PRIVATE INSURANCE AND UNIVERSAL HEALTHCARE: HOW CAN PRIVATE INSURANCE BE UTILIZED WITHIN A UNIVERSAL HEALTHCARE SYSTEM IN THE UNITED STATES?

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I. BACKGROUND: THE CURRENT LANDSCAPE OF AMERICAN HEALTHCARE AND INSURANCE

Healthcare reforms dominated the Presidential debates leading up to the 2020 election. The flawed United States healthcare system has many problems, especially surrounding insurance coverage. As a result, a majority of Americans favor the implementation of a universal healthcare system.[1] However, the population is also hesitant to rid the system of private insurance altogether.[2] In response, this paper will analyze the current shortfalls of the American health insurance model, how other countries utilize private insurance in universal healthcare systems, and the best solution for doing the same in the United States.

A. THE AMERICAN HEALTH INSURANCE MODEL

The United States uses a mix of private and public health insurance with the burden of coverage being shared between the government, employers, and individuals.[3] Americans can get private health insurance through employers or by buying it directly.[4] Others receive public insurance through Medicaid[5] or the Veterans Administration ("VA").[6] Additionally, Medicare provides coverage for elderly individuals.[7] Medicare is unique in that it provides public coverage but still maintains a significant role for private insurance.[8]

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[1] Matthew Sheffield, *Poll: Most Americans Want Universal Healthcare but Don't Want to Abolish Private Insurance*, HILL (Feb. 7, 2019), https://thehill.com/hilltv/what-americas-thinking/428958-poll-voters-want-the-government-to-provide-healthcare-for.

[2] *Id.*

[3] Roosa Tikkanen et al., *International Health Care System Profiles: United States*, COMMONWEALTH FUND, (June 5, 2020), https://international.commonwealthfund.org/countries/united_states.

[4] *Id.*

[5] *Id.*

[6] *VA Health Care*, U.S. DEP'T VETERANS AFFS., https://www.va.gov/health-care (last updated Oct. 30, 2020).

[7] Tikkanen et al., *supra* note 3.

[8] *Id.*

1. Private Insurance: Employer-Provided Insurance and Market Exchanges

The Census Bureau estimated that 55.1 percent of the country's population received health insurance through their employers in 2018.[9] The Federal Government subsidizes these employer-sponsored health insurance plans through the Internal Revenue Code ("IRC").[10] Employers are allowed to deduct the cost of health insurance provided to their employees as business expenses, while the cost is excluded from employees' income.[11] Further, these costs are also exempted from payroll taxes.[12]

Beyond being subsidized, the ACA further encouraged employers to provide their employees with health insurance. With exceptions for small employers, the ACA required employers to cover workers or face penalties.[13] The ACA also extended tax credits equal up to 35 percent of premium costs to small business that provided insurance for their employees, another tax-related subsidy for private employer-provided insurance.[14]

The ACA also required states to create individual insurance exchanges.[15] Small businesses could purchase insurance through these exchanges, as well as individuals who did not receive employer-provided or public coverage.[16] Low-income individuals have these marketplace policies subsidized by the Federal Government.[17] The Census Bureau estimated that 10.8 percent of the American population directly purchased insurance in 2018.[18]

2. Medicare: Public Coverage with Role for Private Insurers

Medicare was established in 1965 under the Social Security Act.[19] Medicare provides health insurance for persons at least 65 years in age, as well as qualified disabled persons.[20] People receiving Social Security benefits are automatically enrolled in Medicare at age 65, while those who are not yet retired at that age may still apply for Medicare.[21] Medicare is funded through payroll taxes, as well as income-based premiums.[22] Medicare is unique as it provides compulsory public insurance coverage, but

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[9] EDWARD R. BERCHICK ET AL., HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018, at 2 (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf. However, other sources have estimated the percentage of the population receiving employer-based health insurance to be as low as 49 percent. *Health Insurance Coverage of the Total Population*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/total-population (last visited Aug. 4, 2020).

[10] Edward D. Kleinbard, We Are Better Than This: How Government Should Spend Our Money 307 (2015).

[11] *Id.*

[12] *Id.*

[13] *The Affordable Care Act: A Brief Summary*, NAT'L CONF. STATE LEGISLATURES (Mar. 2011), http://www.ncsl.org/research/health/the-affordable-care-act-brief-summary.aspx.

[14] *Id.*; *History and Timeline of the Affordable Care Act (ACA)*, EHEALTH, https://www.ehealthinsurance.com/resources/affordable-care-act/history-timeline-affordable-care-act-aca (last updated Oct. 24, 2020).

[15] The Affordable Care Act: A Brief Summary, supra note 13.

[16] *Id.*

[17] *Id.*

[18] BERCHICK ET AL., *supra* note 9, at 2.

[19] Sheffield, *supra* note 1.

[20] SOC. SEC. ADMIN., MEDICARE 1 (2021), https://www.ssa.gov/pubs/EN-05-10043.pdf.

[21] *Id.* at 9–10.

[22] *Id.* at 3.

individuals still have options to have basic or additional coverages provided by private insurers, as well.[23]

Medicare is comprised of four parts.[24] Part A provides hospital insurance for inpatient hospital expenses, as well as some health and hospice care expenses.[25] Part A coverage is provided at no cost to the recipients.[26] Part B provides medical insurance to cover expenses from doctors and preventative services.[27] Part B is partially funded by income-based premiums.[28] High-income individuals enrolled in Part B will pay higher premiums than lower-income individuals.[29] Part D provides prescription drug coverage and is also subject to income-based monthly premiums, as well.[30] Parts B and D are not mandatory.[31] Medicare enrollees have the option to supplement their Medicare coverage by purchasing a Medigap plan.[32] Medigap coverage is provided by a private insurance company and covers additional costs that are otherwise not covered by Medicare.[33]

Medicare Advantage ("MA") was previously known as Part C.[34] MA gives enrollees the option to choose a Medicare-approved health insurance plan with a private company.[35] Companies providing MA plans contract directly with the Federal Government, who pays a fixed amount for an enrollee's coverage every month.[36] Due to their contract with the Federal Government, MA plans cover the same services as Medicare Parts A and B,[37] but they may also offer additional benefits that are not covered by the government-provided Medicare plan.[38] Most MA plans also provide Part D coverage.[39] However, MA enrollees will usually have to utilize doctors within the plan's network, unlike Medicare, which is accepted by all doctors and hospitals.[40] This option provides Medicare-enrolled individuals flexibility and freedom to pursue private rather than public insurance if preferred.

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[23] *See Id.* at 3–5.
[24] *Id.* at 2.
[25] *Id.*
[26] *Id.* at 3.
[27] *Id.* at 2.
[28] *Id.* at 4.
[29] *Id.*
[30] *Id.* at 2, 6.
[31] *Id.* at 4, 6.
[32] *Id.* at 1.
[33] *Id.*
[34] *Id.* at 2.
[35] *Id.* at 5.
[36] CTRS. FOR MEDICARE & MEDICAID SERVS., UNDERSTANDING MEDICARE ADVANTAGE PLANS 9 (2020), https://www.medicare.gov/Pubs/pdf/12026-Understanding-Medicare-Advantage-Plans.pdf.
[37] *How Do Medicare Advantage Plans Work?*, MEDICARE.GOV, https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-advantage-plans/how-do-medicare-advantage-plans-work (last visited Aug. 4, 2020).
[38] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 36, at 9.
[39] *Id.* at 5.
[40] *Id.* at 6.

3. Medicaid and Veterans Administration: Limited Public Insurance

Public health insurance coverage is provided for low-income individuals through Medicaid[41] and for military veterans through the VA.[42] The Census Bureau estimated that 17.9 percent of the population received health coverage through Medicaid in 2018, while 1 percent received coverage through the VA.[43] Responsibility for Medicaid is shared by the Federal Government and state governments, with the Federal Government covering much of the costs.[44] One problem with these programs is that eligibility and coverages can vary by state.[45] This is especially demonstrated by state responses to Medicaid expansion under the ACA.

The ACA sought to expand Medicaid eligibility and coverage in all states to households with incomes up to 133 percent of the poverty level.[46] In *National Federation of Independent Business v. Sebelius* ("*Sebelius*"), Chief Justice Roberts held that withholding Medicaid funding if states did not expand coverage was unconstitutionally coercive.[47] Thus, states hold the ultimate power to decide whether to expand Medicaid or not.[48] As a result, Medicaid expansion has been inconsistent, including twelve states that still have not adopted plans to expand income eligibility.[49]

4. Other Changes Prescribed by the ACA

The ACA established regulations that gave the Federal Government power to prescribe minimum coverages that private insurers must provide through their policies.[50] Private insurers are also limited in the percentage of revenue that they can dedicate to profit and administrative expenses in order to limit premium costs.[51] For certain insurance plans, the ACA also prohibited insurers from denying coverage to those with preexisting health conditions or basing prices on these health conditions.[52]

One of the most important, yet controversial, provisions of the ACA was the individual mandate. The individual mandate required Americans to get

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[41] Tikkanen et al., *supra* note 3.

[42] *VA Health Care*, *supra* note 6.

[43] BERCHICK ET AL., *supra* note 9, at 2.

[44] *Medicaid Program*, BENEFITS.GOV, https://www.benefits.gov/benefit/606 (last visited Aug. 4, 2020).

[45] Tikkanen et al., *supra* note 3; Jeanine Skowronski, *A State-by-State Guide to Medicaid: Do I Qualify?*, POLICYGENIUS (Jan. 26, 2018), https://www.policygenius.com/blog/a-state-by-state-guide-to-medica*Id.*

[46] The Affordable Care Act: A Brief Summary, supra note 13; Louise Norris, A State-by-State Guide to Medicaid Expansion, Eligibility, Enrollment and Benefits, HEALTHINSURANCE.ORG (Nov. 18, 2020), https://www.healthinsurance.org/medica*Id.*

[47] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 585 (2012).

[48] *Id.* at 587.

[49] *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 22, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/; Bruce Japsen, *Medicaid Expansion Wins in Red State Missouri*, FORBES (Aug. 5, 2020, 12:01 AM), https://www.forbes.com/sites/brucejapsen/2020/08/05/medicaid-expansion-wins-in-red-state-missouri; *see* Appendix: Figure 1 for states that have not adopted plans to expand Medica*Id.*

[50] The Affordable Care Act: A Brief Summary, supra note 13.

[51] Michael J. McCue & Mark A. Hall, *How Have Health Insurers Performed Financially Under the ACA's Market Rules?*, COMMONWEALTH FUND (Oct. 11, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-have-health-insurers-performed-financially-under-acas-market.

[52] The Affordable Care Act: A Brief Summary, supra note 13.

health insurance coverage or pay a fine with their tax return.[53] The goal was to encourage persons that would otherwise go uninsured to gain coverage, thereby lowering adverse selection in healthcare markets and leading to lower premium costs.[54]

The constitutionality of the individual mandate was challenged in *Sebelius*.[55] In *Sebelius*, the Supreme Court held that the individual mandate could not be upheld by use of the Commerce Clause, as Congress cannot regulate inactivity.[56] Chief Justice Roberts held that the individual mandate forced individuals to participate in the marketplace, which the Commerce Clause does not give Congress the power to do.[57]

However, the individual mandate was ultimately upheld.[58] The individual mandate was distinguished from a penalty,[59] and the Court held that it functioned as and could be characterized as a tax on those without proper health insurance coverage.[60] Therefore, the individual mandate was protected by Congress's taxing power.[61]

Despite its constitutionality, the individual mandate proved unpopular. A majority of Americans viewed the individual mandate unfavorably.[62] Eventually, the individual mandate penalties were repealed, effective in 2019, so individuals will no longer face a government-imposed penalty for lack of insurance coverage.[63]

B. SHORTFALLS OF THE AMERICAN MODEL

Despite the efforts of the ACA, the American healthcare model continues to fall short when compared to peer countries. Three major areas of failure are costs, lack of coverage, and health outcomes.

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[53] Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, COMMONWEALTH FUND (July 11, 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors.

[54] *Id.*

[55] See generally Sebelius, 567 U.S. 519.

[56] *Id.* at 558.

[57] *Id.* at 552, 557.

[58] *Id.* at 574.

[59] *Id.* at 567–68.

[60] *Id.* at 574.

[61] *Id.*

[62] Ashley Kirzinger et al., *Kaiser Health Tracking Poll: November 2016*, KAISER FAM. FOUND. (Dec. 1, 2016), https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-november-2016.

[63] Eibner & Nowak, *supra* note 53. The repeal of the Individual Mandate led to a lawsuit challenging the constitutionality of the penalty-less mandate and its severability from the remainder of the ACA, which the Supreme Court agreed to hear on appeal from the Fifth Circuit. The case had not yet been decided at the time this paper was submitted for publication. Katie Keith, *Supreme Court to Hear Challenge to ACA*, HEALTH AFFAIRS (Mar. 2, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200302.149085/full/; *see* Texas v. United States, 945 F.3d 355 (2019), *cert. granted sub nom.* California v. Texas, No. 19-840, 2020 WL 981804 (U.S. Mar. 2, 2020).

1. Costs

The Organisation for Economic Co-operation and Development ("OECD") tracks a variety of statistics on its thirty-six member states, including healthcare statistics.[64] The comparative results come to an alarming conclusion: The United States spends, by far, more on healthcare than any of its peers. In 2018, the United States spent the equivalent of 16.9 percent of its GDP on healthcare expenditures.[65] This was over 90 percent greater than the OECD average of 8.8 percent.[66] The second-highest ratio on this list was Switzerland, which, at 12.2 percent, still spent nearly 40 percent less on healthcare expenditures as a percentage of GDP.[67] Even when taking population into account, the United States vastly outspends its peers. In 2018, the United States spent $10,586 per resident on healthcare, 165 percent greater than the OECD average of $3,994 per resident.[68] Again, Switzerland was second on this list, but Switzerland still spent over $3,000 less per capita on healthcare expenditures than the United States.[69] These costs may not be as alarming if not for the fact that these expenditures have not translated to greater coverage or better results,[70] both issues that will be discussed in the succeeding sections. Using the United States Bureau of Economic Analysis' estimate of 2018 GDP of $20.49 trillion,[71] if healthcare expenditures as a percentage of GDP were decreased even just to the level of Switzerland, the United States would have saved $963 billion in 2018.

The out-of-control costs in the United States can be attributed to many factors.

Ultimately, the United States has much higher price levels than its peers.[72] Using United States price levels as a base, the OECD determined that the United States' price levels for health-related goods and services were 28 percent higher than the average for other OECD countries.[73] The complexity of the United States' healthcare system leads to higher administrative costs, which have been estimated to be a quarter of health costs.[74] Prescription drug

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[64] OECD, HEALTH AT A GLANCE 2019: OECD INDICATORS 3 (2020), https://doi.org/10.1787/4dd50c09-en.

[65] OECD, *Health Expenditure in Relation to GDP*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 152, 152–53 (2020); *see* Appendix: Figure 2.

[66] *Id.*

[67] *Id.*

[68] OECD, *Health Expenditure Per Capita*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 150, 150–51 (2020); *see* Appendix: Figure 3.

[69] *Id.*

[70] *How Does the U.S. Healthcare System Compare to Other Countries?*, PETER G. PETERSON FOUND. (July 14, 2020), https://www.pgpf.org/blog/2019/07/how-does-the-us-healthcare-system-compare-to-other-countries.

[71] News Release, Bureau of Economic Analysis, Gross Domestic Product, 4th Quarter and Annual 2018 (Third Estimate); Corporate Profits, 4th Quarter and Annual 2018 (Mar. 28, 2019), https://www.bea.gov/news/2019/gross-domestic-product-4th-quarter-and-annual-2018-third-estimate-corporate-profits-4th.

[72] How Does the U.S. Healthcare System Compare to Other Countries?, supra note 70.

[73] OECD, *Prices in the Health Sector*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 154, 154–55 (2020); *see* Appendix: Figure 4.

[74] Lisa Rapaport, U.S. Health Spending Twice Other Countries' with Worse Results, REUTERS (Mar. 13, 2018, 2:07 PM), https://www.reuters.com/article/us-health-spending-idINKCN1GP2YN; The Strikingly High Administrative Costs of US Health Care, in 3 Charts, ADVISORY BOARD (July 23, 2018, 9:30 AM), https://www.advisory.com/daily-briefing/2018/07/23/administrative-costs (estimating 25.3 percent of hospital costs can be attributed to administrative costs).

spending is also much higher than in peer countries, which may be attributable to the lack government-negotiated prices, especially as compared to its peers.[75] As a result, the United States spends over 92 percent more on prescription drugs per resident than its peers' average.[76] Other potential cost drivers include the lack of preventative care, greater use of specialists, and advertising and branding for the many products and companies within the healthcare market.[77]

Rising costs continue, which adversely affects low-wage workers. Employer health insurance is becoming less affordable. A 2019 survey by the Kaiser Family Foundation ("KFF") found that the average annual premiums for a family's employer-provided insurance plan was over $20,000, and over $7,000 for individuals' plans, the cost of which is split by employers and employees.[78] However, the survey found that employees at lower-wage companies paid more than $1,000 more towards family plan premiums than employees at higher-wage companies.[79] Further, premiums have increased 54 percent since 2009, and the cost of families' contributions to their employer-sponsored health insurance has increased 71 percent.[80]

According to a study by the Commonwealth Fund, the rising costs that employees have to cover has not been matched by increases in income, as the combined contributions towards premiums and deductibles grew at a faster rate than median income between 2008 and 2018.[81] The costs of premiums for employer-sponsored plans increased, especially between 2016 and 2018, as premiums for family plans rose 5.1 percent and premiums for single plans rose 4.9 percent.[82] The subsidies for employer-provided health insurance through the IRC were estimated to cost the Federal Government $273 billion in 2019.[83] It is expected that these costs will be exacerbated by the repeal of the individual mandate penalties.[84] The Congressional Budget Office ("CBO") expects premiums to increase by an average of 7 percent in the next decade,[85] while the Commonwealth Fund estimated that the cost of premiums could increase by up to 13 percent.[86] Although reinsurance

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[75] *6 Reasons Healthcare Is So Expensive in the U.S.*, INVESTOPEDIA (May 12, 2020), https://www.investopedia.com/articles/personal-finance/080615/6-reasons-healthcare-so-expensive-us.asp.

[76] The United States spent $1,443 per resident on prescription drugs, while the average across other countries was only $749 per person. Rapaport, *supra* note 74.

[77] 6 Reasons Healthcare Is So Expensive in the U.S., supra note 75.

[78] Reed Abelson, *Employer Health Insurance Is Increasingly Unaffordable, Study Finds*, N.Y. TIMES (Sept. 25, 2019), https://www.nytimes.com/2019/09/25/health/employer-health-insurance-cost.html; Tara Golshan, *Health Care Is Getting More and More Expensive, and Low-Wage Workers Are Bearing More of the Cost*, VOX (Sept. 30, 2019, 5:30 PM), https://www.vox.com/policy-and-politics/2019/9/30/20891305/health-care-employer-sponsored-premiums-cost-voxcare.

[79] Golshan, *supra* note 78.

[80] *Id.*

[81] Sara R. Collins et al., *Trends in Employer Health Care Coverage, 2008-2018: Higher Costs for Workers and Their Families*, COMMONWEALTH FUND (Nov. 21, 2019), https://www.commonwealthfund.org/publications/2019/nov/trends-employer-health-care-coverage-2008-2018.

[82] *Id.*

[83] *How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?*, TAX POL'Y CTR., https://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work (last visited Aug. 4, 2020).

[84] CONG. BUDGET OFF., FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2018 TO 2028, at 2–3 (May 2018), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf; Eibner & Nowak, *supra* note 53.

[85] CONG. BUDGET OFF., *supra* note 84, at 2–3.

[86] Eibner & Nowak, *supra* note 53.

programs have successfully reduced insurance premiums in Maryland and Oregon, this practice is not widespread and does not address rising costs elsewhere in the healthcare industry.[87]

These rising costs have been especially difficult on lower-wage workers. Health benefits are now approximately 20 percent of total compensation due to the rising cost of premiums.[88] For many low-wage workers, the amount can reach up to 30 percent of total compensation.[89] These and other health-related cost burdens are a driving force of bankruptcies, as studies have found that about 530,000 bankruptcies filed annually are attributed to medical debts.[90] Up to 66.5 percent of bankruptcies are due to, at least in part, medical costs, more than any other factor.[91]

It should also be noted that the United States does not consistently utilize strict price controls or government regulations in the healthcare market like other countries do.[92] Some states have successfully taken steps to regulate costs and control prices. Maryland has implemented healthcare spending and hospital revenue caps that are similar to regulations that many European countries use to stabilize costs.[93] Another example are the price caps that Colorado, Illinois, and Virginia have placed on insulin.[94] However, the United States' healthcare market is fragmented, especially state-to-state, which means such regulations are not seen on a consistent basis throughout the country.[95]

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[87] *State Reinsurance Programs Lower Premiums and Stabilize Markets – Oregon and Maryland Show How*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Jan. 14, 2019), https://nashp.org/state-reinsurance-programs-lower-premiums-and-stabilize-markets-oregon-and-maryland-show-how/.

[88] Rana Foroohar, *The American Way of Health Care*, FIN. TIMES (Feb. 4, 2018), https://www.ft.com/content/9eaa44ca-082e-11e8-9650-9c0ad2d7c5b5.

[89] Golshan, *supra* note 78.

[90] Michael Sainato, *'I Live on the Street Now': How Americans Fall into Medical Bankruptcy*, GUARDIAN (Nov. 14, 2019, 2:00 AM), https://www.theguardian.com/us-news/2019/nov/14/health-insurance-medical-bankruptcy-debt.

[91] Lorie Konish, *This Is the Real Reason Most Americans File for Bankruptcy*, CNBC (Feb. 11, 2019, 11:32 AM), https://www.cnbc.com/2019/02/11/this-is-the-real-reason-most-americans-file-for-bankruptcy.html.

[92] Dylan Scott, *9 Things Americans Need to Learn from the Rest of the World's Health Care Systems*, VOX (Jan. 29, 2020, 8:30 AM), https://www.vox.com/health-care/2020/1/29/21075388/medicare-for-all-what-countries-have-universal-health-care.

[93] Tara Golshan, *The Answer to America's Health Care Cost Problem Might Be in Maryland*, VOX (Jan. 22, 2020, 8:00 AM), https://www.vox.com/policy-and-politics/2020/1/22/21055118/maryland-health-care-global-hospital-budget.

[94] Aila Slisco, *Illinois Becomes Second State to Cap Monthly Insulin Prices, and More States Are Considering It*, NEWSWEEK (Jan. 24, 2020, 10:00 PM), https://www.newsweek.com/illinois-becomes-second-state-cap-monthly-insulin-prices-more-states-are-considering-it-1483987; Brooke Seipel, *Virginia Lawmakers Pass One of the Lowest Insulin Price Cap in Nation at $50 a Month*, HILL (Mar. 6, 2020, 10:15 PM), https://thehill.com/policy/healthcare/486419-virginia-lawmakers-pass-lowest-insulin-price-cap-in-nation-at-50-a-month.

[95] Scott, *supra* note 92.

2. Lack of Coverage

Although the ACA was successful in expanding health insurance coverage to millions of previously uninsured persons,[96] the Census Bureau determined that 27.5 million Americans, 8.5 percent of the population, remained uninsured for the entire year in 2018.[97] Both the uninsured rate and the number of uninsured persons increased in 2018 for the first time in a decade.[98] Unfortunately, the uninsured population is expected to continue growing.

The CBO expects the number of uninsured persons to increase by another 3 million in 2019.[99] The CBO mainly attributes this increase to two factors: the elimination of the individual mandate penalties through the TCJA and continued increases of premium costs.[100] However, other estimates predict that the CBO's estimate could represent the best-case scenario, as the Commonwealth Fund foresees a scenario in which the number of uninsured increases by 13 million.[101] Beyond 2019, the CBO estimates that the uninsured population will continue to grow over the next decade under the current healthcare regime in the United States, growing to 35 million in 2028, or 13 percent of the non-Medicare-eligible population.[102]

Various policies will continue to affect the number of uninsured individuals, specifically related to Medica*Id.* As five states have Medicaid expansion rolling out over the next few years, thousands more can expect to be covered in these states.[103] However, stricter work requirements for Medicaid coverage in states such as Indiana also threaten coverage for thousands.[104] Even worse results are found for low-income individuals and families in the remaining twelve states that have not expanded Medica*Id.* In states that had not yet expanded Medicaid, the median income limit in 2020 was $8,905 for a family of three, while adults without children remain ineligible.[105] Even worse, as the ACA did not anticipate low-income individuals to require insurance through the marketplace, many do not make

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[96] Sherry A. Glied et al., *Effect of the Affordable Care Act on Health Care Access*, COMMONWEALTH FUND (May 8, 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access.

[97] BERCHICK ET AL., *supra* note 9, at 2.

[98] *Id.*; Associated Press, *Number of Americans Without Health Insurance Rises for 1st Time in a Decade*, NBC NEWS (Sept. 10, 2019, 10:18 AM), https://www.nbcnews.com/politics/politics-news/number-americans-without-health-insurance-rises-1st-time-decade-n1052016.

[99] CONG. BUDGET OFF., *supra* note 84, at 1.

[100] *Id.*

[101] Eibner & Nowak, *supra* note 53.

[102] CONG. BUDGET OFF., *supra* note 84, at 1.

[103] *See* Norris, *supra* note 46; Louise Norris, *Idaho and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Jan. 6, 2020), https://www.healthinsurance.org/idaho-medicaid/; Louise Norris, *Nebraska and the ACA's Medicaid Expansion*, HEALTHINSURANCE.ORG (Oct. 20, 2020), https://www.healthinsurance.org/nebraska-medicaid/; *Medicaid Expansion*, UTAH DEP'T HEALTH (June 4, 2020), https://medica*Id.*utah.gov/expansion/; Japsen, *supra* note 49; Jackie Fortier, *Oklahoma Votes for Medicaid Expansion Over Objections of Republican State Leaders*, NPR (July 1, 2020, 4:44 PM), https://www.npr.org/sections/health-shots/2020/07/01/886307241/oklahoma-votes-for-medicaid-expansion-over-objections-of-republican-state-leader.

[104] Leighton Ku & Erin Brantley, *Indiana's Medicaid Work-Requirement Program Is Expected to Cause Tens of Thousands to Lose Coverage*, COMMONWEALTH FUND (Oct. 28, 2019), https://www.commonwealthfund.org/blog/2019/indianas-medicaid-work-requirement-program-expected-cause-tens-thousands-lose-coverage.

[105] *Id.*

enough money to qualify for marketplace subsidy options.[106] The KFF estimates that more than 2 million people fall within this gray area that they describe as the "coverage gap," a problem directly harming low-income individuals, and an example of inequity within the American healthcare system.[107]

3. Outcomes

Despite the United States vastly outspending its peers in healthcare, this has not led to better outcomes for its population. Life expectancy at birth in the United States is 78.6 years, less than the OECD average of 80.7 years, and comparable to the likes of Estonia, Turkey, and the Czech Republic.[108] Additionally, the United States had the largest decrease in life expectancy gains between 2012 and 2017, decreasing by 2.4 percent.[109]

Furthermore, the United States had a mortality rate from preventable and treatable causes higher than the OECD averages.[110] Mortality rates from avoidable causes in the United States were 175 per 100,000 population, while the OECD average was 133.[111] The mortality rate from treatable causes was 88 per 100,000 population compared to the OECD average of 75 per 100,000.[112]

The United States also experiences high infant mortality rates. The OECD notes that vulnerable groups, such as the socioeconomically-disadvantaged and indigenous groups, are especially at risk.[113] According the OECD, the United States had an average infant mortality rate between 2015 and 2017 of 4.8 deaths per 1,000 live births, while the average among OECD countries was 3.5.[114] According to the Centers for Disease Control and Prevention ("CDC"), there were over 21,000 infant deaths in the United States in 2018, a rate of 5.7 deaths per 1,000 live births.[115] In addition to high infant mortality rates, the United States also reported that 8.3 percent of live births in 2017 resulted in low birthweight infants.[116] The OECD average is 6.5 percent.[117] The United States' rate of low birthweight infants was comparable to the rates in Turkey, Hungary, and Brazil.[118]

Finally, the United States also has an opioid-related epidemic. Over-prescription and misuse of prescription medications are useful indicators of

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[106] *Id.*

[107] *Id.*

[108] OECD, *Trends in Life Expectancy*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 66, 66–67 (2020); *see* Appendix: Figure 5.

[109] OECD, *Trends in Life Expectancy*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 66, 66–67 (2020); *see* Appendix: Figure 6.

[110] OECD, *Infant Mortality (Preventable and Treatable)*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 72, 72–73 (2020).

[111] *Id.*; *see* Appendix: Figure 7.

[112] OECD, *supra* note 110, at 72–73; *see* Appendix: Figure 7.

[113] OECD, *Infant Health*, in Health at a Glance 2019: OECD Indicators 80, 80–81 (2020).

[114] *Id.*; *see* Appendix: Figure 8.

[115] *Infant Mortality*, CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last updated Sept. 10, 2020).

[116] OECD, *supra* note 113, at 80–81; *see* Appendix: Figure 9.

[117] OECD, *supra* note 113, at 80–81.

[118] *Id.*

quality of care, or lack thereof.[119] Compared to OECD countries, the United States has by far the greatest availability of prescription opioids,[120] and had a rate of 58 such prescriptions per 100 people in 2017.[121] The rate of opioid-related deaths in the United States, 131 per million people, dwarfs the OECD average, quintupling the OECD average of 26 opioid-related deaths per million people.[122]

These indicators, among many others, show that the rate of expenditures the United States make on healthcare are not justified by higher quality care. Though more money is spent, Americans continue to endure lesser outcomes as compared to their peers in other countries.

C. ENERGIZED CALLS FOR UNIVERSAL HEALTHCARE IN THE UNITED STATES

Due to the high costs and ineffective outcomes of the current healthcare model in the United States, pressure to implement a universal healthcare system has grown.[123] Polls regarding the topic show that most Americans want the Federal Government to implement a form of universal healthcare in the United States.[124] However, these polls also indicate that there is no general consensus as to what model of universal healthcare should be implemented.[125] Such disagreements persist even within the same political parties, as seen during the Democratic Presidential primaries.[126]

One area of great debate is the role of private health insurers. Some proposals, such as Vice President Biden's and Senator Klobuchar's, sought to build upon the ACA, rather than replace it, by introducing a public, government-sponsored health insurance option to compete with private insurers.[127] Another model, proposed by Senator Harris, would expand Medicare in its current form, continuing to utilize MA and preserving a major role for private insurance.[128]

Senators Bernie Sanders and Elizabeth Warren championed plans to expand government-sponsored health insurance to cover all Americans in

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[119] OECD, *Safe Primary Care - Prescribing*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 120, 120 (2020).

[120] OECD, *Opioids Use*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 92, 92–93 (2020); *see* Appendix: Figure 10.

[121] *Prescribing Practices*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html (last updated Aug. 13, 2019).

[122] OECD, *supra* note 120, at 92–93; *see* Appendix: Figure 11.

[123] *See* Dana P. Goldman & Kip Hagopian, *It Is Time for Universal Coverage Without Breaking the Bank*, 37 J. POL'Y ANALYSIS & MGMT. 182 (2017).

[124] Sheffield, *supra* note 1. Polling indicates that the Covid-19 pandemic has further affected the public's view on universal healthcare, as over 40 percent of the public is more likely to support universal healthcare in the United States now than they were prior to the pandemic. Yusra Murad, *41% of Public More Likely to Support Universal Health Care Amid Pandemic*, MORNING CONSULT (Mar. 13, 2020, 3:00 PM), https://morningconsult.com/2020/03/13/coronavirus-universal-health-care/.

[125] Sheffield, *supra* note 1.

[126] Lauren Fedor, *Democrats in a Fever Over Universal Healthcare Pledges*, FIN. TIMES (Sept. 22, 2019), https://www.ft.com/content/3e5bcc84-d964-11e9-8f9b-77216ebe1f17.

[127] *Id.*; Sarah Ewall-Wice, *Where All the 2020 Democratic Presidential Candidates Stand on Health Care*, CBS NEWS (July 25, 2019, 5:49 PM), https://www.cbsnews.com/news/2020-presidential-election-where-all-the-2020-democratic-presidential-candidates-stand-on-healthcare/.

[128] Danielle Kurtzleben, *Kamala Harris Releases 'Medicare for All' Plan With a Role for Private Insurers*, NPR (July 29, 2019, 6:00 AM), https://www.npr.org/2019/07/29/746051105/kamala-harris-releases-medicare-for-all-plan-with-a-role-for-private-insurers.

their Medicare-for-All plans.[129] Senator Sanders even proposed legislation in April 2019 that would expand Medicare to establish a national health insurance program.[130] Both Senators Warren and Sanders have been critical of private health insurance companies in the past,[131] and their plans left little to no role for private health insurance.[132] However, other Democratic candidates have criticized the proposals for being too costly[133] and for eliminating the role of private insurance.[134]

The role of private health insurance in the United States is an area of great debate. Polling suggests that Americans would prefer to keep private health insurance in some capacity,[135] but that role has been called into question through reforms such as those proposed by Senators Sanders and Warren. This debate raises two important questions: can private insurance be efficiently utilized in a universal healthcare system, and, if so, what is the best way to do so in the United States?

II. HOW PRIVATE INSURANCE HAS BEEN UTILIZED IN UNIVERSAL HEALTHCARE SYSTEMS WORLDWIDE

There are four models of healthcare throughout the world.[136] While some countries utilize single-payer, government-run systems, many countries still use private health insurance within their models.[137] As the OECD's statistics show, the United States lags behind all other countries in terms of healthcare expenditures, regardless of system.[138] Since polling suggests that Americans would prefer to keep a role for private insurance within a universal healthcare system, I will analyze the German and Swiss healthcare models and how private insurance is utilized to determine how such a system may be implemented.

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[129] Fedor, *supra* note 126; Thomas Kaplan et al., *Elizabeth Warren Proposes $20.5 Trillion Health Care Plan*, N.Y. TIMES (Nov. 1, 2019), https://www.nytimes.com/2019/11/01/us/politics/elizabeth-warren-medicare-for-all.html.

[130] The proposed legislation was sponsored by four other Democratic Senators that ran for President: Senators Warren, Harris, Gillibrand, and Booker. Medicare for All Act of 2019, S. 1129, 116th Cong. § 101 (2019).

[131] Glenn Kessler, *Sen. Bernie Sanders on the Health-Care Industry*, WASH. POST (July 30, 2019, 5:59 PM), https://www.washingtonpost.com/politics/2019/live-updates/general-election/fact-checking-the-second-democratic-debate/sen-bernie-sanders-on-the-health-care-industry; Elizabeth Warren (@ewarren), TWITTER (Sept. 12, 2019, 5:28 PM), https://twitter.com/ewarren/status/1172305963182768128; Sydney Ember, *Sanders Calls for Rivals to Reject Money From Health Care Industry*, N.Y. TIMES (July 17, 2019), https://www.nytimes.com/2019/07/17/us/politics/bernie-sanders-health-care.html.

[132] Fedor, *supra* note 126; Kaplan et al., *supra* note 129.

[133] Fedor, *supra* note 126.

[134] John Fritze, *Amy Klobuchar Hits Hard Against Bernie Sanders' Medicare for All Plan at 3rd Dem Debate*, USA TODAY (Sept. 12, 2019, 9:02 PM), https://www.usatoday.com/story/news/politics/elections/2019/09/12/democratic-debate-klobuchar-slams-sanders-medicare-all-plan/2306601001.

[135] Sheffield, *supra* note 1.

[136] Mimi Chung, *Health Care Reform: Learning from Other Major Health Care Systems*, PRINCETON PUB. HEALTH REV. (Dec. 2, 2017), https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems.

[137] Sarah Kliff, *Private Health Insurance Exists in Europe and Canada. Here's How It Works.*, VOX (Feb. 12, 2019, 7:30 AM), https://www.vox.com/health-care/2019/2/12/18215430/single-payer-private-health-insurance-harris-sanders.

[138] *See generally* OECD, *supra* note 68.

A. SWITZERLAND

1. System Overview

a. Private Insurance Markets

Switzerland's healthcare system, Santésuisse has no government-provided coverage, only private insurance.[139] Much like the ACA sought to achieve through the individual mandate, buying insurance in Switzerland is mandatory.[140] If you are staying in Switzerland for more than three months, even just as a tourist, you must buy health insurance by an approved health insurance provider.[141]

Individuals must buy their own insurance through regional exchanges, as there are no government-provided options or employer-sponsored plans.[142] Residents pay for their own health insurance, although the government, mostly cantonal, will provide subsidies, as well.[143] Basic health insurance plans provide the same government-mandated coverages across providers.[144] Basic insurance plans cover general check-ups, hospital services, prescription costs, dental emergencies, and women's health services, among other services.[145] Due to the mandated coverage, every Swiss resident is guaranteed a minimum level of coverage and care as prescribed by the government.[146]

Individuals may choose higher deductibles to lower premium costs, or they may choose plans with higher premium costs but lower deductibles.[147] When providing basic coverage, insurance companies may not deny coverage based on age or health status, and premiums are based on the insured's age and region.[148] Premiums may differ across companies, but premiums may not differ within the same company for anyone within the same age group and region.[149]

In addition to basic coverages, an individual may elect to buy supplemental or complementary coverage for expenses not covered by the

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[139] David Rook, *How Does Healthcare in Europe Work?*, JP GRIFFIN GRP.: EMPLOYEE BENEFITS BLOG (Jan. 11, 2018), https://www.griffinbenefits.com/employeebenefitsblog/how-does-healthcare-in-europe-work; Kevin D. Williamson, *Why the Swiss Health Care Model Will Never Work in America*, FOUND. ECON. EDUC. (July 6, 2017), https://fee.org/articles/why-the-swiss-health-care-model-will-never-work-in-america.

[140] Isabelle Sturny, *International Health Care System Profiles: Switzerland*, COMMONWEALTH FUND., https://international.commonwealthfund.org/countries/switzerland (last updated June 5, 2020).

[141] *Id.*; *Health Insurance and the Healthcare System in Switzerland Explained*, INTERNATIONS GO!, https://www.internations.org/go/moving-to-switzerland/healthcare (last updated Sept. 8, 2020).

[142] Sturny, *supra* note 140; Avik Roy, *Why Switzerland Has the World's Best Health Care System*, FORBES (Apr. 29, 2011, 5:27 PM), https://www.forbes.com/sites/theapothecary/2011/04/29/why-switzerland-has-the-worlds-best-health-care-system/#1ae1740b7d74.

[143] Sturny, *supra* note 140.

[144] *Id.*

[145] *Id.*

[146] *Id.*

[147] *Id.*

[148] Tsung-Mei Cheng, Understanding the 'Swiss Watch' Function of Switzerland's Health System, HEALTH AFFS., Aug. 2010, at 1442, 1442–44.

[149] *Id.*; Ewout van Ginneken et al., Health Insurance Exchanges in Switzerland and the Netherlands Offer Five Key Lessons for the Operations of US Exchanges, HEALTH AFFS., Apr. 2013, at 744, 747.

basic insurance.[150] Coverages and costs will vary depending on provider, but voluntary insurance can cover costs of medical accessories, dental treatments, home nursing services, and even gym memberships.[151] The anti-discrimination requirements for the basic health insurance do not apply to voluntary health insurance.[152] Premiums for voluntary insurance are risk-based, so your payments will depend on a number of factors such as age, sex, and health status.[153]

b. Mechanisms to Ensure Compliance

A number of regulations ensure individuals comply with the Swiss insurance mandate. As previously discussed, health insurance is mandatory for everyone residing in Switzerland for more than three months.[154] Harsh penalties are enforced against uninsured individuals.[155] The Swiss government will garnish wages and assess steep penalties that can exceed the cost of insurance premiums if an individual is uninsured.[156] Eventually, the government has the power to sign you into an insurance contract with a provider, and the provider can sue for payment of premiums over the period in which you were uninsured.[157] Overall, individuals have strong economic incentives to comply with mandated coverage. These regulations have proven effective, as Switzerland has achieved 100 percent insurance coverage for its residents.[158]

c. Mechanisms to Ensure Low Costs

Insurance coverages and other cost drivers within the healthcare market are subject to heavy regulations to ensure lower costs for their residents.

With regard to health insurance, subsidies are provided for low-income individuals to make premiums more affordable.[159] If an individual or family pays more than 8 percent of their personal income for premiums, they will receive cash subsidies, based on income level, to assist with payments.[160] Up to 40 percent of households in Switzerland are estimated to receive some form of subsidy.[161] Additionally, to make premiums more affordable, insurance providers are prohibited from profiting off of the mandatory basic coverage plans.[162] However, the markets for supplementary and

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[150] Sturny, *supra* note 140; *Supplemental Health Insurance: 5 Key Questions and Answers*, COMPARIS.CH (Aug. 8, 2016), https://en.comparis.ch/krankenkassen/zusatzversicherung/information/krankenkasse-zusatzversicherung.

[151] Supplemental Health Insurance: 5 Key Questions and Answers, supra note 150.

[152] Cheng, *supra* note 148, at 1444.

[153] *Id.*; Ginneken et al., *supra* note 149, at 747.

[154] Sturny, *supra* note 140.

[155] Williamson, *supra* note 139.

[156] *Id.*

[157] *Id.*

[158] OECD*, Population Coverage for Health Care*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 104, 104–05 (2020); *see* Appendix: Figure 12.

[159] Sturny, *supra* note 140; Cheng, *supra* note 148, at 1443; Nelson D. Schwartz, *Swiss Health Care Thrives Without Public Option*, N.Y. TIMES (Sept. 30, 2009), https://www.nytimes.com/2009/10/01/health/policy/01swiss.html.

[160] Schwartz, *supra* note 159.

[161] *Id.*

[162] Williamson, *supra* note 139; Sturny, *supra* note 140.

complementary plans are subject to far fewer regulations, and companies may seek profit from these packages.[163]

After an individual reaches the deductible specified in their plan, they will be subject to coinsurance charges of 10 percent of the cost of services and prescriptions.[164] Coinsurance charges make individuals partially cover payments in an attempt to disincentivize unnecessary treatments and costs.[165] To further encourage patients to lower costs on prescriptions, 20 percent coinsurance charges are enforced if a patient elects to receive brand-name prescriptions instead of generic alternatives.[166] However, coinsurance charges are capped to prevent residents from incurring excessive costs.[167] These additional costs are capped annually at the equivalent of about $550 per adult and $275 per child.[168]

Beyond health insurance, Swiss Federal and local governments regulate other areas of the medical market, as well. The Federal Government regulates costs for prescription drugs, medical devices, and lab tests,[169] while local governments regulate prices for specific procedures in their region.[170] The government will also deter doctors from providing drugs and procedures that are unnecessary and expensive. If a doctor provides an unnecessary treatment to a patient, the doctor will be forced to repay insurance companies for a portion of the cost.[171] Additionally, the Swiss government reimburses health insurance companies for the costs of expensive procedures, thereby socializing the costs.[172] These regulations aim to cut down fees, lowering end costs for patients.[173]

2. Results

Healthcare costs in Switzerland are high when compared to nearly all OECD countries, but they remain far cheaper than the United States. In 2018, Switzerland had the second-highest health expenditures per capita among OECD countries at $7,317 spent per resident.[174] However, this was still over $3,000 less than the United States spent per capita.[175] Further, although they also had the second-highest rate of health expenditures in relation to GDP at 12.2 percent, this was still nearly 40 percent lower than the United States.[176] Though expenditures compare favorably to the United States, costs are still a cause for concern, especially as price levels in Switzerland are 39 percent higher than the United States.[177]

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[163] Sturny, *supra* note 140.
[164] Rook, *supra* note 139.
[165] *Id.*
[166] *Id.*
[167] *Id.*; Arthur Appleton, *The Swiss Also Have a Private Health Care System. But Theirs Works.*, FORTUNE (Sept. 26, 2017, 9:06 AM), https://fortune.com/2017/09/26/health-care-bill-obamacare-repeal-switzerland.
[168] Sturny, *supra* note 140.
[169] Schwartz, *supra* note 159.
[170] Appleton, *supra* note 167.
[171] Schwartz, *supra* note 159.
[172] Williamson, *supra* note 139; Sturny, *supra* note 140.
[173] Schwartz, *supra* note 159.
[174] OECD, *supra* note 68, at 150–51; *see* Appendix: Figure 3.
[175] *see* Appendix: Figure 3.
[176] OECD, *supra* note 65, at 152–53; *see* Appendix: Figure 2.
[177] OECD, *supra* note 73, at 154–55; *see* Appendix: Figure 4.

Although costs and prices may be high compared to other OECD countries, Switzerland has very favorable outcomes. In 2017, the average life expectancy at age 65 in Switzerland was 21.4 years, third-best among OECD countries and 8.6 percent higher than the OECD average of 19.7 years.[178] Switzerland also only reported 73 diabetes-related hospital admissions for every 100,000 people, over 40 percent lower than the OECD average.[179] Switzerland also posted above-average survival rates for breast, lung, and stomach cancers, as well as childhood leukemia.[180] Overall, Switzerland experiences great results from their healthcare system, and received the highest grade for outcomes in Europe, according to the Euro Health Consumer Index ("EHCI").[181]

Overall, Santésuisse is considered by many to be among the best healthcare systems in the world, with some considering it the best.[182] In 2018, per the EHCI, Switzerland rated as the best healthcare system in Europe, mainly due to its high marks in patients' rights, outcomes, and prevention scores.[183]

B. GERMANY

1. System Overview

a. Public Insurance with Optional Opt-Out

Health insurance in Germany is mandatory.[184] If you intend to reside in Germany, health insurance is required, no matter the length of residency.[185] However this requirement is more lenient than Switzerland, as coverage could be provided in another country and does not have to be through an approved German provider.[186]

Working residents are required to enroll in a public or private health insurance policy.[187] Unemployed individuals are covered by the German government.[188] If a worker's income is below a specified threshold, 60,750 Euros in 2019, they are required to enroll in a public insurance plan.[189] Workers must choose an insurance provider from over 100 non-profit

[178] OECD, *Life Expectancy and Healthy Life Expectancy at Age 65*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 220, 220–21 (2020); *see* Appendix: Figure 13.

[179] OECD, *Diabetes Care*, in Health at a Glance 2019: OECD Indicators 128, 128–29 (2020); *see* Appendix: Figure 14.

[180] OECD, *Breast Cancer Outcomes*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 138, 138–39 (2020); OECD, *Survival for Other Major Cancers*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 142, 142–43 (2020); *see* Appendix: Figures 15–18.

[181] Arne Björnberg & Ann Yung Phang, Euro Health Consumer Index 9 (2019).

[182] *Id.* at 8–9; Roy, *supra* note 142.

[183] BJÖRNBERG & PHANG, *supra* note 181, at 8–9, 28.

[184] *Germany Healthcare System and Health Insurance*, VISAGUIDE.WORLD, https://visaguide.world/international-health-insurance/germany (last visited Mar. 20, 2021).

[185] *Id.*

[186] *Id.*

[187] *How to Choose German Health Insurance*, ALL ABOUT BERLIN, https://allaboutberlin.com/guides/german-health-insurance (last updated Feb. 1, 2021).

[188] Olga Khazan, *What American Healthcare Can Learn From Germany*, ATLANTIC (Apr. 8, 2014), https://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133.

[189] *Id.*

companies,[190] although employers will usually choose one for their employees.[191] Dependents and spouses are covered at no additional cost if they are not also employed.[192]

However, above that statutory threshold, workers can choose between public statutory health insurers or a private insurer.[193] Certain groups are also provided the option to enroll in either public or private insurance regardless of income level.[194] These groups include students, self-employed persons, doctors, and civil servants.[195] Private insurance can offer members full coverage similar to public insurance coverage, or they can provide partial or complementary coverages.[196] Private insurance may be attractive as it offers more services with lower premium costs depending on coverage and income level.[197] But, private insurance has many disadvantages, too. It can be more expensive because premiums are based on risk factors rather than income.[198] Unlike public coverage, private insurance will not automatically cover your family.[199] Private insurance is not subsidized by the government.[200] Finally, private insurance plans have deductibles, so individuals pay up to the deductible level personally, with coverage starting after the deductible is reached.[201]

The non-profit public insurers providing mandatory public coverage are called "sickness funds".[202] These insurers contract with organizations representing hospitals, physicians, pharmacies, and other healthcare providers to ensure individuals covered by their plans receive proper insurance and medical care.[203] The Federal Government forms a committee, the Federal Joint Committee ("FJC"), made up of members representing doctors, dentists, insurers, hospitals, and even patients to determine the coverages provided by the public statutory health insurers and ensure a standard quality of care.[204]

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[190] Bryan Lee, *How to Get Health Insurance in Germany*, N26 MAG. (Mar. 28, 2017), https://mag.n26.com/how-to-get-health-insurance-in-germany-11b215291acc; Spencer Kimball, *Why Germans Love Their Health Insurance*, HANDELSBLATT TODAY (May 15, 2017, 3:29 PM), https://www.handelsblatt.com/today/politics/handelsblatt-explains-why-germans-love-their-health-insurance/23569646.html.

[191] *Health Insurance in Germany*, EXPATICA, https://www.expatica.com/de/healthcare/healthcare-basics/a-guide-to-german-health-insurance-693463 (last updated Feb. 8, 2021).

[192] Rook, *supra* note 139.

[193] Lee, *supra* note 190; *Health Insurance in Germany*, EXPATRIO, https://www.expatrio.com/living-germany/health-insurance-germany (last visited Feb. 22, 2021).

[194] *How to Choose German Health Insurance*, *supra* note 187.

[195] *Id.*

[196] *Health Care in Germany: The German Health Care System*, INFORMEDHEALTH.ORG (May 6, 2015), https://www.ncbi.nlm.nih.gov/books/NBK298834 (last updated Feb. 8, 2018).

[197] Miriam Blümel & Reinhard Busse, *International Health Care System Profiles: Germany*, COMMONWEALTH FUND, https://international.commonwealthfund.org/countries/germany (last updated June 5, 2020).

[198] Lee, *supra* note 190.

[199] *Id.*

[200] Blümel & Busse, *supra* note 197.

[201] Lee, *supra* note 190.

[202] *Id.*; *How to Choose German Health Insurance*, *supra* note 187.

[203] Kimball, *supra* note 190; *Health Care in Germany: The German Health Care System*, *supra* note 196.

[204] *Health Care in Germany: The German Health Care System*, *supra* note 196; Blümel & Busse, *supra* note 197.

The statutory health insurance provides a variety of coverages including preventative care, prescriptions, and dental coverage.[205] The public sickness funds must accept any applicant.[206] Comparatively, private insurance is largely regulated by self-governing associations rather than the Federal Government. [207] Private insurers still have representatives on the FJC,[208] but they are not subject to the same regulations as public insurers. One example is that private health insurers may discriminate against applicants due to risk factors, as described previously in the pricing effects on private coverage.[209] In the end, a vast majority of the population opt for public statutory insurance, with around 90 percent enrolling in a statutory plan and only 10 percent using private insurance.[210]

b. Funding Public Insurance

Employers and employees fund the public sickness funds.[211] Sickness funds are financed mostly through payroll taxes, with general tax revenue also contributing.[212] Between 14.6 and 15.6 percent of a worker's salary is contributed to the public fund, split evenly between employer and employee.[213] Payments for students are set by statute, and self-employed individuals pay the full contribution percentage between 14.6 and 15.6 percent of income.[214] These funds are provided directly to the non-profit statutory insurance providers, who reimburse doctors and hospitals when services are rendered.[215] The sickness funds set the premiums to be paid by workers covered by their fund.[216] Since the funds are non-profit, they cannot hold reserves.[217] If a fund holds reserves for greater than three months, the fund must lower premiums.[218] But, if funds are depleted and do not cover the expenses incurred, premiums must be increased.[219] In addition, workers must also pay a 2.5 percent nursing care contribution that will cover elderly care costs.[220]

c. Regulating Costs

Germany's healthcare markets are strictly regulated to keep end costs down for patients.[221] Out-of-pocket costs are a specific focus, and the German

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[205] *Health Insurance and the Healthcare System of Germany Explained*, INTERNATIONS GO!, https://www.internations.org/go/moving-to-germany/healthcare (last updated Aug. 20, 2020).

[206] Andrea Döring & Friedemann Paul, *The German Healthcare System*, 1 EPMA J. 535, 537 (2010).

[207] Blümel & Busse, *supra* note 197.

[208] *Health Insurance in Germany*, *supra* note 193.

[209] Lee, *supra* note 190; Döring & Paul, *supra* note 206, at 538.

[210] OECD, *supra* note 158, at 105; *How to Choose German Health Insurance*, *supra* note 187; *see* Appendix: Figure 12.

[211] Chung, *supra* note 136.

[212] Health Care in Germany: The German Health Care System, supra note 196.

[213] Germany Healthcare System and Health Insurance, supra note 184; How to Choose German Health Insurance, supra note 187.

[214] *How to Choose German Health Insurance*, *supra* note 187.

[215] *Health Insurance in Germany*, *supra* note 193.

[216] Dietlind L. Wahner-Roedler et al., *The German Health-Care System*, 72 MAYO CLINIC PROC. 1061, 1062 (1997), https://www.mayoclinicproceedings.org/article/S0025-6196(11)63549-0/pdf.

[217] *Id.*

[218] *Id.*

[219] *Id.*

[220] *Health Insurance in Germany*, *supra* note 193.

[221] Khazan, *supra* note 188.

government imposes regulations to prevent excessive costs and surprise billings.[222] For example, fees for overnight stays in hospitals not covered by statutory insurance must be provided in a contract between the patient and the hospital prior to the stay or further treatment.[223] Copays are capped, as well.[224] Copays for outpatient services, prescriptions, and hospital visits vary, but they all are around 10 Euros.[225]

Costs for public insurance and treatment are socialized. Large hospitals usually receive public financing through federal or local governments.[226] Public insurance is generally funded through payroll taxes with subsidies from the general tax fund.[227] Contributions are based on a percentage of income, so low-wage workers pay lower rates than higher-income individuals.[228] Finally, the sickness funds are non-profit organizations, so premiums will not be affected by profit margins.[229] These features help premiums and out-of-pocket costs remain lower, especially for individuals with a lesser ability to pay, promoting the system's principle of solidarity.[230]

2. Results

Much like Switzerland, Germany's healthcare expenditures are high compared to other OECD countries, but they remain much less than the United States. Germany had the third-highest health expenditures as a percentage of GDP among OECD countries at 11.2 percent.[231] However, Germany still spent over 50 percent less than the United States.[232] Health expenditures per capita tell an even more harrowing tale when compared to the United States. Germany's health expenditures per capita in 2018 were $5,986, fourth-highest among OECD countries.[233] But, Germany's health expenditures per capita were still nearly 77 percent less than the United States', as they spent $4,600 less per capita in 2018.[234] If the United States had a similar rate of healthcare expenditures as a percentage of GDP in 2018, over $1.16 trillion would have been saved.[235]

Although Germany compares favorably to the United States, its expenditures remain high among its peers. Its healthcare expenditures as a percentage of GDP are only outpaced by the United States and Switzerland among OECD countries.[236] Additionally, some express concerns about rising

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[222] Erika Edwards & Lauren Dunn, *Is Germany's Health Care System a Model for the U.S.?*, NBC NEWS (June 30, 2019, 12:59 PM), https://www.nbcnews.com/health/health-news/germany-s-health-care-system-model-u-s-n1024491.

[223] Health Care in Germany: The German Health Care System, supra note 196.

[224] *Id.*; Kimball, *supra* note 190.

[225] *Id.*

[226] Health Care in Germany: The German Health Care System, supra note 196.

[227] *Id.*

[228] *How to Choose German Health Insurance*, *supra* note 187; Khazan, *supra* note 188.

[229] Kimball, *supra* note 190.

[230] Health Care in Germany: The German Health Care System, supra note 196.

[231] OECD, *supra* note 65, at 152–53; *see* Appendix: Figure 2.

[232] OECD, *supra* note 65, at 152–53; *see* Appendix: Figure 2.

[233] OECD, *supra* note 68, at 150–51; *see* Appendix: Figure 3.

[234] *see* Appendix: Figure 3.

[235] Determined using the United States Bureau of Economic Analysis' (BEA) 2018 GDP estimate of $20.49 trillion and the percentage point difference in healthcare expenditures as a percentage of GDP provided by the OECD. OECD, *supra* note 65, at 153; News Release, Bureau of Economic Analysis, *supra* note 71; *see* Appendix: Figure 2.

[236] OECD, *supra* note 65, at 152–53; *see* Appendix: Figure 2.

costs.[237] In 2016, the German government had to spend an additional 14.5 billion Euros from the general tax revenue fund, in addition to the payroll taxes, to subsidize sickness funds.[238] However, according to OECD statistics, Germany's price levels for health-related goods and services remain below average and are 32 percent lower than in the United States.[239]

Germany's health outcomes lag behind Switzerland, but the EHCI still rated the country eighth in outcomes amongst European countries, noting that the country has shown improvement since 2012.[240] There are some encouraging signs indicating that outcomes may continue to improve. Germany had above-average survival rates for lung cancer, stomach cancer, and childhood leukemia between 2010 and 2014.[241] German citizens also had a slightly above-average life expectancy in 2017, 81.1 years compared to the OECD average of 80.7.[242] Also, in 2017, Germany had below-average mortality rates from both preventable and treatable causes.[243] The mortality rate from preventable causes per 100,000 people in Germany was 120, over 10 percent less than the OECD average and over 45 percent less than the United States.[244] Finally, Germany's mortality rate from treatable causes was 66 per 100,000 people, 13.6 percent less than the OECD average and 33 percent less than the United States.[245]

While the influence of private insurance is controversial,[246] Germany has received great reviews for its healthcare system. The system is based on the principle of solidarity: everyone has an equal right to care and treatment no matter their income level.[247] This principle makes the German system renowned for its generosity and focus on the general welfare,[248] as it provides a safety net to prevent the uncertainty of misfortune in an individual's life and health.[249] Overall, Germany's model has achieved 100 percent coverage for the population,[250] and it is viewed very favorably among Germans.[251]

III. PRIVATE INSURANCE'S ROLE IN A UNIVERSAL HEALTHCARE SYSTEM IN THE UNITED STATES

As the previous section demonstrated through the examples of Switzerland and Germany, private insurance can be part of a universal

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[237] Khazan, *supra* note 188; Kimball, *supra* note 190.
[238] Kimball, *supra* note 190.
[239] OECD, *supra* note 73, at 154–55; *see* Appendix: Figure 4.
[240] BJÖRNBERG & PHANG, *supra* note 181, at 12–13.
[241] OECD, *supra* note 180, at 143; *see* Appendix: Figures 16–18.
[242] OECD, *supra* note 108, at 66–67; *see* Appendix: Figure 6.
[243] OECD, *Avoidable Mortality (Preventable and Treatable)*, in HEALTH AT A GLANCE 2019: OECD INDICATORS 72, 72–73 (2020); *see* Appendix: Figure 7.
[244] *see* Appendix: Figure 7.
[245] *see* Appendix: Figure 7.
[246] Experiences indicate that patients with private insurance will receive services faster than those with statutory insurance, possibly because private insurance provides more money to doctors. Kimball, *supra* note 190.
[247] Health Care in Germany: The German Health Care System, supra note 196.
[248] Germany Healthcare System and Health Insurance, supra note 184.
[249] Edwards & Dunn, *supra* note 222.
[250] OECD, *supra* note 158, at 104–05; *see* Appendix: Figure 12.
[251] Kimball, *supra* note 190 (stating that 84 percent of the German population approved of the German healthcare system).

healthcare system providing cost-effective coverage. Its utilization takes a number of forms around the world,[252] an indication to the United States that it does not need to abandon private insurance to achieve a successful universal healthcare system. The question remains: what system would be best implemented in the United States? In the end, as the analysis that follows concludes, the Swiss and German models raise questions regarding constitutionality. However, the blueprint for the United States is likely already in place in the form of Medicare.

A. THE SWISS MODEL CANNOT BE APPLIED IN THE UNITED STATES

The ACA had a number of similarities with the Swiss model when it was enacted in 2010, specifically the penalties imposed for uninsured individuals and the establishment of individual marketplaces. Despite the similarities between the models, enacting a model mirroring the Swiss model would be untenable in the United States. The two main reasons: (1) the unpopularity of the individual mandate and (2) the likely unconstitutionality of the model's enforcement mechanisms.

First, the United States likely would not implement enforcement mechanisms needed to ensure compliance with the model. As stated before, the individual mandate was an immediately unpopular provision of the ACA, with polls showing a majority of the population viewing it unfavorably.[253] Also, the penalties for being uninsured were not nearly as strict as those implemented in Switzerland, so there were cases where it was more financially prudent to pay the uninsured penalty and bypass insurance.[254] In the end, these penalties were repealed, effective January 1, 2019, in accordance with the tax reform bill passed in 2017.[255] Due to the unpopularity of the individual mandate and the related penalties, it is questionable whether stricter penalties would be enforced to the level needed to incentivize individuals to partake in the insurance market.

More importantly, based on *Sebelius*, the model would likely be unconstitutional. [256] Per Chief Justice Roberts' opinion in *Sebelius*, penalties weighed for not buying insurance would be a constitutional exercise of Congress's taxing power.[257] But, the Chief Justice also held that the individual mandate was likely an improper use of the Commerce Clause, as Congress could not regulate inactivity and force individuals to enter into a private market.[258] To ensure compliance, Switzerland's government retains the power to force uninsured individuals into private insurance contracts.[259] This would be an unconstitutional use of Commerce Clause powers. As the Chief Justice stated, the Commerce Clause cannot regulate inactivity and "does not

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[252] Kliff, *supra* note 137.

[253] Liz Hamel et al., *5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court*, KAISER FAM. FOUND. (Dec. 18, 2020), https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court.

[254] Williamson, *supra* note 139.

[255] Eibner & Nowak, *supra* note 53.

[256] *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

[257] *Id.* at 568.

[258] *Id.* at 558.

[259] Williamson, *supra* note 139.

authorize Congress to direct [individuals] to purchase particular products."[260] Without these enforcement mechanisms, individual compliance would likely falter, making the model unsustainable in the United States.

B. CONSTITUTIONAL CONCERNS REMAIN REGARDING GERMANY'S MODEL

A healthcare system like Germany's would also run into constitutional questions. Similar to issues with the Swiss model and the ACA, compulsory insurance through sickness funds may be a regulation of inactivity. Alternatively, public insurance could be an exercise of taxing and spending power, which would allow a German model to maintain constitutionality.

There is already precedent for automatic enrollment and compulsory participation in government programs in the United States, specifically Social Security.[261] Additionally, this program has been upheld as constitutional, providing support for the constitutionality of a similar healthcare model.[262] But this could be distinguished from the German healthcare model, as Germany requires compulsory insurance through non-governmental companies.[263] The constitutionality of automatic enrollment programs is discussed below, along with an analysis of the German healthcare model's constitutionality.

1. *Helvering v. Davis*: The Constitutionality of Social Security

In 1935, Congress passed the Social Security Act, establishing a program to provide benefits to the elderly, among many other groups, that would be funded through payroll taxes.[264] The constitutionality of the Social Security Act was challenged soon thereafter. In *Helvering v. Davis*, the Supreme Court upheld the Social Security Act as a constitutional exercise of Congress's power to "spend money in aid of the 'general welfare'" as established by Article I, Section 8 of the Constitution.[265]

In 1965, Medicare was established under the Social Security Act.[266] At the age of 65, individuals are automatically enrolled in Medicare if they are receiving Social Security benefits.[267] Medicare's constitutionality has not been challenged before the Supreme Court, likely because it is also protected by Congress's power to spend to provide for the population's general welfare

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[260] *Sebelius*, 567 U.S. at 557.

[261] *See generally* Social Security Act, 42 U.S.C. §§ 301–1305 (1935).

[262] *See generally* Helvering v. Davis, 301 U.S. 619 (1937).

[263] Lee, *supra* note 190.

[264] *See generally* 42 U.S.C. §§ 301–1305; *Social Security Act (1935)*, U.S. NAT'L ARCHIVES & RECS. ADMIN., https://www.ourdocuments.gov/doc.php?flash=false&doc=68 (last visited Aug. 4, 2020).

[265] *Davis*, 301 U.S. at 640, 645.

[266] *See generally* Title XVIII of the Social Security Act, 42 U.S.C. §1395; Barbara S. Klees & Christian J. Wolfe, *Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of the Social Security Act*, CTRS. FOR MEDICARE & MEDICAID SERVS. 3 (Nov. 1, 2009), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2009.pdf.

[267] Klees & Wolfe, *supra* note 266, at 7; *Do I Have to Enroll in Medicare at Age 65 if I Am Already Collecting Social Security*, AARP, https://www.aarp.org/retirement/social-security/questions-answers/medicare-enroll-collecting-ss (last updated Dec. 24, 2020).

as an amendment to the Social Security Act.[268] As a separate program, *Davis*'s holding would certainly lead to the same conclusion: Medicare, as a program providing for the general welfare, would be a constitutionally permissible exercise of Congress's Article I, Section 8 spending power.

The deciding question regarding the German model's constitutionality is whether the compulsory public insurance funds are more comparable to Social Security or Switzerland's private insurers.

2. Is Germany's Healthcare Model Still an Option?

First, not considering the constitutionality of Germany's model, a system like Germany's could begin to resolve some of the main issues facing healthcare in the United States. As mentioned earlier, the United States spends more on healthcare expenditures as a percentage of GDP than any other OECD country,[269] and the system is growing increasingly inequitable.[270] A healthcare system like Germany's could begin to address both issues. If the United States spent only 11.2 percent of GDP on healthcare expenditures like Germany did in 2018, it would have saved over $1 trillion.[271] Additionally, since everyone in the German public insurance coverage is guaranteed the same level of care, this could help address the inequalities facing the American system.[272] Further, since premiums are based on income level, with higher-income individuals paying higher premiums and helping fund the program for lower-income individuals,[273] costs would be less burdensome on lower- and middle-income families. A system built on solidarity like Germany's would be more equitable for the United States.

Despite this, constitutional questions still arise. Germany's system of compulsory enrollment in a public health insurance plan for lower-income individuals could be compared to Medicare, as both are funded mainly by payroll taxes.[274] There are, however, important distinctions: Medicare enrolls individuals into a government-run program,[275] whereas Germans must choose between non-profit companies.[276] Additionally, payroll taxes in Germany are paid directly to the sickness funds rather than the government.[277] While the funding is certainly for the general welfare, the direct funding into non-profit companies rather than the government could prevent protection if it is construed that the government is not spending the

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[268] Kathleen S. Swendiman, Health Care: Constitutional Rights and Legislative Powers 10 (2012).

[269] OECD, *supra* note 65, at 152–53; *see* Appendix: Figure 2.

[270] Golshan, *supra* note 78; Katharina Janus & Etienne Minvielle, *Rethinking Health Care Delivery: What European and United States Health Care Systems Can Learn From One Another*, HEALTHAFFAIRS: BLOG (Dec. 15, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171214.835155.

[271] Calculated using the United States Bureau of Economic Analysis' 2018 GDP estimate of $20.49 trillion and the percentage point difference in healthcare expenditures as a percentage of GDP provided by the OECD. OECD, *supra* note 65, at 152–53; News Release, Bureau of Economic Analysis, *supra* note 71.

[272] Health Care in Germany: The German Health Care System, supra note 196; Germany Healthcare System and Health Insurance, supra note 184.

[273] Health Care in Germany: The German Health Care System, supra note 196.

[274] Blümel & Busse, supra note 197; Klees & Wolfe, *supra* note 266, at 3.

[275] *See Welcome to Medicare*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2020), https://www.medicare.gov/sites/default/files/2020-02/11095-Welcome-to-Medicare-package-in-United-States.pdf; AARP, *supra* note 267.

[276] Lee, *supra* note 190.

[277] *Health Insurance in Germany*, *supra* note 193.

funds. The compulsory insurance through non-governmental companies also resembles Switzerland's program. Since the German model forces individuals into a non-governmental market, it may not be protected under the Commerce Clause based on the holding in *Sebelius*.

A stronger argument for constitutionality could be made if the payroll taxes were paid to the government and subsequently disseminated to the sickness funds. Even further, if German workers were automatically enrolled in government programs with the option to opt out for private insurance, this program would certainly be constitutional based on the holding of *Davis*. In the end, it seems as though a strict copy of the German model may not a viable option.

Based on the analysis of the Swiss and German models and the holdings in *Sebelius* and *Davis*, two important points emerge: first, private insurance can be utilized in a universal healthcare system; second, doing so in the United States almost certainly relies on automatic enrollment in a government program with optional private coverages. Luckily, such a program is already in operation: Medicare.

C. THE SOLUTION IN PLAIN SIGHT: MEDICARE

Polling indicates that Americans support universal healthcare, but they would prefer to preserve a role for private insurance.[278] Again, as has been demonstrated, these two ideas are not mutually exclusive. However, due to Constitutional concerns, a universal healthcare model utilizing private insurance in the United States would have to rely upon automatic enrollment into a public program. From there, individuals could either supplement coverage with private insurance or opt out of the public coverage into private coverages, like in Germany. Such a system already exists in the United States: Medicare.

As stated in the previous section, Medicare's constitutionality relies upon Congress's taxing power and the power to spend for the general welfare.[279] Historically, as Kathleen Swendiman's stated in her 2012 Congressional Research Service Report for Congress, "the Supreme Court accords great deference to a legislative decision by Congress that a particular spending program provides for the general welfare."[280] Expanding Medicare to provide health insurance coverage to all individuals would be a protected spending program for the general welfare. This idea is further enhanced by Medicare's inclusion within the Social Security Act, which is likely a reason why Medicare's constitutionality has not been challenged before the Supreme Court.[281]

Beyond Medicare's legality, Medicare has further advantages. Medicare would provide greater equity, and it has proven to be effective at moderating spending as compared to private insurance. Finally, Medicare is a popular

[278] Sheffield, *supra* note 1.
[279] Swendiman, *supra* note 268, at 10.
[280] *Id.* at 8.
[281] *Id.* at 10.

program[282], as is MA.[283] Expanding the current Medicare model would preserve both well-received programs while providing coverage.

Medicare expansion could provide for greater equity in the healthcare system. Increasing costs are falling on low-wage workers harder,[284] and medical costs are still the most-often-cited reason for persons filing bankruptcy.[285] Medicare is similar to Germany's system in that it provides the same coverages under its various parts regardless of income.[286] In fact, in 2018, 12 percent of Medicare beneficiaries were below the federal poverty level.[287] Further, higher-income Medicare beneficiaries pay greater premiums under Medicare Part B and for Medicare prescription drug coverage, helping to keep out-of-pocket costs down for lower-income beneficiaries.[288]

Medicare has proven to effectively moderate spending per enrollee. As noted earlier, one of the shortfalls of the American system is increasing costs, especially as contributions towards premiums grow at a faster rate than median income.[289] According to the Urban Institute, Medicare controlled costs better than private insurance from 2006 through 2017.[290] During that period, Medicare's average annual growth in spending per enrollees was 2.4 percent; whereas, private insurance's average annual growth was 2 percentage points higher.[291] Additionally, growth in Medicare spending per enrollee never outpaced GDP per capita growth in that same time span, while private spending grew 2 percentage points faster than GDP per capita.[292] Medicare has been more efficient in controlling its spending per enrollee, which could help regulate costs of healthcare.

Beyond achieving universal coverage, the Federal Government must consider cost regulations, as well, to address the healthcare spending problem in the United States. As mentioned earlier, the spending problem in the United States' healthcare industry is a complex one with no easy solutions. But the United States can look to other countries, and even some states, for potential solutions.[293] As evidenced by other countries, a successful universal healthcare system requires government intervention in some

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[282] *See* Mira Norton et al., *Medicare and Medicaid at 50*, KAISER FAM. FOUND. (July 17, 2015), https://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50; Mollyann Brodie et al., *Medicare as Reflected in Public Opinion*, 39 AM. SOC. ON AGING 134 (2015).

[283] *See* Phil Galewitz, *Medicare Advantage Riding High as New Insurers Flock to Sell to Seniors*, KAISER HEALTH NEWS (Oct. 15, 2018), https://khn.org/news/medicare-advantage-riding-high-as-new-insurers-flock-to-sell-to-seniors; *Seniors Highly Satisfied With Medicare Advantage*, BETTER MEDICARE ALL. (Mar. 11, 2015), https://bettermedicarealliance.org/news/seniors-highly-satisfied-with-medicare-advantage.

[284] Golshan, *supra* note 78.

[285] Konish, *supra* note 91.

[286] *See* SOC. SEC. ADMIN., MEDICARE (2021), https://www.ssa.gov/pubs/EN-05-10043.pdf.

[287] *Distribution of Medicare Beneficiaries by Federal Poverty Level: Timeframe: 2019*, KAISER FAM. FOUND., https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-fpl (last visited Dec. 17, 2019); *see* Appendix: Figure 19.

[288] *Medicare Premiums: Rules for Higher-Income Beneficiaries*, SOC. SEC. ADMIN., https://www.ssa.gov/benefits/medicare/medicare-premiums.html (last visited Aug. 4, 2020).

[289] Sara R. Collins et al., *supra* note 81.

[290] John Holahan & Stacey McMorrow, Slow Growth in Medicare and Medicaid Spending per Enrollee Has Implications for Policy Debates 5 (2019).

[291] *Id.*

[292] *Id.*

[293] *See* Dylan Scott, *A CT Scan Costs $1,100 in the US—and $140 in Holland*, VOX (Dec. 17, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/17/21024614/us-health-care-costs-medical-prices.

form.[294] The government does not need to look far for examples of successful regulations, either. As discussed in previous sections, Maryland has successfully utilized cost-limiting regulations with their global hospital budget.[295] Additionally, Colorado, Illinois, and Virginia have placed maximum caps on the price of insulin.[296] No matter the role of the government or private insurance in other countries' universal healthcare systems, they have all demonstrated that the United States' spending problem can be partially attributed to the lack of consistent government regulation on spending and costs in the industry.[297]

IV. CONCLUSION

Universal healthcare and private health insurance are not mutually exclusive ideas. Other countries, such as Germany and Switzerland, demonstrate that private health insurance can be utilized while achieving 100 percent health insurance coverage and lower health expenditures. While further action, such as health market regulations, would likely be needed to significantly lower costs, these examples show that the United States can fulfill public desires for universal healthcare while maintaining a role for private insurance. In the end, an expansion of Medicare provides the best solution, as it is an unquestionably constitutional policy that can satisfy the public's desires.

Medicare demonstrates that a potential healthcare model is already in place in the United States that can moderate costs, provide more equitable system, and that provides coverage for all. Expanding Medicare could effectively satisfy the public's desires to have both universal coverage and the option for private insurance. Senator Kamala Harris' Presidential platform supported the expansion of Medicare to give all Americans coverage.[298] As Harris stated on a blog post, Medicare has proven to work and it is popular, so we should "not lose sight that we have a…system that's already working."[299]

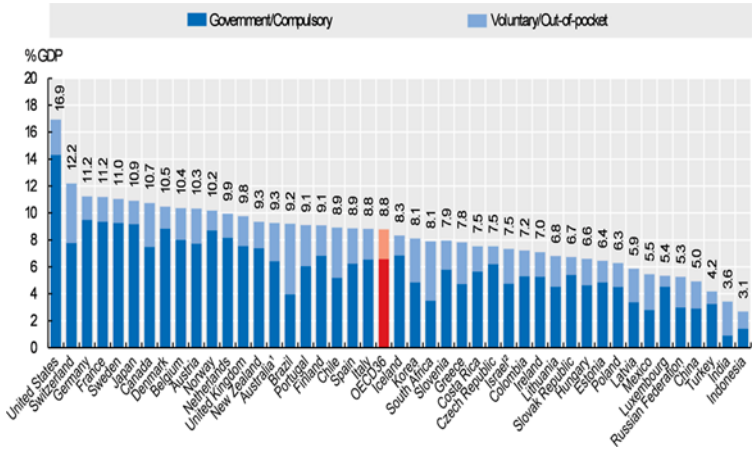
[294] Scott, *supra* note 92.
[295] Golshan, *supra* note 93.
[296] Slisco, *supra* note 94; Seipel, *supra* note 94.
[297] Scott, *supra* note 92.
[298] Kurtzleben, *supra* note 128.
[299] Kamala Harris, *My Plan for Medicare for All*, KAMALA HARRIS (July 29, 2019), https://kamalaharris.medium.com/my-plan-for-medicare-for-all-7730370dd421.

V. APPENDIX

Figure 1. States That Have Yet to Medicaid[300]

Alabama	Florida
Georgia	Kansas
Mississippi	North Carolina
South Carolina	South Dakota
Tennessee	Texas
Wisconsin	Wyoming

Figure 2. OECD Statistics – Health Expenditure as a Share of GDP, 2018[301]



[300] *Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 49; Japsen, *supra* note 49.

[301] OECD, *supra* note 65, at 153.

Figure 3. OECD Statistics – Health Expenditures per Capita, 2018[302]

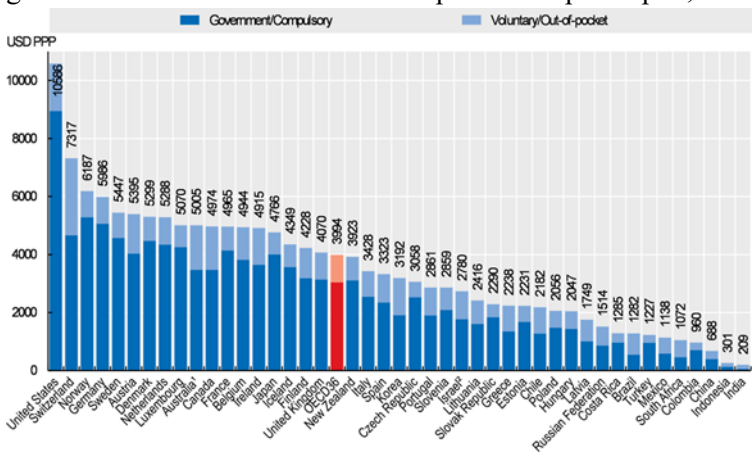
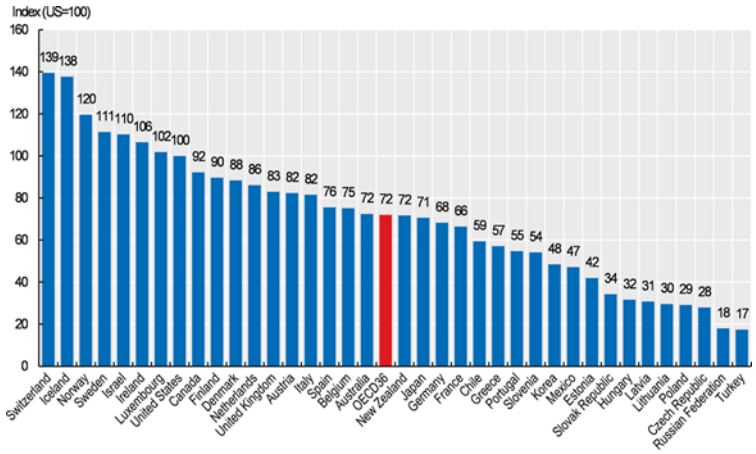


Figure 4. OECD Statistics – Comparative Price Levels for Health, 2017, US=100[303]



[302] OECD, *supra* note 68, at 151.
[303] OECD, *supra* note 73, at 155.

Figure 5. OECD Statistics – Life Expectancy at Birth, 1970 and 2017[304]

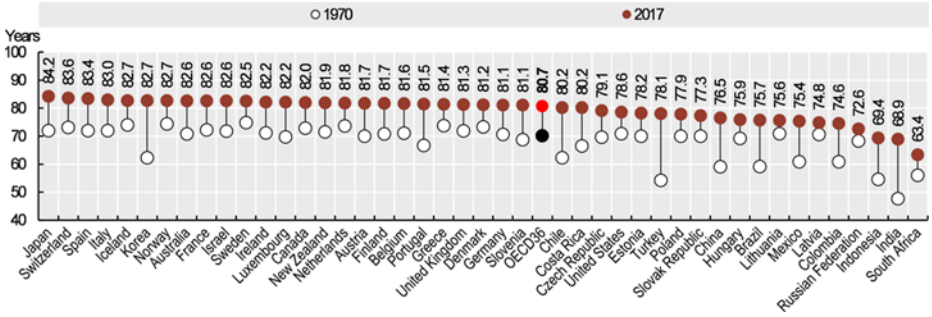
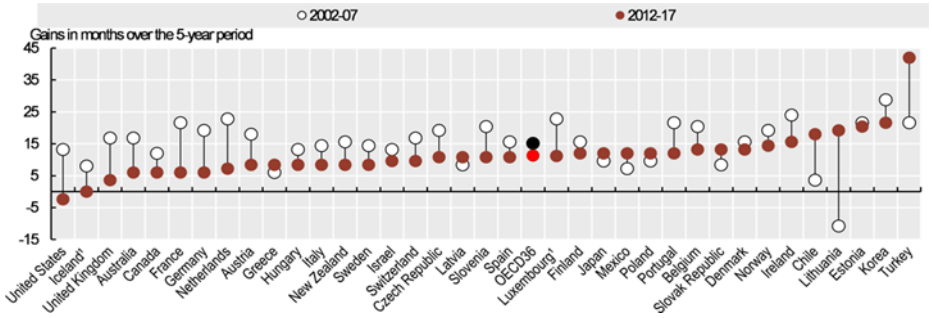


Figure 6. OECD Statistics – Slowdown in Life Expectancy Gains, 2012-17 and 2002-07[305]



[304] OECD, *supra* note 108, at 67.
[305] *Id.*

Figure 7. OECD Statistics – Mortality Rates From Avoidable Causes, 2017[306]

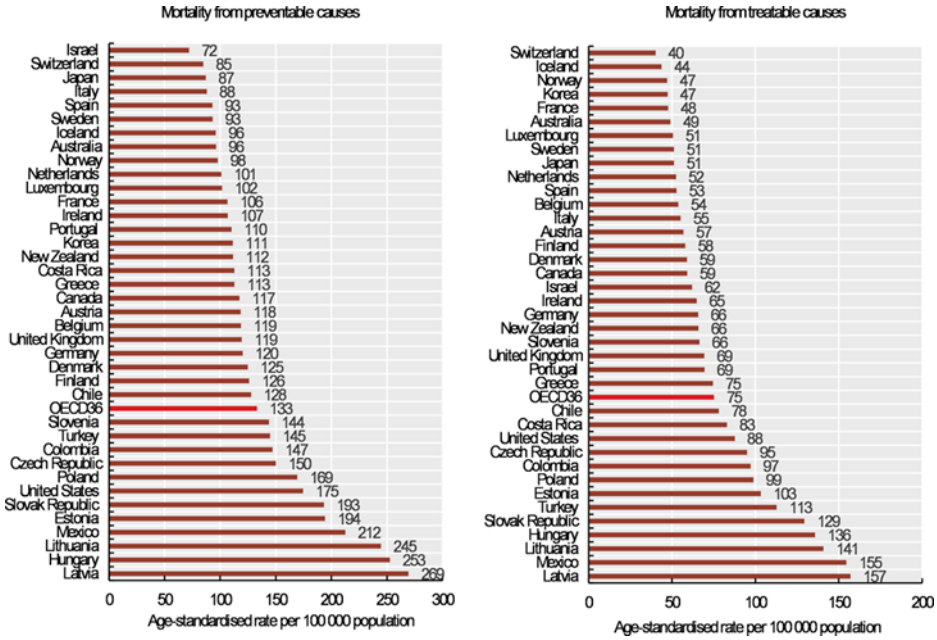
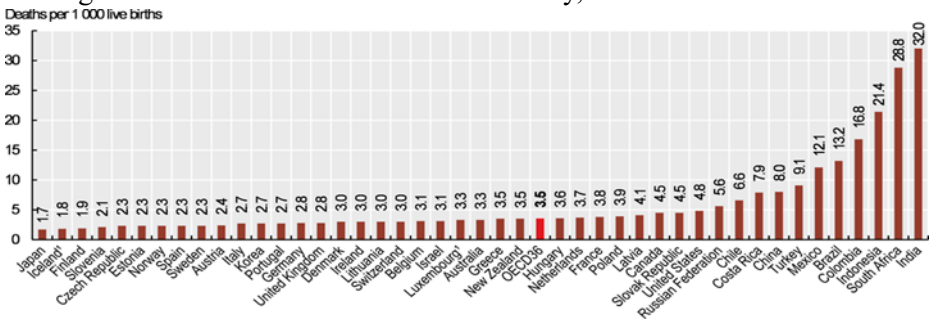


Figure 8. OECD Statistics – Infant Mortality, 2017[307]



[306] OECD, *supra* note 243, at 73.
[307] OECD, *supra* note 113, at 81.

Figure 9. OECD Statistics – Low Birthweight Infants, 2017 and change 2000-17[308]

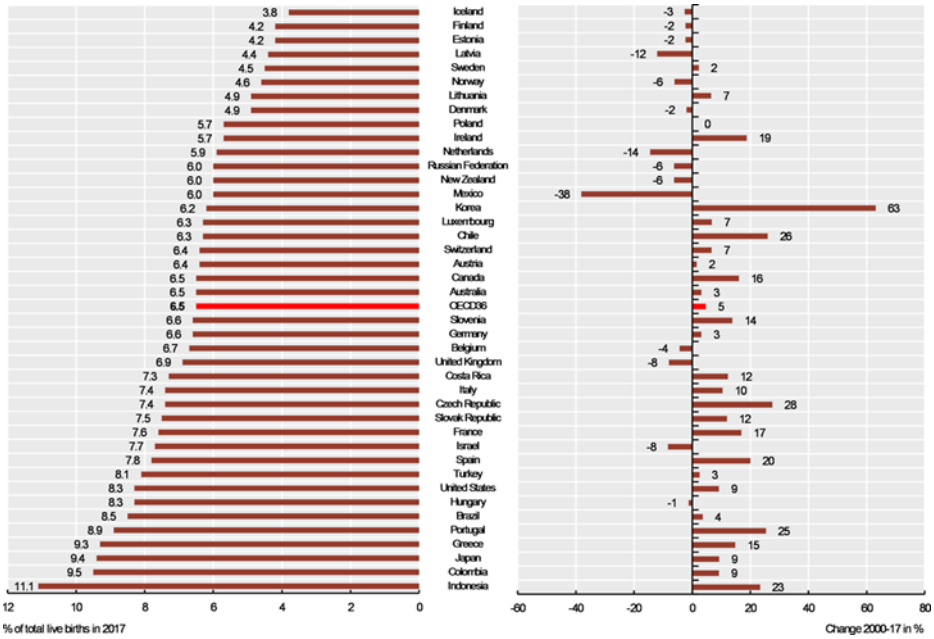
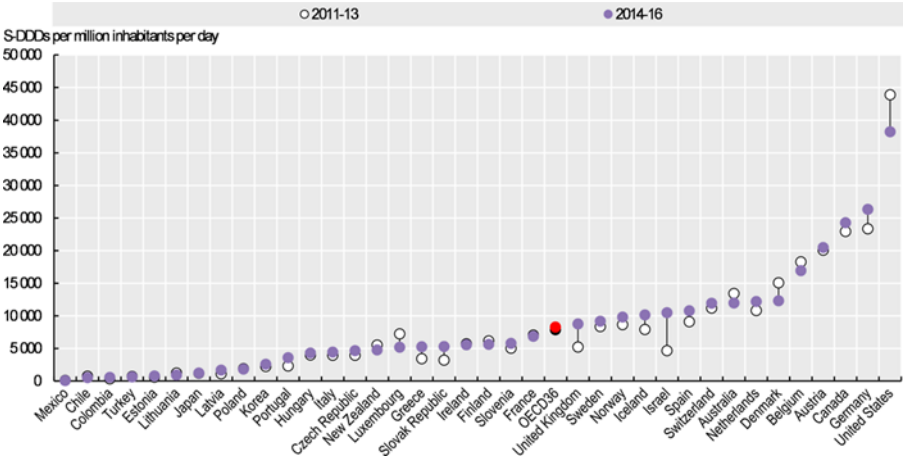


Figure 10. OECD Statistics – Availability of Analgesic Opioids, 2011-13 and 2014-16[309]



[308] *Id.*
[309] OECD, *supra* note 120, at 93.

Figure 11. OECD Statistics – Opioid-related Deaths, 2011 and 2016[310]

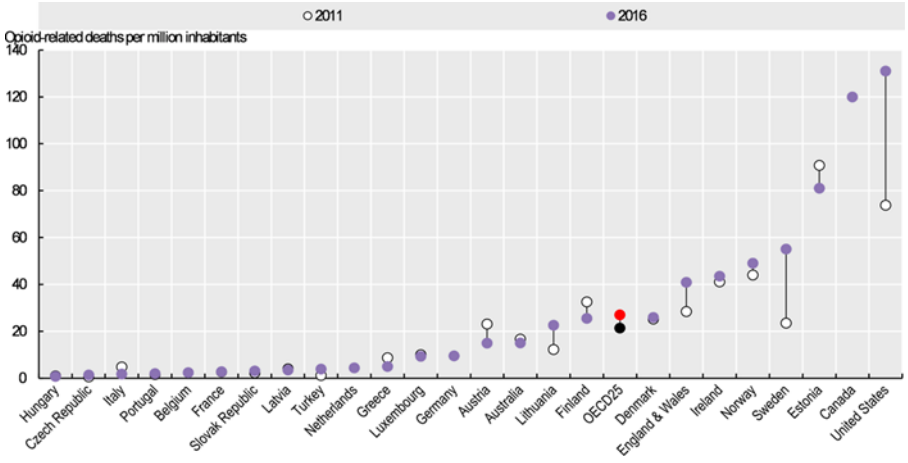
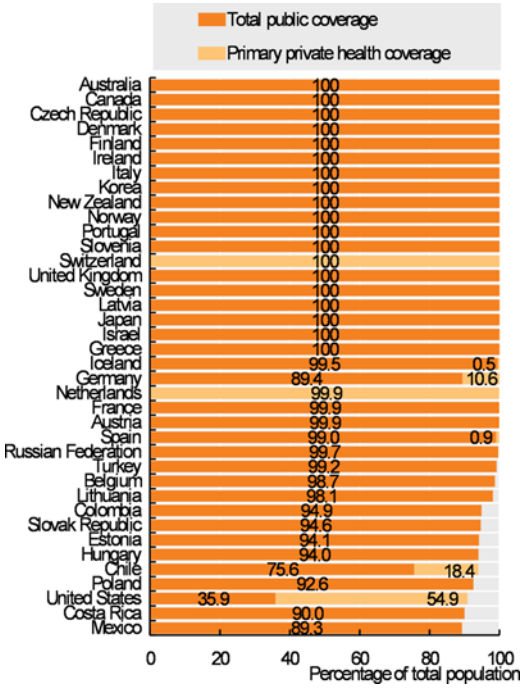


Figure 12. OECD Statistics – Population Coverage for a Core Set of Services, 2017[311]



[310] *Id.*
[311] OECD, *supra* note 158, at 105.

Figure 13. OECD Statistics – Life Expectancy at Age 65, 1970 and 2017[312]

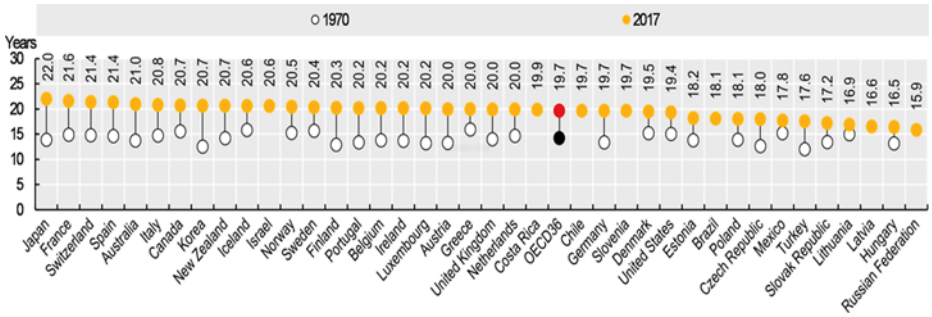


Figure 14. OECD Statistics – Diabetes Hospital Admissions in Adults, 2012 and 2017[313]

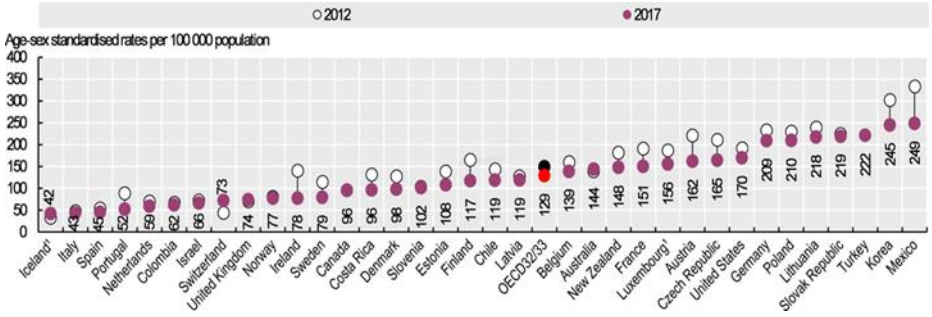
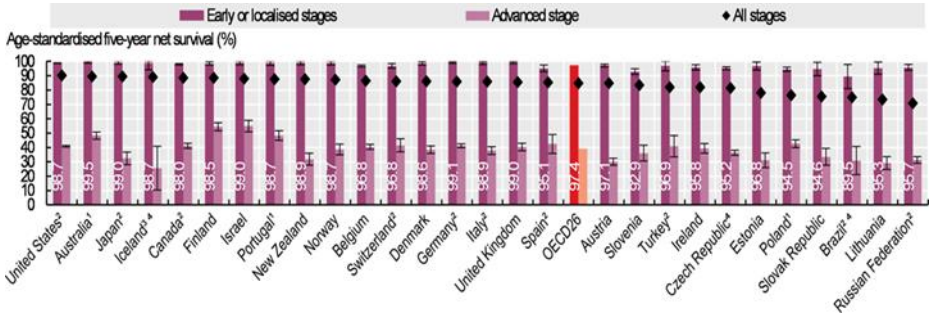


Figure 15. OECD Statistics – Breast Cancer Five-Year Net Survival By Stage of Breast Cancer At Diagnosis, 2010-14[314]



[312] OECD, *supra* note 178, at 221.
[313] OECD, *supra* note 179, at 129.
[314] OECD, *supra* note 180, at 139.

Figure 16. OECD Statistics – Lung Cancer Five-Year Net Survival, 2010-14[315]

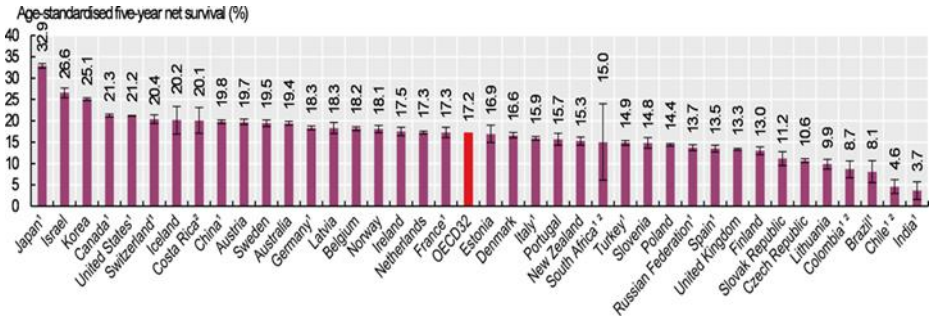


Figure 17. OECD Statistics – Stomach Cancer Five-Year Net Survival, 2010-14[316]

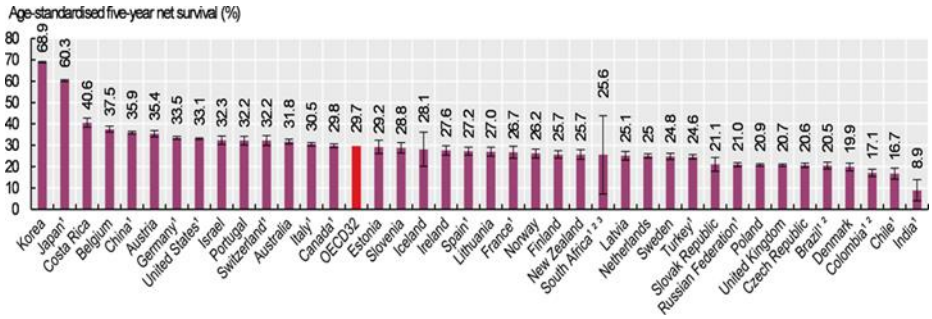
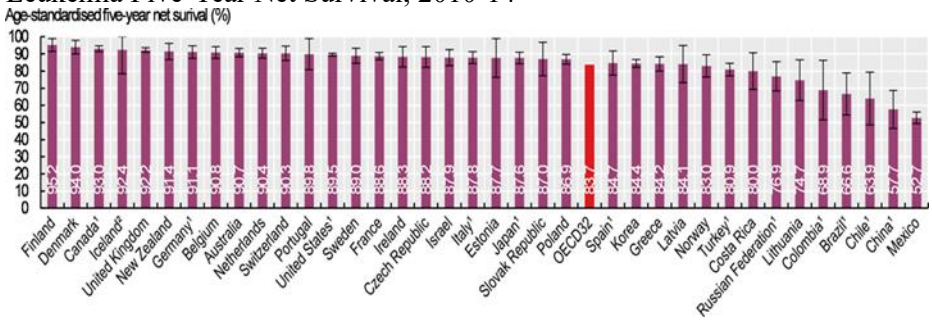


Figure 18. OECD Statistics – Childhood Acute Lymphoblastic Leukemia Five-Year Net Survival, 2010-14[317]



[315] OECD, *supra* note 179, at 143.
[316] *Id.*
[317] *Id.*

Figure 19. Distribution of Medicare Beneficiaries by Federal Poverty Level[318]

Under 100%	100%-199%	200-399%	400%+	Total
12%	21%	31%	35%	100%

[318] *Distribution of Medicare Beneficiaries by Federal Poverty Level: Timeframe: 2018*, *supra* note 287.