

Achieving Universal Health Insurance Coverage In the United States: Addressing Market Failures or Providing a Social Floor?

Based on BFI Working Paper 2023-05, [“Achieving Universal Health Insurance Coverage In the United States: Addressing Market Failures or Providing a Social Floor?”](#) by Katherine Baicker, UChicago’s Harris School of Public Policy; Amitabh Chandra, Harvard University; and Mark Shepard, Harvard University

Providing a basic bundle of publicly funded services, while allowing individuals to purchase additional coverage, could expand US health coverage in a financially sustainable way that maintained incentives for innovation.

How is it that among developed nations, the United States lags so far behind in health insurance coverage, with nearly 10 percent of its citizens uninsured? (See Figure 1). Evidence has shown that health insurance provides greater access to beneficial care with substantial health benefits. What would it take to ensure that all US citizens have at least a basic level of health insurance?

These and related questions motivate this new paper, which readers are encouraged to examine for an overview of the potential rationales for universal health insurance coverage, the evolution

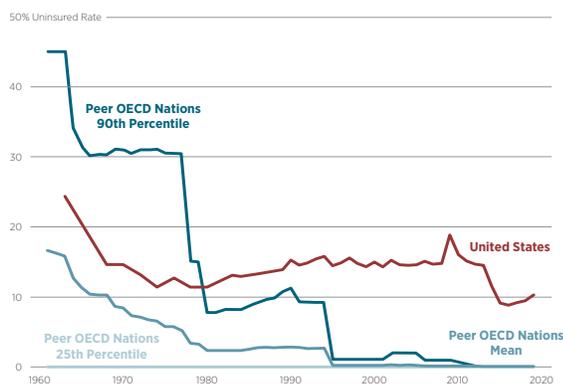
of US health insurance, comparisons to other systems, and a detailed discussion of the authors’ assessment of different policy options. This Finding highlights the authors’ dual approach to understanding the United States’ less-than-universal coverage and their assessment of how best to expand coverage.

1. The “Market Failures” Approach

To begin, a market failure refers to an instance where the distribution of goods and/or services via a private market is inefficient. Common examples are public goods, like streetlights, which are accessible to everyone and are nonrival (i.e., use by one person does not hinder use by another) – leading private markets to provide too little. Other examples include market concentration, where there is not enough competition to generate efficient prices; or asymmetric information, such as individuals knowing more about their health care needs than insurers.

Health markets abound in market failures, which has driven the predominant approach to insurance expansion. While this approach has yielded a large body of fruitful research elucidating the (many) problems affecting insurance markets, the authors argue that it has been less effective as a guide to universal coverage. This incremental approach via targeted policies to correct market failures results in a patchwork of policies, including expanding program eligibility, increasing subsidies, streamlining or nudging enrollment, finetuning risk adjustment, and penalizing uninsurance through individual and employer mandates. Indeed, many

Figure 1 • Health Uninsurance Rate in the United States and Peer OECD Nations, 1961-2019



Note: This figure shows the share of populations who lack health insurance coverage in the US and peer nations. Peer OECD nations are the 19 countries with consistent uninsurance data from 1961-2019 in the OECD Health Statistics database: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, Germany, Iceland, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Sweden, Switzerland, and the United Kingdom. We report the mean, 25th and 90th percentiles across these nations. US data is from Fiedler and Furman (2014), who compiled it from the National Health Interview Survey and other sources. Non-US data is from OECD Health Statistics.

of the policies in the 2010 Patient Protection and Affordable Care Act are based on this approach.

Unfortunately, this incremental approach has sustained a fragmented US insurance system with many inherent limitations, including labor market “job lock” (in which workers remain in a job for fear of losing health insurance), regressive financing, costly complexity, and limited incentives for investing in population health. Finally, this approach fails to coherently define the social welfare goal of how much insurance (and health care access) should be available “universally,” nor the effect of insurance design on system-level investment in medical capacity and innovation.

2. The “Social Floor” Approach

An alternative approach, similar to that of other high-income countries, would automatically provide a basic level of insurance to everyone and then focus attention on key questions about the design of basic coverage and the availability of alternatives. This approach makes explicit many of the underlying goals and tradeoffs that are obscured in the incremental approach grounded in correcting market failures.

The devil, of course, is in the details, and the authors describe how economics can play a key role in framing the questions and understanding tradeoffs that arise under a social floor approach. In brief, they raise the following central issues:

- First, the actual social floor, or “basic bundle,” must be defined, and the framing must not be on whether health care is a right, but how much health care is a right, given real-world funding, capacity, and resource constraints. This means more than just defining coverable services. For example, almost all health services can be “medically necessary” for certain patients in certain situations but quite wasteful (with virtually no health benefit) in other situations. The generosity of basic coverage depends on which mechanisms are used to limit spending on covered services, such as global medical budgets, provider prices, capacity constraints, patient cost sharing, and utilization controls.

- This first issue raises the second: Who is in charge of administering and delivering basic coverage? Importantly, who decides how much to pay for which services and for which patients? A more coherent system than the current one, which delegates some decision-making to private insurers and some to various regulations, could yield benefits of simplicity and lower administrative costs.
- Finally, what about individuals with the resources to purchase additional coverage? Decisions about allowing such “top up” options have economic, ethical, and distributional implications. Complicating the issue of fairness, for example, is the possibility that a top-up system could increase incentives for innovation in new treatments, with the benefits of such innovations redounding to all.

Of course, myriad political and logistical concerns would arise should the US move to a different framework, but those concerns need not be paralyzing. Other countries offer lessons and models. The United Kingdom, for instance, automatically covers all residents in its National Health Service, a public healthcare system with no out-of-pocket costs. The Netherlands and Switzerland provide universal coverage through a health insurance market in which people can choose among competing private plans offering basic coverage. Germany and Israel have systems of basic coverage through competing nonprofit plans, and Australia has a basic public medical system like the UK system, but with a much larger role for private hospitals and insurance. Finally, it is worth noting that the United States shares some similar components with these countries, so the idea of drawing on pieces of them is not farfetched.

Bottom line: Universal health insurance coverage is within reach for the United States if citizens and policymakers agree on what they mean by universal coverage and are willing to prioritize funding it. We could have a financially sustainable system in which all citizens have a basic level of health insurance and there are incentives for medical innovation that would benefit all. We just need to commit to a shared set of goals.

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