Progressive Prescriptions for a *Healthy America*

The Progressive Priorities Series

Center for American Progress

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Progressive Prescriptions for a Healthy America

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The Progressive Priorities Series:
An Action Agenda for Progressive Policymakers

by the

Center for American Progress

As a new presidential term and a new Congress begin, the Center for American Progress has launched the Progressive Priorities Project to provide policymakers and the public with a positive vision for progressive policymaking supported by a series of new and bold policy ideas in priority areas identified by American Progress. *Progressive Prescriptions for a Healthy America* is the tenth of more than a dozen papers in the series that American Progress will issue over the course of the coming weeks. In addition to providing broad policy recommendations, each of the papers in the series proposes specific steps that policymakers can take to achieve the broader policy goals. Each of the papers is posted on our website as they are released at www.americanprogress.org, and all of the papers in the series will be compiled and published as a book early this year.

The Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just and free America that ensures opportunity for all. We believe that Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect these values. We work to find progressive and pragmatic solutions to significant domestic and international problems and develop policy proposals that foster a government that is "of the people, by the people, and for the people."

Progressive Prescriptions for a Healthy America

When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.

—Herophilus of Chalderon, Greek physician and philosopher, 335-280 BC

Executive Summary

America's health system is in crisis, leaving out too many and costing too much. To meet this challenge, the Center for American Progress proposes a bold but practical approach to guaranteeing an American right to affordable, quality health care. It knits together employer insurance and Medicaid; promotes prevention, research and information technology; and finances its investments through a small, dedicated value-added tax. This paper builds on the main description of the plan[1] to identify concrete, immediate steps that the administration and Congress can take to set us on the path toward a seamless, value-oriented health system.

INTRODUCTION

America's health system is in crisis, leaving out too many and costing too much. Forty-five million Americans lack health insurance today. Millions more are struggling to pay premiums that are growing five times faster than wages, even as their benefits shrink. While some Americans have access to the most sophisticated medical care in the world, others are left to overcrowded emergency rooms, underfunded clinics, or no health care at all—all because they lack the insurance it takes to pay for the care they need. These injustices are inconsistent with Americans' respect for human dignity and commitment to opportunity for all. Unlocking our health care system's potential for everyone in America is the great moral challenge of our time.

To meet this challenge, the Center for American Progress proposes a practical, fair, and responsible plan to improve our health, not just our health care system. Rather than dismantling our current system and starting from scratch, the Center's plan builds on the system's strengths while responding to its serious shortcomings. By embracing this approach, the Center's plan guarantees affordable, valuable health coverage for everyone, including those who have coverage today. Our reforms ensure that cost is not a barrier to coverage by providing income-related financial assistance. Additionally, by investing in key areas to improve health care quality and outcomes while reducing costs, Americans will get better value for their health care dollars. In return for these advancements, all individuals will be expected to contribute toward the health care system they will inevitably use. Accordingly, we propose to help pay for the investments necessary to improve access, affordability, and quality through a small value-added tax, the revenues from which will be dedicated exclusively to health system improvements. The Center's plan requires tough choices and shared sacrifice, but Americans do not shy away from the hard work necessary to ensure greater opportunity and security for all.

The benefits from securing affordable, valuable health coverage for all are not abstract. Modern medicine provides us with innumerable opportunities to live our lives to the fullest. For example, proper prenatal care dramatically reduces complications during pregnancy, birth defects, and infant mortality. Immunizations protect infants, children, and adults from illnesses and death caused by infectious diseases. Scientific advancements in the diagnosis and treatment of mental illnesses enhance the hope of recovery. Medications enable otherwise impaired people to work. State-of-the-art heart treatments, such as the implanted defibrillator received by Vice President Cheney and the quadruple bypass surgery received by former President Clinton, reduce the risk of dying from a heart attack.

Today, millions of Americans are denied such opportunities because they lack one simple protection: health insurance. Health insurance is the portal to our health care system. Without it, even routine health care services can be priced out-of-reach or otherwise denied, resulting in prolonged illnesses and worse health outcomes. When uninsured individuals do receive care, they are likely to be treated differently than those who have health insurance. For example, uninsured persons with traumatic injuries are less likely to be admitted to the hospital, receive fewer services if they are admitted, and are more likely to die than insured trauma patients.[2] Experts estimate that lack of health insurance causes 18,000 unnecessary deaths among adults each year in the United States.[3] Other effects of our failing health system are less obvious but no less devastating. For example, parents desperate to get their children much-needed mental health treatment are sometimes left with no option but to relinquish their children to the foster care system.[4] Americans face these difficult choices every day in their struggle to get the health care they and their families need.

Guaranteeing an American right to affordable, quality health coverage will not only lead to unprecedented gains in personal health and opportunity, it will also improve the economic health of our nation. Uninsured individuals pay $33 billion out-of-pocket for the care they receive each year, and an additional $41 billion in "uncompensated" care costs placed on and passed through the health system.[5] These costs are borne by everyone, in the form of higher premiums for those who are insured and higher taxpayer costs to support safety net providers. In addition, the potential economic value to the nation to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year.[6] Accordingly, the costs to the nation of our failing health system—even apart from the individual gains to be had with respect to personal health and opportunity—justify securing affordable, valuable health coverage for everyone.

America's health care crisis is not inevitable or a conundrum that defies solution. It is a pressing national problem festering in the midst of political paralysis. Our nation's leaders have issued urgent warnings of a Social Security crisis that in fact does not exist. Yet, they have turned their backs on the suffering and insecurity millions of Americans face each day. Just as our nation has overcome tough challenges in the past, we can do so again. Our history is marked by moments where leaders broke through what were then viewed as insurmountable obstacles to achieve what are now considered basic, even

sacred, protections. Ensuring affordable, high-quality health care is this generation's great challenge. With conviction and a practical, fair, and responsible plan, it can be achieved.

Practical. The human and economic costs of large and persistent insurance gaps require that our nation expand affordable health coverage to all as quickly as possible. Policy solutions must be streamlined and simplified. Elements necessary to achieve the goal must be the highest and most pressing priority, while excessive details and extraneous issues that could derail success must be tabled. Policy options that build on existing structures and areas of consensus must be embraced.

Fair. Health care must be affordable and accessible to all, irrespective of health, age, income, or work status. Improving fairness and expanding opportunity necessarily means targeting those left out of the system by providing new options and financial assistance to remove existing barriers to coverage. It also means lowering the cost and improving the value of coverage for those who struggle to pay for it today. Coverage should be improved as it is expanded.

Responsible. Achieving and sustaining affordable, valuable health care coverage for all requires increased responsibility from each of us and the nation as a whole. In exchange for a seamless, affordable health system, everyone must be held responsible to either sign up for health coverage or pay into this system which they will inevitably use. And at a time of mounting federal deficits and concern about rising health care costs, a credible, responsible approach to improving health and health care for all must tackle difficult financing questions. Americans recognize that few good things in life are free. To reap the tremendous personal and national benefits of improving health and health care for all, we must secure adequate, sustainable financing necessary to achieve the goal.

CURRENT STATE OF PLAY

The United States has a health care crisis that is getting worse, not better over time. After a brief decline in the number of uninsured from 1998 to 2000, five million additional Americans lost their health insurance from 2000 to 2003.[7] At latest count, 45 million Americans lack health insurance.[8] Meanwhile, there are many troubling warnings signs about the state of Americans' health. For example, the United States has lower life expectancy than 22 other nations,[9] near-epidemics of preventable conditions,[10] and an infant mortality rate that actually rose in 2002 for the first time in 40 years.[11] We can improve our health through better health care. For example, approximately one in six pregnant women, and one in four pregnant African-American women, do not get early prenatal care.[12] By improving access to such care, we can dramatically reduce infant mortality, birth defects, and low birth weight—which will in turn reduce health problems later in life. Nothing will do more to improve access to health care than extending health coverage to all and improving the value of health coverage for all.

The majority of uninsured individuals report that they lack coverage because it is too expensive.[13] This is no surprise: the average total premium for an employer-based family plan was $9,950 in 2004[14]—representing nearly the entire annual income of a full-time, minimum-wage worker. The cost of premiums for employer-based plans has outpaced wage growth by nearly fivefold since 2000,[15] affecting not just employees and their families, but businesses and jobs. Unlike other industrialized nations, the United States relies heavily on employers to pay for health benefits as part of employee compensation, rather than broad-based financing sources. As a result, employers are forced to choose between maintaining health benefits, increasing wages, and adding jobs.

Most employers offer health benefits and want to continue to do so. In 2004, 63 percent of small employers (3 to 199 workers) and 99 percent of large employers (200 or more workers) offered health benefits.[16] Most employers believe it is very important to provide or contribute to their employees' health coverage and support efforts to expand employment-based coverage to more working families.[17] Yet employer-based coverage is eroding. In 2004, at least five million fewer jobs provided health insurance than in 2001.[18]

These trends in employment-based coverage would have translated into even greater growth in the number of uninsured had it not been for Medicaid, the federal-state health program for low-income individuals. Medicaid enrollment among the non-elderly increased by nearly 6 million from 2000 to 2003,[19] despite significant fiscal pressures in the states resulting from the economic downturn and federal tax cuts. Like employers, states are struggling with health care costs, as governors project average state Medicaid spending growth rates of 12.1 percent in FY 2005.[20]

These cost and coverage pressures in both the public and private sectors have created a growing consensus for change and an opportunity to achieve long overdue reforms. By pursuing a practical, fair, and responsible plan for improving health and health care coverage, we can ensure that everyone in the United States has an equal opportunity to affordable, high-quality health care. The resulting health and economic gains will benefit individuals, employers, communities, and the nation as a whole.

PROGRESSIVE POLICY RECOMMENDATIONS AND ACTION PLAN

Achieving affordable, valuable health care coverage for all requires action in three major policy areas: expanding access to coverage by building on existing structures; promoting fairness in the system by improving the affordability, adequacy, and value of coverage; and fully funding these improvements through shared responsibility.

Expanding Access to Coverage

Today, the majority of insured, non-elderly Americans have either employment-based coverage (78 percent) or Medicaid (13 percent).[21] Rather than dismantling our health system and starting from scratch, we propose filling the gaps between these two primary sources of coverage. We recommend supplementing the employer system with a new health insurance pool, modeled on the federal employees' health insurance system, for individuals as well as employers seeking a stable, affordable choice of private health insurance plans. Furthermore, we recommend expanding and strengthening Medicaid. These policies are described below.

Expand stable, affordable coverage options for individuals and employers

Building on the two largest sources of coverage today—job-based health benefits and Medicaid—would vastly improve access to health care. But these options are not enough to ensure access for all. Those who make too much to qualify for Medicaid, but have no access to affordable coverage through their job or a family member's coverage, can be left without options. Today, most such individuals are either uninsured or get coverage through the individual market. However, obtaining coverage through the individual market presents a number of challenges, particularly for those with limited incomes or known health problems. Rather than pursue the aggressive regulation and oversight that would be required to ensure access to coverage through the individual market, the Plan for a Healthy America proposes to ensure access through a new national health insurance pool.

A national health insurance pool modeled on the one available to federal employees will ensure a stable, affordable choice of private insurance plans. The Federal Employees Health Benefits Program (FEHBP) currently provides coverage throughout the nation to more than 8 million federal enrollees and their dependents.[22] Coverage is available to anyone who is eligible for FEHBP and premiums are community rated, so that no one can be denied coverage or charged more simply because of his or her age or health status. Because of its size and organization, FEHBP can offer a range of options with low administrative costs. Similar attributes will apply to the new health insurance pool. Additionally, our plan will further stabilize the costs and options for coverage available through the pool by creating reinsurance protections, as described below.

Through this health insurance pool, everyone will have access to the same stable, affordable coverage options available to federal employees—including the president, members of Congress, and Supreme Court justices. All employers will also have access to the new health insurance pool, but no employer will be required to join it. Employers with successful health benefit programs can keep them in place without disruption. But for those employers looking to streamline their efforts to provide quality health benefits, this pool will be an attractive option.

At the same time, employers will be encouraged to continue their present role in providing health benefits. The current tax advantages of job-based health benefits will be maintained, whether the employer contributes to its employer-sponsored plan or to coverage provided through the new health insurance pool. Employers who participate in the pool will reap the benefits of its administrative efficiencies and reinsurance protections.

To extend the private health insurance options that are available through FEHBP to additional individuals and employers, Congress should enact legislation creating the new health insurance pool. The legislation should provide that:

- Private insurers offering coverage through FEHBP must also offer coverage through the new health insurance pool.

- Individuals can directly enroll in coverage through the new pool.

- Any employer can offer its employees and their dependents coverage through the pool. Employers must make an all-or-none decision about the health benefits they offer to their employees: tax-advantaged employee health benefits can either be offered through the new pool or outside it, but not both. This approach will prevent employers from selectively enrolling relatively healthy (and inexpensive) employees in the employer-sponsored plan while enrolling relatively unhealthy (and expensive) employees into the new pool.

- Reinsurance protections will be created to prevent unexpectedly high premiums due to enrollment of sicker individuals. This reinsurance will reimburse insurers participating in the new pool for a percentage of any individual's claims costs in excess of an annual threshold, effectively spreading the costs of the highest-cost individuals across society.

Strengthen and expand Medicaid

Medicaid provides essential protections for more than 52 million of the nation's most vulnerable children, low-income parents, persons with disabilities, and seniors.[23] Yet, due to complex eligibility rules and competing demands on limited state resources, many low-income Americans remain uninsured. In 2003, more than one-third of non-elderly Americans with incomes below the federal poverty level ($14,860 for a family of three in 2003) were uninsured.[24]

Medicaid should be expanded to protect the working poor and indigent adults who often fall through the cracks of today's system. Federal constraints on program eligibility will be removed so that every person earning less than a certain percentage of the poverty level (*e.g.*, 100 to 150 percent of poverty, or $19,350 to $29,025 for a family of four in 2005) will qualify. To offset new state costs due to this expanded eligibility, the proportion of Medicaid spending funded by the federal government will be increased. States are already struggling to make ends meet in the wake of the economic downturn

and lost revenues from federal tax cuts. To prevent these state fiscal constraints from impeding progress in covering the uninsured, new federal revenues will be dedicated to ensuring coverage for all low-income individuals. However, states will receive full federal assistance to extend coverage only if they effectively enroll those eligible for the program.

Using its administrative authority, the Department of Health and Human Services (HHS), under the direction of the Center for Medicare and Medicaid Services, should take the following two steps to encourage full enrollment. First, HHS should promote simplification and ease current Medicaid eligibility requirements (as permitted under existing legislative authority). It should issue program guidance that clarifies that states can in many cases drop the Medicaid asset tests or set it to the lowest common denominator across low-income programs like Temporary Assistance for Needy Families (TANF) and food stamps. An interagency working group should establish the definition of this minimum allowable asset test.

Second, HHS should undertake an aggressive effort to enroll all individuals who are currently eligible for Medicaid and the State Children's Health Insurance Program by: issuing a letter to state Medicaid directors emphasizing the availability of enhanced federal matching funds for all state outreach, eligibility, and enrollment activities; issuing program guidance clarifying the quality control safe harbors to assure states that they will not be penalized for using presumptive eligibility and other aggressive enrollment standards; and increasing federal outreach initiatives (*e.g.*, through media campaigns and partnerships with local and charitable organizations).

Congress should enact legislation to enable more individuals to qualify for Medicaid. The legislation should:

- Expand Medicaid eligibility to all individuals with incomes below a certain percentage (*e.g.*, 100 or 150 percent) of the federal poverty level, with full federal financing of expansions. Specify that states will receive this increased federal assistance to extend coverage only if they effectively enroll those eligible for the program.

- Change the definition of assets under the Supplemental Security Income (SSI) program, for purposes of determining Medicaid eligibility only. This follows the precedent set in the regulations for the Medicare low-income drug benefit, which use the SSI definition of assets as the basis for determining Medicare low-income drug benefit eligibility in the first year, but then index those asset limits to inflation in subsequent years.[25] The result is an asset limit that grows with inflation, rather than staying at the same nominal level and effectively restricting eligibility over time.

- Clarify that states can allow families earning up to 250 percent of the federal poverty level to obtain Medicaid coverage for their children with serious disabilities, as contemplated in the Family Opportunity Act.[26]

Promoting Fairness

The policy recommendations described above would ensure that everyone in the United States has access to health insurance, regardless of their health status, state of residence, age, gender, or other characteristics. Additional protections are necessary, however, to ensure that the coverage is affordable, adequate, and provides value. Under our plan, as described below, Medicaid expansions and tax credits will make coverage more affordable for low- and middle-income Americans. We also recommend policies to ensure the adequacy of Medicaid benefits so that cost-sharing is not a barrier to appropriate care for low-income Americans. In addition, the value of health coverage can be improved, ensuring that Americans get the most out of their health care dollar. While American health care can be the most advanced in the world, it is also bedeviled by high costs and inconsistent quality of care. Those on the receiving end of health care too often encounter a system that focuses on diseases rather than patients, is geared toward treating rather than preventing problems, and frequently promotes high-cost but low-value care. Therefore, rather than only expanding access to the current system, we must lay the groundwork for improving health care quality and value by focusing on three key areas that could produce large returns on investment: health promotion, improved information, and cutting-edge information technology.

Ensure affordability and adequacy of coverage

The federal government currently subsidizes health benefits, but those subsidies are not distributed fairly. Although the United States leads the world in its health spending, it trails all other industrialized nations in the government's share of spending on health care.[27] Generally, the only federal assistance available to working families is a tax subsidy for employer contributions to coverage. Those contributions are not counted as individual income and therefore are not taxed. Because the value of this subsidy is based on tax rates, the average federal tax benefit increases with income; it is nearly 28 times higher for an individual with income above $100,000 than below $10,000.[28]

Expanding Medicaid to all low-income individuals, as described above, will begin to correct this imbalance. Yet, even with expanded Medicaid eligibility, inequities in Medicaid benefits across states and among eligible populations can still leave health care unaffordable. Medicaid waivers approved by the Bush administration that allow further leeway on benefits and eligibility have exacerbated these inequities. Therefore, we also recommend policies to ensure the adequacy of Medicaid benefits for low-income Americans.

Middle-income Americans also struggle with high insurance premiums and the inequities of the current system. For example, more than one-third of uninsured individuals in 2003 lived in households with income of more than $37,000.[29] To ease these burdens, under our plan, no individual will ever have to pay more than a small percentage (*e.g.*, 5 to 7.5 percent) of his or her income on health insurance premiums. This protection, administered as an easy-to-access, refundable tax credit, will apply to employer-based health insurance as well as coverage obtained through the new health

insurance pool. In addition, we propose to extend existing employee protections to ensure that all employers that offer health benefits provide equal opportunity for all employees to participate. The following steps should be taken to implement the above approach:

First, using existing authority, the Department of Health and Human Services, under the direction of the Center for Medicare and Medicaid Services, should reduce the inequities in Medicaid benefits and assure a minimum level of protection for all beneficiaries. To do so, the Department should: refuse to approve any new or pending section 1115 waiver that restricts benefits or eligibility; and issue program guidance establishing minimum specifications for assessing state compliance with current benefit rules.[30]

Second, Congress should direct the Government Accountability Office (GAO) to conduct a review of all existing waivers to assess compliance with existing benefit laws and recommend modifications as necessary.

Third, Congress should enact legislation to protect individuals and families from excessive health insurance premiums. The legislation should include provisions that:

- Create a refundable tax credit to ensure that an individual's premiums for health insurance available through an employer or the new health insurance pool never exceeds a certain percentage (*e.g.*, 5 to 7.5 percent) of the individual's income. This tax credit should be efficiently administered, minimize barriers to coverage due to cost (*e.g.*, address liquidity concerns for low-income individuals), and provide adequate protections against fraud and abuse. In implementing this provision, the Department of Treasury should determine whether the administration of the existing Health Coverage Tax Credit[31] can be adapted without prohibitive costs.

- Clarify that employers that offer health benefits, whether those benefits are fully insured or self-insured, must provide all workers with equal opportunity to participate in those benefits, in terms of both eligibility and contributions.

Enhancing value: three approaches

The United States spends more on health care than any other nation. In 2003, U.S. health care spending totaled $1.7 trillion, which is an average of $5,670 per person.[32] Yet Americans do not always receive the best quality care. In fact, American adults receive recommended care only about half the time, with under-utilization more common than over-utilization.[33] The mismatch between what we spend and what we get, in terms of the uneven quality of health care, presents a crucial challenge in achieving affordable, valuable health care coverage for all. It is not enough merely to expand access to the current system. Americans must also secure better value for their health care dollars through improved health care quality, outcomes, and efficiency. We focus on three key value improvements that could produce large returns on investment.

First, we must create a national focus on disease prevention and health promotion. The United States is plagued by preventable diseases that have a devastating impact on personal health and contribute to the nation's soaring health costs. Yet our current health system focuses on treating these diseases after they occur, rather than promoting good health and reducing the incidence of disease in the first place. This misguided approach is due, in large part, to disincentives embedded in the system. With no guarantee that an enrollee will remain in a specific insurance plan, insurers have little incentive to invest in keeping that enrollee healthy over an extended period of time. Instead, they simply try to avoid enrolling people who are, or likely to become, sick.

To ensure that these failings are not perpetuated, we propose a new model for preventive care and health promotion. Preventive services will be carved out of private health insurance, removing the perverse incentives from the current system. In particular, Congress should enact legislation creating a universal preventive benefit. The legislation should provide that:

- The core preventive services to be included in the benefit should be based on current recommendations of the U.S. Preventive Services Task Force.[34]

- The U.S. Surgeon General, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the U.S. Preventive Services Task Force should work together and with state and local public health officials to carry out the following activities:

    - Develop a process for updating the covered preventive services over time, based on future recommendations from the U.S. Preventive Services Task Force and other evidence-based guidelines.

    - Consolidate and strengthen health promotion activities by creating an aggressive, community-based system to educate individuals about ways to promote health, prevent disease, and manage mild health problems. Preventive care will be available through both the new community-based system and through physicians and other providers, who will continue to deliver both preventive and other medical services as they do today. Irrespective, such care will be reimbursed by the new preventive benefit.

    - Develop population-based measures for delivering preventive care to encourage better immunization rates, earlier detection of disease, and other improvements. Establish reimbursement guidelines for the preventive health benefit that encourage improvement on these measures. Ensure that investments in health information technology improvements (described below) facilitate these data efforts and enable providers to seamlessly integrate preventive care with care for chronic and acute conditions.

Second, we must develop better information about what constitutes high-quality, high-value care. Most health research focuses on determining whether a particular medicine or treatment is safe and works. There is little credible information comparing the relative value of one treatment with another. As a result, patients often receive care that drives up costs without improving health outcomes, while forgoing high-quality, high-value care. Federal investment in research on the comparative clinical and cost effectiveness of available treatment options will enable patients, providers, and payers to make sensible health care choices. We recommend that:

- Administratively, the Department of Health and Human Services, under the direction of the Agency for Healthcare Research and Quality (AHRQ), should aggressively implement section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[35] to the maximum extent possible under existing legal and budgetary authority. Section 1013 provides legislative authority for AHRQ to study the comparative effectiveness of therapies. In implementing this authority, AHRQ should establish strong conflict-of-interest protections for all research efforts. For the results of the research to be useful, the credibility of the methodologies used and individuals conducting the research must be beyond reproach.

- Congress should enact legislation to strengthen the research envisioned in section 1013. Congress originally authorized $50 million for implementation of section 1013, a very small fraction of the $1.7 trillion Americans spend on health care each year. Congress initially failed to appropriate even these amounts, however, instead earmarking $12 million of AHRQ's existing budget for fiscal year 2004. Appropriators also narrowed the research scope from all medical services to pharmaceuticals only. For fiscal year 2005, Congress reaffirmed the full scope of research contemplated in section 1013, but only appropriated $15 million. Congress should strengthen this research agenda by significantly increasing the amount of dedicated funding for the full scope of research. We also recommend housing this activity under a new, quasi-governmental organization to leverage private funding, facilitate broad public and private participation, and protect controversial findings from political pressure.

Third, we must bring health care out of the information "dark ages" and deliver critical information when and where it is needed. The health care sector has yet to reap the benefits of the information revolution. While doctors' offices and hospital rooms whir with exciting new medical technology, information technology is largely absent. Medical equipment churns out volumes of information, most of which is reduced to paper and stuffed in files along with handwritten notes. Cutting-edge information technology, structured to safeguard patients' privacy, has the potential to dramatically improve health care quality and produce a better care experience, while reducing total health care costs through administrative and clinical efficiencies. In particular, we recommend:

- Administratively, the Department of Health and Human Services, under the direction of the Center for Medicare and Medicaid Services, should establish Medicare and Medicaid demonstration programs to test reimbursement and programmatic changes specifically designed to encourage the implementation of clinical information technology and evaluate its impact on quality and outcomes, particularly for individuals with chronic conditions such as diabetes and hypertension.

- Congress should enact legislation establishing a health information infrastructure improvement fund to further the widespread adoption of standardized, compatible, and scalable information technology solutions. This fund will make available a combination of grants and loans to health care providers and others implementing technology solutions. The legislation should include specifications on standards and conditions that funding recipients must meet and the agency's priorities for approving grants and loans.

Sharing Responsibility

Ensuring affordable, valuable health coverage for all is an investment in the nation's health and economic wellbeing from which everyone will benefit. Those who are uninsured will benefit from the health and financial protections afforded by health insurance. Those who have health insurance will benefit from the added security of knowing that no change in work status, health status, or any other unforeseen circumstance will ever jeopardize their coverage. The entire nation will benefit from the reductions in costs from "uncompensated" care (*i.e.*, care that is provided but not paid for and therefore ultimately passed on to those who do pay); the health care quality improvements that result from increasing our emphasis on preventive care and making better use of health care information and information technology; and the productivity and other economic gains from a healthier population. The investment necessary to achieve these benefits is vital. However, any responsible plan for expanding affordable, valuable coverage to all must include a means to pay for that investment. The Center's Plan for a Healthy America takes on that challenge, calling on individuals and the nation as a whole to share the responsibility for fully funding this effort.

At the individual level, we call on each person to recognize the importance of maintaining health coverage. No one can accurately predict his or her future health or wealth. Even relatively minor illnesses can lead to large, unforeseen expenses. To enable all individuals to access the health care they need, when they need it—without unduly burdening society—it is critical that all individuals have health insurance. Therefore, in exchange for the guarantees of affordability and access, we expect individuals to either sign up for health insurance or pay an annual, income-related contribution to maintaining the health care system. It will be a choice as to which option to take, but individuals who decide not to sign up for health insurance must contribute to the cost of care that they will inevitably use and will have their care reimbursed by Medicaid by default.

At the national level, we recognize that investments in coverage and value will benefit all and should therefore be funded by all. The federal costs of the access, affordability, and value improvements we recommend, however, will exceed the potential savings of those improvements, at least from the relatively short-term federal budget window perspective. The nation currently faces a dismal federal budget outlook. Even without the current fiscal imbalance, securing affordable health care for all and realigning the system toward value-based health care will require greater federal funding. The premium revenues from newly insured individuals and the contribution from those who fail to sign up for coverage will provide some, but not all, of the necessary revenues.

Accordingly, we propose a broad-based mechanism to fund the necessary investments: a small value-added tax whose revenue is exclusively dedicated to improving the health system. A value-added tax (VAT) is a tax on the value of a good or service added in its various stages of production—effectively the difference between what a business sells and what it buys from other businesses. Currently, the United States has no national sales tax, few federal excise taxes, and state sales taxes that are applied to a relatively narrow set of goods. A broad-based VAT of 3 to 4 percent with targeted exemptions (*e.g.*, exempting small businesses, food, education, religion, and/or health care)[36] will be sufficient to offset the rough annual federal cost of the health care reforms we propose—between $100 and $160 billion per year.[37] Revenue from the VAT will go to a trust fund and be used exclusively to finance the plan.

The effect of a VAT on low- and middle-income families will be offset by the reduction of health insurance premiums for precisely those families. In addition, the targeted exemptions from the VAT will reduce its impact on those families. Thus, our proposal is progressive in its financing. For this reason, other scholars and policy makers have supported the VAT as a way to finance health system improvements.[38] With a history of bipartisan support, the VAT offers the simplest, most logical, least controversial way to fund our plan to extend affordable, valuable health care coverage to everyone in the United States. That said, the use of the VAT matters. Using a large VAT to replace the federal income tax system, for example, would be highly regressive since it would provide tax relief for high-income people rather than health assistance to low-income people and health benefits to all.

Thus, Congress should enact legislation to ensure responsible, sustainable funding of the health system improvements described above. In particular, the legislation should:

- Establish an appropriate contribution from those individuals who fail to select among health coverage options.

- Establish Medicaid reimbursement for services provided to individuals who are not otherwise insured. These additional Medicaid costs will be 100 percent federally financed.

- Establish a VAT that is dedicated to financing the access, affordability, and value improvements included in this health care proposal. The VAT should be broad-

based and have targeted exemptions. Revenue from the VAT will go to a trust fund and be used exclusively for investments in health care.

CONCLUSION

The United States can and must do more to ensure the health of its people by opening the door for all to the incredible benefits of 21st century health care. The crisis in America's health system, in which 45 million people lack health insurance and millions more struggle to pay for their health care and coverage, is neither inevitable nor unsolvable. This problem has been eradicated in virtually all of the leading nations of the world—including a number of nations with significantly less wealth than our own. In the United States, we can take inspiration from our history, which is marked by moments where our nation's leaders and citizens broke through what were then viewed as insurmountable obstacles to achieve what are now considered basic and sacred protections. A similar challenge faces this generation. Ensuring affordable, quality health care for all Americans is not an easy task. But it is an essential one that furthers the promise of justice for all and strengthens the fabric of our society. With conviction and determination, armed with a practical, fair, and responsible plan, this worthy goal can be achieved.

Endnotes

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