of their choices. For example, rather than pursuing treatment for a minor affliction, say a bad cough, the insuree will go without care as medical treatment may be inconvenient in the moment. In the case of worsening symptoms, such as a bad cough actually being a case of pneumonia, then the insuree can receive treatment at little cost. The insurer, the company paying for the treatment, would have preferred an insuree receive care back when the treatment was cheap and preventable rather than the expensive and arduous process of curing pneumonia that may lead to sepsis. A reverse symptom of moral hazard may also occur in which an insuree may go to an emergency room regularly for minor afflictions that could be better served at an urgent care or an over-the-counter medication at a pharmacy. Because insurees are insured from the higher cost of the emergency room visit, insurees will not pursue the more cost effective option.

Therefore, when the insuree uses prevention healthcare too little or emergency healthcare too much, Moral Hazard occurs. While Moral Hazard occurs in all insurance programs, it is mitigated by sensible co-pays, fees, and deductibles that do charge an insuree some amount for using healthcare but do not charge enough to again cause Moral Hazard via the insuree avoiding care because of upfront costs. Typically, private healthcare charges higher co-pays, fees, and deductibles to discourage overuse of emergency healthcare while Medicare uses lower co-pays, fees, and deductibles to encourage prevention healthcare. Both come with their own Moral Hazard problems in that private insurers may end up paying more when an ailment turns into a major illness while Medicare cannot cover their costs with their generous policy. However, Medicaid has the greatest problem with Moral Hazard because the poor are not charged anything for their care. In addition to this complete free ride, Medicaid recipients also have an incentive not to pursue better paying jobs because they may lose this free riding coverage due to an increase in household income.

Insurance also creates an asymmetrical information problem because, in various ways, either party will know more about a given subject. For insurers, they have an intimate knowledge of both the insurance market and the healthcare market. Through their sheer economies of scale of servicing so many people, they can largely eliminate the adverse selection of servicing costly insurees by bargaining with hospitals for better rates than individuals could alone. Through this monopsony power, disproportionate power given to a dominant purchaser of healthcare for a given area, they will regularly create most-favored nation clauses with hospital groups which specify a lower cost for the particular insurance company subsidized at the cost of other insurers. While this may sound great to a person receiving this specific insurance, insurers will not always

[4] David Leo Weimer and Aidan R. Vining, *Policy Analysis: Concepts and Practice*, 6th ed. (New York City, New York: Routledge, 2017), 120.

pass these cost savings on to consumers because the insurance market has largely agglomerated into a few regional monopolies. Therefore, insurers can largely set their own prices without having to compete. On the client side, the insuree knows more about their health than an insurance agency. They may know about certain conditions that may run in their family and choose not to disclose this information to avoid higher insurance rates. Insurers try to mitigate this risk through medical examinations; however, these examinations are expensive and some insurees may not have a history of medical visits to analyze. A final negative externality, primarily but not exclusively found in government run care, is the rapidly inflating cost of these policies. When first designed, the programs were financed based on a payroll tax. This tax is paid partly by workers and partly by employers. Therefore, it is a tax on labor thus making the employment of workers more expensive. While arguments about the implications between tradeoffs of labor and automation are fascinating, they are sadly beyond the scope of this paper. However, the massive cost overruns of Medicare and Medicaid are a large impetus for healthcare reform.

In summary, the private health insurance market cannot effectively be a private good because of federal law. Therefore, it is forced to be a common good. Because common goods are unable to exclude those who cannot pay, Medicare and Medicaid were created. However, Medicare and Medicaid are unable to reconcile their generous programs with their finite resources. Thereby, a fiscal crisis is looming that threatens both programs' solvency and possibly the federal government as a whole. Moreover, the US federal government has proven unable, or at least unwilling, to achieve the goal of providing healthcare to all who cannot afford it within reasonable constraints. Furthermore, politicians seem loathe to address the core issues of the programs. Conversely, private health insurers have begun to agglomerate power becoming, at best, monopsonies where their market share allows significant control over health insurance in a given region or state, or, at worst, a statewide monopoly within a larger apparatus of oligopolies that prevent new entrants from entering the market. Therefore, the greatest obstacle to providing citizens with affordable healthcare is the inefficient and expensive insurance pools diseased with market and government failures. Only a circumspect reform to the apparatus as a whole can solve the endemic issues to the current insurance apparatuses.

Regulatory Environment: Market and Government Failure

Market Failure:

As previously mentioned in the Introduction and Policy Problem sections, the US has debated the role of the federal government in controlling the healthcare industry for almost a century, yet the existence of private insurance markets was not always assured. A large minority of the US population did not have access to healthcare insurance even by the mid-1900s. This underserved minority were typically members of one or more groups with the largest groups being the poor and elderly. Poor workers usually worked without healthcare benefits despite being employed. They could either not afford an individual plan or could not find access in their area. The elderly, typically not working and living off of a fixed income from pensions, struggled to afford insurance because they were considered an at-risk group due to their advanced age. Some western countries created single-payer insurance programs where everyone is largely treated equally, and priority is based on apparent need. The US, instead, took a market approach that created different tiers of care for different costs with the exception of emergency need. Some

citizens could afford excellent healthcare while other citizens used healthcare sparingly according to income and need. Citizens and unions proceeded to lobby legislatures to deal with the negative externalities the market based healthcare system created. Namely, they cited issues such as insufficient coverage in certain geographic areas, the high premiums for those least able to pay, and the disastrous effect a medical emergency for a primary household earner can have on a family. These arguments then led Congress to conclude that the free market was ineffective for the reasons cited above and to enact legislation to address the negative externalities of the free market healthcare system financed by a payroll tax.

Despite the drawbacks of the payroll tax, namely its tax upon labor making labor proportionally more expensive than capital, the overall machinations of the program involved all workers paying this tax to finance the initial Medicare and Medicaid enrollees. Furthermore, the new employment of workers could offset the poor who qualify for Medicaid and the next round of elderly insurees. However, the rapid retirement of the Baby Boomer generation, those that have been paying into the program their entire lives and expect their due entitlement, has created a looming demand shock that may permanently disrupt the program. Therefore, it is in the interest of citizens to not only ensure that healthcare is being provided in an efficient manner but also to mitigate the costs to taxpayers. But how high are Medicare and Medicaid costs, and why are they a problem?

As stated above, the federal government funds these programs through a payroll tax called the Federal Insurance Contributions Act tax (FICA tax).[5] This payroll tax takes 6.2% of an individual's income, before paying federal and state income taxes, as well as another 6.2% from their employer to fund various programs including Social Security. The contributions from within this payroll tax for Medicare and Medicaid amount to 1.45% for both the worker and employer for a total of 2.9%. However, the self-employed pay both portions of this tax as they are both the worker and the owner. Regarding the structure of these programs, Medicare is run by the federal government while Medicaid is run by the states who receive block grants from the federal government with some guidelines on how it must be spent. The Affordable Care Act raised some Medicaid benefits but not all states have adopted them. But how many people does each policy insure, and what is the cost to taxpayers? In 2018, Medicare covered roughly 60 million Americans[6] at a cost of $740 billion or approximately $12,300 per person.[7] In 2017 Medicaid covered an additional 74 million Americans[8] at approximately $605 billion, $375 billion paid by the federal government and $230 billion paid by the state governments.[9]

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[5] "A Primer on Medicare Financing." KFF. The Henry J. Kaiser Family Foundation, January 31, 2011. https://www.kff.org/health-reform/issue-brief/a-primer-on-medicare-financing/

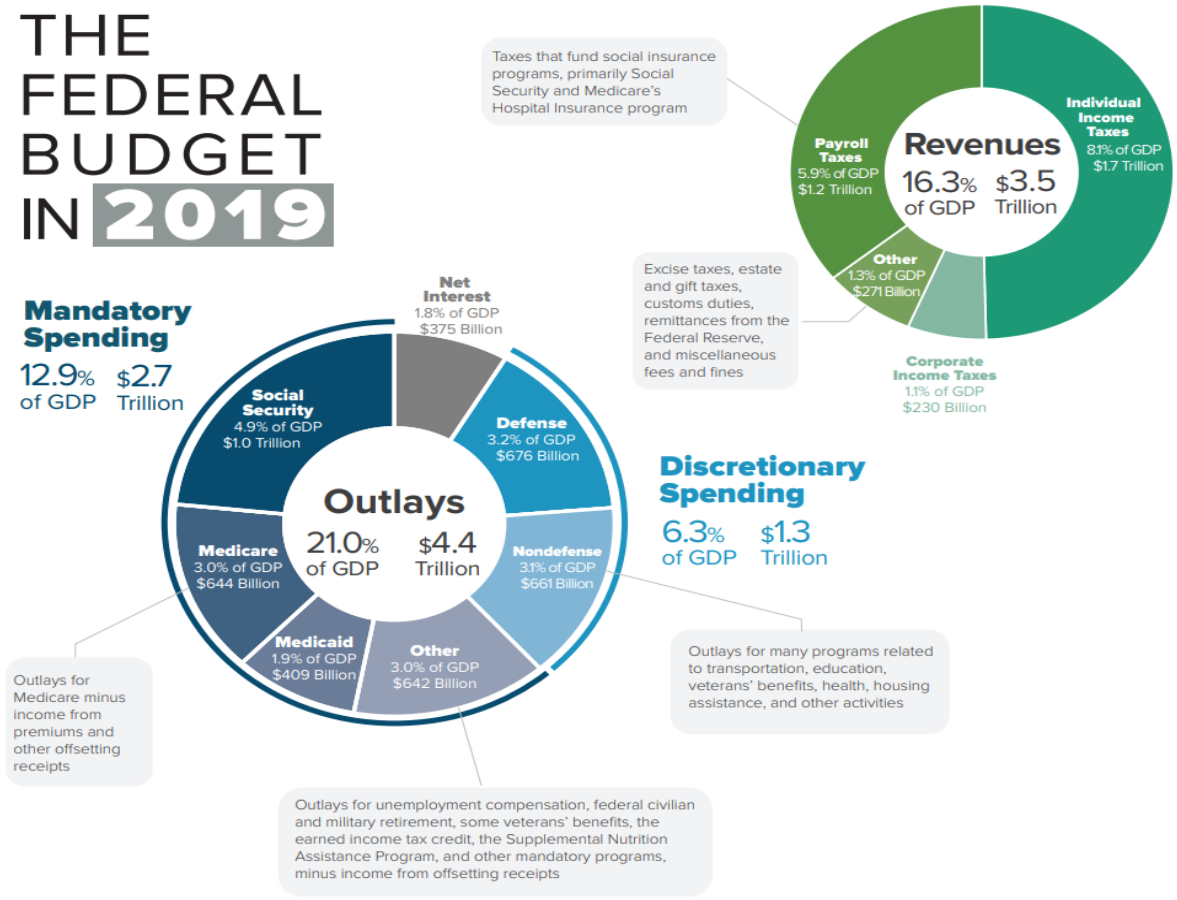
[6] THE BOARDS OF TRUSTEES, FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS. "2019 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS." CMS, April 22, 2019. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds.

[7] "A Primer on Medicare Financing." KFF. The Henry J. Kaiser Family Foundation, January 31, 2011. https://www.kff.org/health-reform/issue-brief/a-primer-on-medicare-financing/

[8] Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017 . United States Census Bureau, 2017. https://archive.ph/20200213010033/https:/factfinder.census.gov/bkmk/table/1.0/en/PEP/2017/PEPANNRES/0100000US.

[9] Daniela Franco Montoya, Puneet Kaur Chehal, and E. Kathleen Adams, "Medicaid Managed CARE's Effects on Costs, Access, and Quality: An Update," Annual Review of Public Health (Department of Health and and

Medicaid, therefore, costs federal government around $5000 per person and costs the state government around $3100 per person. While Medicare does have charges including premiums, co-pays, and deductibles to mitigate some costs, the total costs for Medicare and Medicaid seem immense. Combined with Social Security and the other portion of the FICA tax, the federal government in 2019 spent over $2 trillion in outlays while only receiving $1.2 trillion from the full FICA tax.



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As shown above, expenditures in Medicare and Medicaid, respectively, were $644 billion and $409 billion in 2019 together making up almost 5% of GDP or over $1 trillion. Considering that total federal revenues are only $3.5 trillion while total federal outlays are $4.4 trillion, the federal government is adding around $900 billion dollars in debt every year largely from the $800 billion excess spending on entitlements. Eventually, this substantial interest, merely financing the US's debt, will pullulate from its current $375 billion or 1.8% of GDP a year to an ever larger figure in the future. To add insult to injury, 27.5 million Americans in 2018 still do

Management, the Rollins School of Public Health, Emory University, 2020), https://www.annualreviews.org/doi/10.1146/annurev-publhealth-040119-094345 , 537.

[10] "The Federal Budget in Fiscal Year 2019," The Federal Budget in Fiscal Year 2019 (Congressional Budget Office, April 15, 2020), https://www.cbo.gov/system/files/2020-04/56324-CBO-2019-budget-infographic.pdf.

not have healthcare even with these massive resources being dedicated.[11] While providing medical insurance to the elderly and poor may not be the sole driver of these cost overruns, they are the largest contributing factor and will need reform to remain solvent. However, the cost overruns and future insolvency is but one externality or unforeseen consequence with providing government funded healthcare. As sated above, the externalities of Moral Hazard and Asymmetrical Information also need to be addressed.

Government Failure:

Politicians are always searching for another cause to champion; in essence, that is what they are elected and sworn to do. From a cynical viewpoint, politicians will be self-serving as their service is largely to sate personal goals, namely retaining office, rather than serving the collective people within the nation. Initially, perhaps some politicians' intentions were honest about helping the elderly and poor. However, the bloated apparatuses of Medicare and Medicaid have been causing fiscal crises for decades as Republicans and Democrats seem unwilling to fully reform the policies. On one hand Democrats, the initial creators of the programs, have sought to expand the federal government's role in healthcare by creating single-payer systems ostensibly under pretenses of reducing costs to citizens. Cynically speaking, Democrats want universal healthcare to show that they care about the citizenry to reap the political rewards from any good externalities. However, they can deflect to the bureaucracy of Medicare or Medicaid for any negative externalities. Conversely, Republicans are loathe to give more power to the federal government as it has proven unable to balance FICA taxes and the budget as a whole. Cynically speaking, they want to show they care about taxpayers, yet they can deflect to a particular insurer's ineffectiveness regarding the abundant negative externalities within the private market.

In 2010, the Affordable Care Act (ACA) tried to bridge the gap between both parties by implementing some cost reduction measures with an expanded coverage of the uninsured. Additionally, it mandated that all citizens get either public or private insurance or face substantial fines. However, some Democrats argued that it did not go far enough as private insurers still existed to benefit from their risk pools while Republicans argued that certain portions of the ACA were unconstitutional and that it was fiscally irresponsible. While both groups' arguments have merits, Democrats were unable to convince the public that they can execute a more substantial plan than the ACA with the mandate being rolled back while Republicans have been unable to fully pass legislation since Medicare Part D Plans under Bush in 2003. While Republicans passed the American Health Care Plan (AHCA) in the House under President Trump and Congressman Paul Ryan, it failed to pass the Senate. The main points of the AHCA were an emphasis on healthcare savings accounts, price competition, cost transparency, and a reduced federal cost for programs; however, this proved insufficient to both sides of the isle with former Republican presidential candidate John McCain blocking the bill in the senate.

[11] Smiljanic Stasha, "Uninsured Americans Stats and Facts 2021: Policy Advice," How Many Americans Are Uninsured (Policy Advice, June 27, 2021), https://policyadvice.net/insurance/insights/how-many-uninsured-americans/#:~:text=Data%20from%20the%20US%20Census,no%20health%20insurance%20during%202018.

Policy Goals

Because the government has proven itself incapable of financing its own obligations and the private market has an inherent motive to profit at the expense of insurees or hospitals, the solution to this market and governmental failure must be sweeping and circumspect. Its goal should be to provide the citizenry access to healthcare, regardless of financial status, within budget constraints. To do this, it will need to sweepingly change the frameworks of Medicare and Medicaid as well as mitigate the externalities of an unregulated free market. However, the solution must also be politically feasible to reach fruition. Compromises must, therefore, be engineered to satiate both sides of the aisle.

Fiscal Sustainability

The first measure of any policy must be its fiscal sustainability. If the program bankrupts the state, the policy cannot continue. Therefore, this measure forecasts the ability of the state or private market to fund and sustain whatever outlays it entitles citizens or insurance programs.

Equal Access

The second measure of the policies must measure how it plans on distributing the common good of healthcare. Debates have lasted decades as to the extent of who should be covered under these programs. However, the trend has always sought to include more of the citizenry under coverage rather than less. While unequivocal equal access may not necessarily be needed for passage, it is an important aspect to consider especially to those on the left side of the aisle.

Addressing Government Failures

The third measure of any policy is how it addresses the government failures of Moral Hazard and of inefficient outcomes, namely a benefiting of one group over another. As stated earlier, moral hazard is the benefit from healthcare without having to pay for it which can create perverse incentives like waiting to use healthcare until a condition worsens or using healthcare too frequently. Inefficient outcomes like creating perverse incentives that benefit the elderly or poor can also have unintended consequences. Those about to retire may hold off expensive healthcare until they qualify for Medicare that way taxpayers pay for it rather than themselves. The poor may also have a perverse incentive to remain poor as higher paying jobs may not necessarily come with healthcare coverage, making them actually worse off.

Addressing Market Failures

The fourth measure is how a bill addresses the systematic perversion of profit in insurance pools. While profit is normally a good incentive to encourage innovation, competition, and reducing prices, insurance pools do not operate on these principles. Because they benefit from massive economies of scales, at best these pools become monopolistic competitors with regional monopolies or become a part of an expansive oligopoly of insurers who are price makers not price takers. They are simply a pool system and cannot devise strategies for increasing profit without making enrollees worse off beyond increasing economies of scale. Furthermore, the

asymmetrical information they have given their intensive knowledge of the market give them an advantageous position when negotiating premium rates and other mechanisms such as co-pays and deductibles.

Political Feasibility

Finally, political feasibility gauges the probability of the policy to become an enacted reform. While some ideas may make sense on paper, they are not useful if they fail to convince the public or elicit support from congressional representatives and senators. While some bills may inspire future bills to adopt certain policies, this paper will focus on how the bill would pass the contemporary political atmosphere.

Policy Alternatives

Current Policy

The current policy of the US healthcare system has already been explained at length under the Introduction and Regulatory Environment. To restate, the current system is based on the use of insurance pools. Private pools run by corporations and public pools run by Medicare and Medicaid provide payment to hospitals and doctors' offices in the event of care. However, some uninsured citizens either pay massively out of pocket or do not pay at all, which passes the cost to the hospital which passes the costs on again to other patients. The US's current policy largely follows the rules stated under the Affordable Care Act (ACA), but the provision for mandatory coverage has since been repealed.

Affordable Care Act

The Affordable Care Act is the largest healthcare reform act passed since Medicare Part D coverage under President George W. Bush. It drastically increased premiums for many citizens but increased the amount of insured citizens. Essentially, the ACA insured the most expensive citizens which forced others to subsidize their treatment. Many Americans found this to be distasteful and argued against the legality the individual mandate, forcing Americans to pay for health insurance under penalty of fines. Overall, the ACA failed to provide healthcare to all but managed to reduce uninsured by half while increasing the federal deficit by over $300 billion dollars.[12]

American Health Care Act

The AHCA was created to replace and reform the ACA; however, it did not pass through the Senate. Its main goal of repealing the individual mandate was achieved as it was passed under a

[12] David Blumenthal, Sara R Collins, and Elizabeth Fowler, "The Affordable Care Act at 10 Years: What's the Effect on Health Care Coverage and Access?," ACA at 10 Years: What's the Effect on Coverage and Access? | Commonwealth Fund, February 26, 2020, https://www.commonwealthfund.org/publications/journal-article/2020/feb/aca-at-10-years-effect-health-care-coverage-access.

bill unrelated to healthcare reform. Some ideas, such as the creation of Healthcare Savings Accounts, have seen widespread private adoption since its media coverage.

Medicare for All

Medicare for All seeks to expand the current Medicare system to all citizens which includes absorbing those currently under Medicaid. Other countries have similar systems where the government acts as sole or primary insurer of citizens for healthcare, but the system has proven distasteful to many in America and has been branded as socialism. Arguments over whether universal healthcare insurance is socialism, democratic socialism, or simply a generous welfare state aside, the program has been explored for decades but has never passed the House or Senate. Therefore, comparisons to this hypothetical plan are generalization and not specific.

Equal Healthcare Act

While constructing this paper, the initial aim was simply to reform Medicare and Medicaid using Universal Healthcare Vouchers. However, that single piecemeal change would not substantially change the inherent flaws in the healthcare market. Insurers would continue to be predatory and seek to use their clients rather than serve them. The government programs would fail to cover all citizens while being fiscally irresponsible and potentially undermining the stability of the entire federal government. The problems were many and the solutions few. Therefore, a comprehensive policy just as complex as the problem had to be created. Not only that, but the demands of liberals and conservatives had to be balanced. Neither could be given dominance over the other or else the solution would turn partisan. This system of healthcare had to be made unique and tailored to America's core values. State run hospitals and single payer coverage are anathema to Americans who value freedom of choice; therefore, a market mechanism had to be employed to guarantee widespread support. Additionally, privatizing Medicare and Medicaid without ensuring quality of care is also anathema to aging Americans who have paid into the system their entire lives. Hopefully, this paper or some of its ideas will one day be used as a basis for true healthcare reform to bring equal healthcare opportunities to all citizens.

Assessment of Alternatives

As this paper primarily serves to illustrate the benefits of the EHA, the analysis of policy alternatives will be kept brief.

Current Policy

Fiscal Sustainability

As stated earlier, the current policies of Medicare and Medicaid are draining the state of funds and may lead to insufficient funds by the end of the decade. While the private market is infinitely sustainable, the market may adjust by dropping less healthy individuals as they are not profitable to retain. If the public programs are not maintained, it is unlikely that private market insurances will be likely to enroll the most at risk groups at an affordable rate.

Equal Access

Currently, 90% of the market is covered, but the likelihood of the market retaining the current percentage depends upon whether Medicare and Medicaid will stay fiscally sustainable.[13] If not, the equal access to healthcare for all citizens when they retire may not be a part of the future American Dream.

Addressing Government Failures

The current policies of Medicare and Medicaid still have issues with moral hazard and inefficient outcomes. Enrollees are likely to overuse resources without having to pay for the costs.

Addressing Market Failures

The current market for private insurance uses its advantages in economies of scale and asymmetric information to extract wealth from enrollees while enriching themselves. The private venture into health insurance for monetary gain has necessitated reform into a more competitive system.

Political Feasibility

Sadly, the current policy is the most likely to continue as the lethargy of the legislature and bureaucracy hinders sweeping reform until a crisis looms. Additionally, the rampant debate over the ACA and method of its passage and provisional repeal has left many citizens tired and apathetic to the current situation as high premiums and deductibles have been tolerated for so long.

Affordable Care Act

Fiscal Sustainability

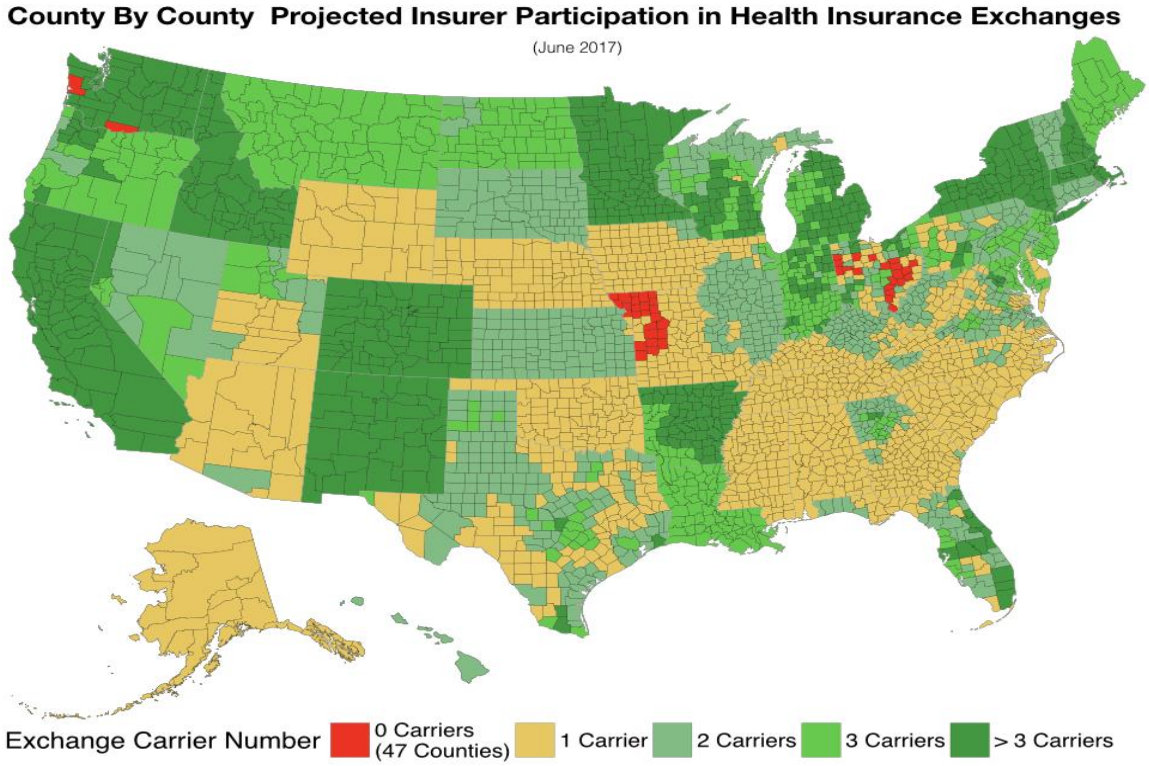
The ACA cost roughly $300 billion and increased federal deficit spending. While not at large as other spending bills such as Medicare for All, the increased costs associated with putting more citizens on Medicaid, the insurance program with the greatest amount of overuse and fewest cost preventions mechanisms, have proven unsustainable when combined with other spending programs.

Equal Access

The ACA sought to increase access for the uninsured and dropped the uninsured rate from 20% to 10% of the population. However as displayed below, the ACA has reduced the number of

[13] Rabah Kamal et al., "How Has U.S. Spending on Healthcare Changed over Time?," How has U.S. spending on healthcare changed over time? Health System Tracker (Peterson-KFF, December 23, 2020), https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_9.

private providers turning many counties in monopolies or oligopolies because compliance has made the market unprofitable or too difficult to administer without agglomeration.



[14]

Addressing Government Failures

The ACA does not address government failures and instead exacerbated the issue with overuse in the Medicaid program by expanding its funding to several states.

Addressing Market Failures

The ACA also helped consumers make more informed decisions by categorizing private plans into four tiers based on expected healthcare payments are Bronze for 60%, Silver for 70%, Gold for 80%, and Platinum for 90%.[15] The ACA also restricted the amount that insurance providers can charge older enrollees. In fact, a community rating is created based off regional costs that prohibit the elderly from being charged more than 3 times what the youngest enrollees are

[14] "CCIIO Exchange Carriers by County - CMS" (Center for Medicare and Medicaid Services), accessed November 22, 2021, https://downloads.cms.gov/files/cciio-exchange-carriers-by-county.pdf.

[15] "Understanding Marketplace Health Insurance Categories," HealthCare.gov, accessed November 22, 2021, https://www.healthcare.gov/choose-a-plan/plans-categories/.

charged to help mitigate the elderly's costs at the expense of the young.[16] Additionally, the ACA banned insurance providers from dropping enrollees from their plan while they are ill. [17]

Political Feasibility

Considering that the ACA was passed into law, the ideas behind the bill are politically feasible. However, the individual and employer mandates were removed in 2017. Many ideas in the program were widely supported including allowing children to stay on family plans until age 26, providing simple categories for plans to be placed under, and some states supported the expansion of Medicaid. However, simmering dislike of the bill has stopped legislative reform on the issue of both private and government insurance pools for the past decade.

American Health Care Act

Fiscal Sustainability

The AHCA was projected to lower the deficit by $350 billion over a decade as $1.2 trillion would not have been paid out while simultaneously collecting $900 billion less in taxes.[18] The AHCA would, therefore, be fiscally sustainable in the long run.

Equal Access

The AHCA was likely to increase the percentage of citizens without coverage from 10% to 20% or higher. However, this figure is an estimate as the bill was not passed.

Addressing Government Failures

The AHCA did not address the issue of Moral Hazard or inefficiencies in the government systems. Perhaps an amendment on such systems could have happened under reconciliation, but no formal amendment was passed with the bill.

Addressing Market Failures

The AHCA did not address the market failures of profit motive and, instead, incentivized private insurers to drop those it added under the ACA.

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[16] "What Is Community Rating?," healthinsurance.org, March 12, 2021, https://www.healthinsurance.org/glossary/community-rating/.

[17] "Cracking down on Frivolous Cancellations," HealthCare.gov, accessed November 22, 2021, https://www.healthcare.gov/health-care-law-protections/cancellations/.

[18] "P2PD-TM5C: Www.cbo.gov : Free Download, Borrow, and Streaming," Internet Archive (House Committees on Ways and Means and Energy and Commerce, March 13, 2017), https://archive.org/details/perma_cc_P2PD-TM5C.

Political Feasibility

Considering that the largest version bill failed, and the removal of the mandates only passed because a skinny version was attached to the Tax Cuts and Jobs Act of 2017, the political feasibility of this bill is low. Even members in the Republican Party who wrote the bill felt that the bill was not bipartisan enough and did not address the issues regarding private profit motive or insurance pool structure.

Medicare for All

Fiscal Sustainability

Estimates of the financial cost of Medicare for All are largely inconsistent with some claiming that it would costs less than Medicare does now and others claiming that it would cost trillions. While no formal act has passed either the House or Senate, the plan would likely cost trillions and massively increase deficit spending, at least in the short term unless a comprehensive tax reform, likely regarding payroll tax rates, was also passed concurrently.

Equal Access

Medicare for all provides a government-sponsored insurance option that can largely outcompete private insurance as profits will not be needed to run the program. Therefore, it is likely that all citizens will enroll in the program for its benefits at the expense of taxpayers. Additionally, taxpayers will likely join the program as arguments against joining are mitigated as free riders will already be using the program. Likely, most citizens will enroll while some citizens who receive sufficient insurance through their employers will stay on their current plans if they are sustainable. Company plans will, however, likely be phased out as the government will provide the service at no charge to the company beyond payroll taxes already paid.

Addressing Government Failures

Medicare for all does not solve the issues of moral hazard but does solve the issues of inefficient outcomes. While users are more likely to overuse healthcare than underuse, the access of all citizens to the pool negates the concerns of benefitting the elderly and poor at the expense of others as all citizens are eligible.

Addressing Market Failures

Medicare for All address market failures in that it is likely to push most private insurers out of the market. Perhaps some will still exist given that some large employers have generous healthcare already sustained by significant endowments. But the majority of insurers, even with a profit motive, will find it difficult to retain enrollees given that Medicare for All does not have to be profitable.

Political Feasibility

As even those on the Democratic side of the aisle think this program is not feasible due to fiscal insufficiency, Medicare is unlikely to be expanded to all citizens. The Republican Party and their supporters expect that individual citizens should have the right to choose who their insurance providers are and that the profit motive to improve and make money prevents catastrophically generous plans.

Equal Healthcare Act

This paper recommends the creation of an Equal Healthcare Act (EHA) that borrows elements from Germany's sickness funds or nonprofit insurance model (NPIs) and Australia's superannuation system. Additionally, it uses provisions from the Affordable Care Act (ACA) regarding the individual mandate while also taking provisions from the American Health Care Act (AHCA) regarding national price competition, cost transparency, and Health Savings Accounts (HSAs). Furthermore, the EHA synthesizes these ideas with the author's take on FICA tax disbursement, Universal Healthcare Vouchers (UHVs), Federal Reserve financing, financial reporting, administrative cost caps, expanding family plans, banning most-favored-nation clauses, eliminating out-of-network fees, and reallocating Medicare and Medicaid enrollees.

As the private market was the cause of the initial market failure with its inability to cover all citizens sustainably, a private solution is unlikely especially given the federal government's authority over the market. Therefore, a state solution is needed to cover the existing market failure of insufficient coverage combined with unsustainable cost outlays. However, why would one call for a state solution to a problem that the state has proven itself incapable or unwilling to solve? Simply put, the state is the only one with the power to do so. It must realign incentives and disincentives in the private market to mandate coverage while excusing the government from running programs like Medicare and Medicaid.

Fiscal Sustainability

The first provision starts with the redistribution of FICA taxes. Instead of FICA taxes being a supplementary component to Medicare and Medicaid, it is now the sole generator of funds in the form of Universal Healthcare Vouchers. Rather than the arguably ageist and classist Medicare and Medicaid, these UHVs are provided to all citizens in equal amounts. If all of FICA taxes from 2019 were equally redistributed to all citizens, each citizen would have $3500 for outlays, assuming a 3.22% administration cost which is on par with the administration costs of Medicare and Medicaid. These UHVs must then be either spent on NPIs or accumulated in Health Savings Accounts. These HSAs are tax deductible accounts that also allow citizens to deposit money for future healthcare outlays. Employers can also fund HSAs or match contributions. However, companies regardless of size are under no mandate to contribute thereby decoupling employment from health insurance. However, a matching increase in salary or a reallotment to the HSAs will be mandated during the shift.

The sublime beauty of UHVs deposited into HSAs is that they will constantly accrue over the lifetime of the citizen. From a citizen's birth, this account will be stocked year after year with FICA tax money and can only be withdrawn by a legal guardian before reaching adulthood to pay for insurance or deductibles. While the citizen is young and healthy, the HSA can accrue

interest which provides for future medical needs. Since these healthy, young citizens are all required to be enrolled in insurance pools subsidized by their UHVs, premiums for the elderly and sick will be lowered. Broadly speaking, the average family of four spends approximately $11000 on healthcare premiums every year[19], but the UHVs will cover all of this with a surplus left over assuming that premiums remain constant. Even if no employer added to the HSAs, parents would only be responsible for deductibles which largely negates issues regarding the ACA forcing every household to purchase insurance. Additionally, while the UHV portion of the HSA will only grow at the rate of federal bonds, all other deposits into the HSA account can be invested as seen fit. Because the Federal Reserve will be supporting this payout through the sale of federal bonds, the UHVs will be matched to the bonds' payouts. The Federal Reserve will be responsible for providing the initial disbursement of UHVs because this plan also provides back pay to all citizens since their birth minus accumulated expenses.

However, if any individual's accumulated expenses overtake FICA backpay, the resulting cost overruns are simply absorbed by the Federal Reserve costing nothing for the citizen out of pocket. Given the large amount of currency reserves that will need to be created to finance this initial wave, it is preferrable for the Federal Reserve to hold on to the reserves and slowly doll it out for medical expenses to prevent inflation shocks. A further externality that may occur is that citizens may encourage an increase in the federal bond percent yields thereby increasing UHVs' returns. This may have a counter balancing effect on the current insistence by Congress that yields remain low to finance their fiscally irresponsible deficit spending. However, studying this possible externality in detail is beyond the scope of this current paper.

Equal Access

As the current market failure is deeply intertwined with government-run health programs which account for 40% of the healthcare,[20] the failure lies in both structuring of the private insurance apparatus as well as the government apparatus. However, while private insurers which account for roughly 50% of the market are not without their own externalities, the primary market failure resides with the government programs as the final 10% of the market, 27 million citizens, are still without insurance. However, the current policies lack in effective implementation and sustainability in that they cannot support their current outlays.

Addressing Government Failures

The EHA addresses the two most significant government failures, Moral Hazard and inefficient outcomes, by forcing all citizens to purchase health insurance. Since UHVs pay a sizable portion of premiums, the moral hazard of not receiving preventive care is largely negated. The moral hazard of overusing care is also negated as citizens will still need to pay deductibles and co pays.

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[19] Rabah Kamal, Giorlando Ramierez, and Cynthia Cox, "How Does Health Spending in the U.S. Compare to Other Countries?," Health System Tracker (Peterson KFF, January 4, 2021), https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-spendingcomparison_health-consumption-expenditures-per-capita-2019.

[20] Rabah Kamal et al., "How Has U.S. Spending on Healthcare Changed over Time?," How has U.S. spending on healthcare changed over time? Health System Tracker (Peterson-KFF, December 23, 2020), https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_9.

If they claim an inability to cover these costs, the government can seize future UHVs to pay for the service and be allowed to access IRS files to check whether this is true or whether they are simply trying to free ride the system. A small, special fund run by Health and Human Services could be created to deal with the most extreme cases such as an orphan child needing expensive surgery with no family HSA savings and a depleted UHV subaccount.

Addressing Market Failures

The next provision regards the nature of insurance pools market. Currently, private insurance has administration costs between 12-18% compared to around 2% for government insurance.[21] While the low percentage for government insurance programs can be partially accounted for by the massive amount of disbursements, economies of scale greatly boost the effectiveness of healthcare pools per administrator. Therefore, an agglomeration of the market would be preferred; however, insurers are currently prevented from competing across state lines which keeps their operations regional but small. The current reason being the insurers may misuse monopsony power and most-favored nation clauses to enrich themselves or their stockholders at the expense of care givers and the insurees. Therefore, private insurers will be mandated to become non-profits insurances (NPIs). The normal profit incentive of insurers dictated that employers, employees, and the hospitals themselves must be underserved to increase profit. Premiums, co-pays, fees, and high deductibles are currently used improperly to extract wealth from clients. By not incentivizing clients to use healthcare when ailments are easily preventable and cost-efficient, for-profit insurers have pushed clients to only use healthcare in an extreme case or to not purchase insurance at all. Instead, NPIs must be forced to use their profits to increase their endowments thereby decreasing premiums. NPIs, therefore, will have proper incentives to serve their clients rather than use their clients. No longer will insurance companies squander funds by squandering money on stock buybacks or be used as simple a tool for investment. Furthermore, NPIs will be required to submit all financial information just like publicly traded companies under GAPP. However, NPIs still have an incentive to increase administration costs in the form of bonuses and other perks. Therefore, the EHA will mandate that no more than 15% of the costs of running the NPI can be used for administration with the costs declining by 1% for each year since implementation until reaching 5%, a comparably generous amount compared to government run insurance pools.

Inspired by Australia's superannuation model, citizens will also be required to deposit 1% of their yearly income into their personal HSA. Households can split their 1% among themselves and their children as they see fit. The 1% can simply be added to the HSA under the federal reserve in which case it will become a federal reserve bond or be sent into the market as a subaccount that can be invested at will. This requirement is to habituate citizens into saving for future expenses without imposing a substantial burden on the citizenry. Inspired from the ACA, some provisions include reintroducing the individual mandate and allowing those under age 26 to remain on family plans. The individual mandate was heavily criticized because it was a forced fee or fine on all citizens who refused to purchase an expensive service. Now, this provision should be tolerated because the state subsidizes the cost of healthcare for all. No longer will an

[21] Manuela Tobias, "Politifact - Comparing Administrative Costs for Private Insurance and Medicare," PolitiFact, September 20, 2017, https://www.politifact.com/factchecks/2017/sep/20/bernie-sanders/comparing-administrative-costs-private-insurance-a/.

individual be forced to pay a $2000 fine for not being able to afford a $3000 premium. Even if the premiums increase to $4000, the estimated $3500 voucher pays for the majority of the cost. The allowance for those under 26 to stay on family plans has also proven popular with the public, and an expansion of allowing any family member of any age to stay on a healthcare plan should be explored.

Inspired from the AHCA, the EHA endorse allowing NPIs to compete across state lines, increasing maximum allowances for family HSA contribution, allowing families to deduct costs of healthcare premiums from taxes, forcing hospitals into transparency by mandating price comparisons, and waving core essential services from NPIs including controversial abortion services and birth control. Republicans argued that not forcing insurances to compete across state lines led to less competitive markets with a few monopsony powered insurances per state. Now, monopsony power is less likely to occur, and even if it does, the profits from said power will be added to endowments. Increasing HSA allowances for families allows for greater cushions against medical losses and allows parents to receive a tax deduction for spending on their own and their children's healthcare. Because family plans and HSAs may now become generational, children can then in turn care for the medical costs of parents as they age. Perhaps most importantly, forcing hospitals to show prices brings the market closer to an ideal economic market as the price axis of a hypothetical supply-demand model is no longer obscured. Because prices are now mandated to be transparent, citizens can now shop around for elective medicine and find the best deal which encourages hospitals to provide better services at lower prices. Finally, mandated core essentials to healthcare are now removed, so families and individuals can now customize their healthcare and remove extraneous features that may add to their expense or violate their morals.

Other provisions include banning most-favored nation clauses for providers and eliminating discrimination on in-network vs out-of-network expenses. Together, these two provisions create a fair and competitive market where NPIs and insurees have clear costs that can be more easily modeled and forecasted. Therefore, NPIs may arrange for elective medicine to take place where the insuree wants it rather than being constrained to a single locale, provider, or specialist. Lastly, all created NPIs will, according to endowment comparison and region, be allocated current Medicare and Medicaid enrollees thereby creating a universal but free market. This market controls for profit motive by mandating all insurances become NPIs and for costs by pegging UHVs to FICA taxes. Former Medicare recipients will either choose to take the backlogged UHV or have their current plan and premiums frozen with some adjustment for inflation. Therefore, Medicare's generous entitlements and plans can be unaltered but slowly phased out over time. Other aspects of the EHA include UHVs providing an insightful metric to citizens, political pundits, and researchers about the overall health of the economy i.e., wages going up or more workers employed increases UHVs. Additionally, extended family plans for insurance will allow NPIs to track genetic or environmental conditions All of these factors together will create a more inclusive and more efficient healthcare marketplace.

Political Feasibility

While the author cannot speak with any definitive substance about the likelihood of passage, some key factors need to be evaluated. Does this current plan restrict future government spending and allow for the market to sustain itself indefinitely? Yes. Does this current plan cover all citizens as Democrats tend to insist upon? Yes. Does this plan address the government

failures Republicans loathe such as moral hazard and benefitting one group at the expense of others? Yes. Does this plan address the inherently uncompetitive insurance market and adjust incentives to focus on benefiting enrollees rather than investor pocketbooks as Democrats want? Yes. Will these combinations of factors ultimately lead to successful passage? No. The wind of changes cannot be forced to blow in any direction. However, this bill gives the ship of state the largest sail, the greatest leverage, to ride the winds of change.

Considering Tradeoffs and Consequences

As shown in Appendix A, the tradeoffs and consequences of not adopting the EHA are possibly catastrophic. No other plan solves the five main issues as well, but timing is everything in politics. According to the author, this may be the correct path; political realities may make the change untenable, at least in the short term. When the consequences of keeping the current policy begin to create political realities about the necessity of reform, the EHA should provide a starting blueprint for reform. Perhaps some find the reform too much of a compromise, but perhaps the ideas inspire a better plan on either side of the aisle and fix these systemic issues before it is too late.

Recommendation

If a Representative or Senator was told that healthcare reform could be implemented in such a way to keep market choice yet provide universal healthcare without implementing any new taxes, a cursory glance at Appendix A should entice them enough for a conversation or deeper read. Assuming that the client of this paper would be a Representative or a Senator concerned about the rising discontent over the current healthcare systems in America, the rationale of this paper is to provide an initial framework to workshop ideas and solutions that will hopefully be optimized in the final edition of the bill.

Adoption

If the EHA in its current guise is sent to a subcommittee and then further on to the floor of the House or Senate, there are likely to be changes. Any bill as complex as this is likely to have detractors trying to insert poison pill amendments. Additionally, pork barrel spending may also occur where unrelated issues and attached to this bill. The focus of the adoption section is not to analyze the theoretical tertiary amendments but to understand and evaluate likely issues with the bill as it stands.

Democrats are likely to take consternation with the locking payouts only to FICA taxes. They may also insist upon a change in the payroll tax amount to increase funding as well as on certain standards on health insurance quality to prevent droppage in effective coverage. Perhaps they want to add core essentials to the plan that force insurers to provide access to birth control or other services beyond emergency medical care. They will also insist that 1% is not enough to mandate each citizen dedicate to healthcare, or perhaps insist that the federal government or state government perform a matching program to that investment to encourage further savings. Some legislators receiving donations from hospital group would not want their benefactors to be forced to reveal prices both to cover their own campaign finances and give hospitals better negotiating

leverage Finally, Democrats may insist that those near retirement age, say age 55, should have the option of Medicare coverage rather than private coverage.

Republicans are likely to take consternation with the newly developed class of nonprofit insurers; they might also insist on stockholder retention or payoffs. Perhaps they will want the idea of nonprofit insurers stricken from the EHA which would bring back the profit incentive at the expense of both insurees and taxpayers. They might disagree that the government has the right to mandate that all citizens purchase health insurance, even if UHVs subsidize that purchase. Most likely, they also view that the 1% investment mandate into HSAs is also not a right of the government to mandate, and Republicans receiving campaign contributions from insurance companies will want the most-favored nation clauses to remain. Finally, their may be some objection to the family-oriented insurance programs that help insurers analyze common family conditions violate personal privacy, and these legislators will want an amendment to insure that all medical data is private and erased if the citizen moves to another insurance pool.

All of these concerns and more should be evaluated when introducing the bill into committee. Some concerns are genuine; some concerns are self-serving. However, UHVs and HSAs being created and tied to FICA taxes are the core of the bill and must be implemented to achieve the broad goals of insuring equal access to healthcare, eliminating government failures, and restoring fiscally sustainable programs. Creating nonprofit insurance is also required to address market failures and insure the citizen is the primary concern. Insurance being used to generate wealth does not serve the citizens, only the citizens rich enough to invest.

Implementation

Firstly, a committee staffed by members from Health and Human Services and other executive departments will calculate the total backlog of vouchers per citizen. This measure is simple as it only requires FICA taxes per year divided by the citizen population at the time. Afterwards, each year's payout will be added according to the citizen's age. It will then subtract any outflows reported under Medicare and Medicaid to that specific citizen. The HSAs will then be stocked with the appropriate level of funds, and in the case of negative funds meaning that the citizen has receive more funding in Medicare and Medicaid than the inflow in backlogged vouchers, the citizen will simply have a neutral balance of zero. Under the circumstance that the citizen needs emergency funding for an ongoing chronic illness or catastrophic care, a commission will evaluate the funding necessary and decide on the course of action.

To reform the private market insurance companies, a committee would be formed to set about criteria for restructuring the firms. Stockholders will be reimbursed their stock prices locked in at their value 1 year before passage but adjusted for inflation and general market growth. The speed of the payouts will be determined by the corporations' board of directors or functional equivalent. Employees will continue to operate while taking on more enrollees as former Medicare and Medicaid enrollees join. As Medicare enrollees retain the same benefits and premiums as before the change, former Health and Human Services employees will educate the private insurances on the details of the benefits which will hopefully open doors of alternative employment and allow time for current workers to transition into other careers. Administration costs will be reviewed by a special commission under the IRS that will provide a framework for reevaluating labor force and capital costs to ensure a smooth transition and compliance under GAAP.

With regards to the funding of Social Security now that the FICA tax subsumed the entirety of the payroll tax, Congress will need to secure alternative funding through other taxes which may prompt needed reform. To reform the government programs of Medicare and Medicaid, current HHS employees responsible for outlays will be shifted to work under the Federal Reserve in a subdepartment to ensure all citizen HSAs are properly accrued in perpetuity. Additionally, this newly reorganized HHS labor force will have the option of becoming liaisons with the new nonprofit insurers to adapt Medicare benefits to the private programs. A severance package will also be included for those unable or unwilling to transition that amounts to two years' salary plus educational benefits. Furthermore, a new measure of economic health will be available to the Bureau of Labor Statistics that keeps track of UHVs to measure the economy's overall health. If UHVs go up, more people are employed proportionally, or their wages are increasing. If UHVs go down, less people are working proportionally, or their wages are decreasing. What effect minimum wage laws, widespread immigration amnesty, or any other economic policy will have will be objects of great interest if the EHA is passed.

Evaluation

The evaluation of the EHA is based on its effect on practical reality. Therefore, if the EHA does become law and is enforced, a guideline for evaluation must be created. This evaluation needs to consider factors such as: are the UHVs sufficient for most citizens' coverage? How much do premiums cost, and are they rising or falling? Are those currently on Medicare finding their HSAs empty, or are there ample reserves? Are the new nonprofits thriving with the influx of new insurees, or are they burdened by the administrative work or rising costs of coverage? Are the endowments used in the nonprofits increasing or decreasing? Are the administrative costs increasing or decreasing for nonprofits? Are the family healthcare plans popular, or are the concerns over family privacy incentivizing individual plans? Have hospitals been complaining of collection issues, or has the collection process been streamlined? Are prices for medical services increasing or decreasing, and why? Can the process of transition be streamlined in any way? Are businesses thriving or struggling under the new system? Are those with company insurance happy or not? Is stability returning to the system? Are the citizens happy, or do they wish for reform in some area? Should the reform happen now, later, or at all?

In a broader sense, the evaluation needs to consider the five initial measures. Is the program fiscally sustainable? Is it providing equal access to all citizens? Is it addressing government failures, or are there unforeseen negative externalities? Is it addressing market failures, and is the market healthy and stable? Finally, does the program seem feasible to keep, or is further reform needed? These questions should provide a starting evaluation criterion for identifying whether the Equal Healthcare Act is living up to its promise of affordable healthcare for all citizens.

Appendix A

	Current Policy	*Affordable Care Act*	*American Healthcare Act*	*Medicare for All*	*Equal Healthcare Act*
Fiscal Sustainability	Currently, Medicare and Medicaid overrun payroll tax revenue and require deficit spending to sustain. **Moderate**	The ACA costed $300 billion in the past 10 years. Further expansion and removal of certain provisions have altered projected costs. **Moderate**	The AHCA was predicted to reduce the overall costs by $300 billion which would finance current outlays without adding to the deficit. **Moderate**	As even conservative estimates range the costs into the trillion of dollars, this plan is fiscally unsustainable without significant tax reform. **Low**	As the EHA is tied directly to FICA payroll taxes, the vouchers program is inherently fiscally sustainable while making the Federal Reserve responsible for administration. **High**
Equal Access	Medicare and Medicaid provide insurance for the elderly and poor respectively, but it leaves all other citizens to obtain private insurance themselves. **Low**	The ACA maintains the current structure of Medicaid but expands Medicare access to a larger pool of citizens and could reduce the uninsured to 25.6 million. **Moderate**	Subsidizing access to healthcare for taxpaying citizens via HSAs increases access but only to those able to afford HSA investments. **Low**	Though it would provide equal access to government run insurance for all citizens, future reductions in benefits, to increase sustainability, jeopardize access. **High**	The EHA provides equal access to private, nonprofit insurance via vouchers to all US citizens. Backlogging the vouchers into Federal Reserve secured HSAs insures funds for immediate and future access. **High**
Addressing Government Failures	Medicare and Medicaid do not address moral hazard well enough to avoid free riders or incentive self-insurance. **Low**	The Affordable Care Act failed to address moral hazard but required free riders to purchase insurance. **Low**	The AHCA maintains the current policy structure and does not include provisions to prevent free riders. **Low**	Creating a publicly run universal insurance benefits from economies of scale, but concerns over unsustainable expenditure remain. **Moderate**	A universal but limited voucher program prevents overuse or underuse of healthcare. Selective programs are also prevented from allowing any group to free ride. **High**
Addressing Market Failures	Currently, there are no controls on the profit incentive other than a premium cap of three times the lowest premium. **Low**	Created the premium cap on private insurers and created a mandate since repealed that required companies to insure full time employees. **Moderate**	Promotes personal saving for future medical outlays via HSAs and retains many restrictions on businesses found in ACA. **Moderate**	Creates a publicly run insurance pool that would largely outcompete private insurances thereby removing the profit incentive. **High**	By capping administrative costs, encouraging competition across state lines, and reforming private insurers into nonprofits, the profit incentive is realigned to serve the consumer. **High**
Political Feasibility	Given the inherent inertia of the legislature, the current policy is most likely to continue with small revisions. **High**	Given that the bill has passed before, it is feasible that the individual and employer mandates could return. **Moderate**	Proved infeasible to even those within the Republican Party; as it was, it did not address core issues in either market. **Low**	Highly controversial to Republicans who believe eliminating private insurance is a large governmental overreach. **Low**	The EHA assuages Democratic concerns over private insurance profiteering and assuages Republican concerns over fiscal irresponsibility. **Moderate**

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