REPORT HEALTH REFORM 2020

A New Strategy for Health Care

JANUARY 4, 2018 — PAUL STARR

With the Trump era only a year old and its full impact on health policy as yet unclear, it may seem premature to discuss what ought to come next. But, driven by new enthusiasm among progressives for Bernie Sanders's single-payer plan, the debate has already begun, and if the past is any indication, supporters of reform will turn to proposals long in gestation when they are finally able to act.

When that time comes, Democrats don't want to discover they have locked themselves into commitments on health care that they cannot fulfill, just as Donald Trump and Republicans did in 2016. Democrats are justifiably angry today about the Republican efforts to sabotage the Affordable Care Act and cut Medicaid that have put health care for millions of people in jeopardy. Supporters of a universal system also have good reason to believe that the ACA was too limited and a stronger government role is necessary. But going to the opposite extreme and nationalizing health insurance has its own problems. Even by Sanders's own estimate his plan would require a larger increase in federal taxes than the United States has ever had in peacetime. For that reason alone (and there are others), Democrats need to look at a broader menu of alternatives.

So, imagine it is January 2021, and a Democrat is ready to assume office as president along with a new Democratic Congress: What priority should health care get, and what policies should a new administration push for?

In Trump's wake, many other legitimate concerns will be clamoring for attention and resources. For four years, the Trump administration will have neglected and in some cases aggravated America's real problems, including economic inequality and insecurity, climate change, and the decaying public infrastructure that Trump shows no signs of fixing. The two previous Democratic presidents made health care their top priority for reform in their first year. Although Bill Clinton failed to pass his Health Security Act, Barack Obama succeeded in passing the ACA. But both of them faced a backlash driven in part by their health policies, lost Democratic congressional majorities after two years, and from then on faced severe limits on what they could accomplish.

I supported Clinton's and Obama's decisions to make health care the early focus of reform in their presidencies, but I'd be hard-pressed to make that argument a third time. That's not to say the Democrats' presidential candidate in 2020 should ignore or downplay health care. The Trump era's damage to national health policy will call for an answer, and the party's primary voters care intensely about the answer their nominee will give. Democrats, however, ought to learn from experience and focus on health-care priorities that make sense as both policy and politics and build popular support over time. Those priorities will have to deal with core concerns about health care yet not absorb every last dollar of revenue a new administration might hope to raise.

Repairing whatever is left of the ACA, if anything is left, will be important but insufficient. Although the ACA has gained in popularity since Trump's election, the law's limitations have also become increasingly apparent. A new Democratic administration should focus on one or two signature health-care proposals that advance the long-term objectives of universal coverage and cost control and respond to people who have insurance but still face financial stress from medical bills. Two ideas could meet these criteria: making available a new Medicare plan for people aged 50 to 64—a program I call "Midlife Medicare"—and directly attacking America's excessive health-care prices. Although the two ideas are independent, they're closely related, since attacking prices also involves an extension of Medicare, in this case the extension of Medicare rates to out-of-network providers in private insurance.

Read all of the articles in the Health Reform 2020 series, co-produced by The Century Foundation and *The American Prospect*.

> See the collection

Limits of the ACA

Advocates for broader access to health care have rightly defended the ACA from Republican attacks, but facing up to its limits is crucial for figuring out what to do next. The law has worked well, but it hasn't worked well enough. From 2010 to 2016, it cut the proportion of Americans without health insurance almost in half, from 16.3 percent to 8.8 percent, and it did that without causing the economic havoc that opponents predicted. But it hasn't effectively addressed the underlying problem of rising costs and consequently hasn't assured a stable and affordable system. Although millions have received care they wouldn't have gotten, Gallup data indicate that 29 percent of Americans—37 percent of women compared with 22 percent of men—still put off medical treatment due to cost in 2017, not significantly different from before the ACA. While seeing improvements in the scope of coverage such as the elimination of annual and lifetime caps,

many Americans with private insurance now face much higher deductibles than in the past. The sense of many people who previously had good health benefits that their own insurance is deteriorating may account for much of the dissatisfaction with the ACA.

Moreover, the two means by which the ACA has extended health insurance—the expansion of Medicaid and reform of the individual insurance market—ran into problems even before Trump took office. Some of those difficulties stem from the Supreme Court's decision about Medicaid and red-state resistance to the program, while others reflect limitations of the ACA itself, now aggravated by Trump's policies.

In 2012, when the Supreme Court made the ACA's Medicaid expansion optional for the states, it put in question an incremental strategy for expanded coverage that reformers had followed for more than two decades. In the 1980s, Congress began increasing Medicaid eligibility for low-income pregnant women and children. If states wanted to get any federal funds for Medicaid (and all states did), they had to cover the new beneficiaries and services that federal law mandated. Congress thereby gradually ratcheted up a program that originally covered only special groups among the poor—the disabled, blind, aged, and single-parent families on welfare. But many low-income people continued to be left out of Medicaid, especially in Southern states that severely restricted eligibility.

In 2010, the ACA took the next step in turning Medicaid into a general health-care program for low-income people by extending eligibility to all those with incomes up to 138 percent of the federal poverty level. (In 2017, that's $16,643 for an individual.) The new national standard would have gone into effect in 2014 if the Supreme Court had not ruled—for the first time since Medicaid's enactment in 1965—that Congress could not condition all federal Medicaid funds on a state's agreement to include a new group of beneficiaries.

The Court's decision hasn't just allowed 19 Republican-led states to reject the ACA Medicaid expansion; it also prevents Congress in the future from ratcheting up national standards for Medicaid coverage as it did in the past. Indeed, the ratchet now will work in the other direction. If Republicans cut the traditional Medicaid program when they are in power, Democrats cannot later restore coverage, much less expand it, and count on states being effectively required to comply.

Leaving Medicaid coverage up to the states has a big impact on low-income people who live in Republican areas. During the first half of 2017, the share of adults aged 18 to 64 who were uninsured was 19 percent in the states that did not expand Medicaid, compared with 8.8 percent in the states that did.

Although Medicaid will continue to be central to financing health care, it is hard to see how it can serve as a firm basis for universal coverage. Democrats can reduce reliance on Medicaid, however, by shifting to the other national framework

for coverage established in 1965—Medicare. Many of Medicare's original supporters hoped to use it eventually to cover everyone, and in 1972 Congress extended it to cover those on disability insurance as well as patients with end-stage renal disease. By incrementally expanding Medicaid in the 1980s and then creating the Children's Health Insurance Program (CHIP) in 1997, Congress was able to offload some of the cost of expanded coverage onto the states. With that route to a universal system now effectively cut off, reformers need to turn back to Medicare, which as a national program doesn't give Republicans in the states a veto point. As a result of its popularity and success in both controlling costs and providing broad access to providers, Medicare also has other advantages that make it a stronger platform than Medicaid for the next phase of health-care reform.

Besides expanding Medicaid, the ACA has increased coverage by helping people afford private insurance. Instead of trying to restructure all private insurance and put a lid on its total costs—as the 1993 Clinton health plan had sought to do—the ACA leaves employer-based health plans for the most part unchanged and focuses primarily on reforming the individual (or "non-group") market.

Before the ACA went into effect in 2014, insurers priced policies for individuals according to the beneficiaries' health and age and limited the scope of coverage through caps and exclusions, including the exclusion of pre-existing conditions. People who bought insurance directly on their own got poor value for money, and millions of individuals remained uninsured because they couldn't afford the rates, were deemed uninsurable, or took the risk of going without coverage and depending on charity care if they got seriously ill.

The ACA deals with these problems through new rules and new subsidies. While allowing for considerable patient cost-sharing, the new rules require insurers to cover all applicants for a list of "essential health benefits" at rates not based on their health and only to a limited extent based on their age. A financial penalty for failing to carry a minimum level of coverage—the so-called "individual mandate"—was supposed to motivate the healthy to insure, deterring people from opportunistically buying insurance only when they needed it. The new sliding-scale tax credits for premiums, available only through state-based marketplaces, go to people with incomes up to four times the federal poverty level, while subsidies for deductibles and co-pays go to insurers for the benefit of people with incomes up to 250 percent of the poverty line.

After an encouraging start in 2014, the individual-market reforms look increasingly inadequate. The premium tax credits have been too low and the penalty for failing to insure has been too small and too weakly enforced to get many healthy people to sign up. The unpopularity of the individual mandate made it a perfect point of attack for Republicans against the whole structure. Insurers have been able to skirt the requirement to sell individual policies at the same community rate by designing separate plans to be sold outside the state marketplaces to lower-risk individuals (a

problem that Trump's policies will exacerbate). Some supporters of the ACA had expected the marketplaces to work so well that they would become a desirable alternative to employer-based insurance. Instead, because of limitations in their design, the marketplaces suffer from adverse selection (disproportionately high-cost enrollment), and the plans they offer typically provide access to a more limited list of doctors and hospitals than Medicare or a good employer plan provides.

The problems of high prices and limited insurance options have intensified in the past year as major insurers have dropped out of many of the ACA's marketplaces. In much of the country, only a single insurer offers coverage, and rates have soared as a result. Lacking even a fallback public option—a public insurance plan triggered by the lack of private competition—the enrollees in the marketplaces have had to settle for whatever remains available to them.

In retrospect, the ACA has neither been generous enough (in its subsidies) nor tough enough (in the individual mandate) nor realistic enough about the market (in its lack of a public option). But the biggest limitation of the ACA's market reforms is that they don't address the underlying problems in health-care prices.

It's the Prices, Stupid

In 2016, the United States devoted nearly 18 percent of national income to health care, compared with about 11 percent for peer countries such as Germany, France, and Sweden and an average of 9 percent for the 35 member nations of the Organization for Economic Cooperation and Development. Although national health spending generally rises with per capita income, the United States is an outlier, spending vastly more on health care than its per capita income predicts. The excess is not the result of Americans going to the doctor or hospital more often or using more drugs or generally consuming more medical services than people in the other economically advanced societies. The single biggest factor is that Americans pay higher prices for health care, as Gerard F. Anderson, the late Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan argued in a 2003 article in *Health Affairs* memorably titled "It's the Prices, Stupid." It is the price system, particularly for patients with private insurance or no coverage, that lies at the heart of the cost problem of the American health system.

While other countries regulate health-care prices or budgets, the United States leaves prices in the private market to insurers and providers, a system that has failed to create any effective check on what providers charge. The sources of market failure arise from the structure of health care and insurance and from trends toward monopoly power that have made a bad situation worse.

Health-care spending is concentrated—I realize this is shocking—among the very sick. In any given year, the most costly 10 percent of a population typically accounts for about two-thirds of total costs. When people face serious health

problems, they often have urgent needs and ties to particular physicians that limit their practical options. It's not realistic to expect most patients in those circumstances to shop around and compare prices, and even if they tried, they usually wouldn't be able to find out beforehand how much different hospitals and other providers would charge.

Imagine if buying gas for your car worked like hospital care. If it did, when you pulled into a gas station, no prices would be posted. What you'd pay would depend on your car insurance, but no one could tell you what those prices or the total cost would be. It would depend on what several different mechanics—not all of whom would necessarily be "in-network"—determined your car needed. The bill would be incomprehensible, and most of it would be paid by your employer's plan. Eventually, the full cost would come out of the wages you and your fellow employees were paid, although you wouldn't be able to do anything about it. One thing we could say for sure: Gas prices would be very high under this system.

In the mid-1990s, when managed care was on the rise, insurers did hold down prices and costs for a while, but the effect was short-lived. Partly in response to managed care, health-care providers at the local and regional level began consolidating into massive health systems that have enabled them to regain market power and jack up prices. Consolidation has also taken place on the insurer side and in other segments of health care, such as pharmacy benefit managers, all to the disadvantage of consumers. Insurers have passed on higher provider costs to employers, who have passed them on their workers, with the sharp increase in deductibles being one of the consequences.

The one relatively bright spot in the American system has been the Medicare program, which has a system of federally set prices. That system, although far from perfect, has kept down Medicare costs relative to private insurance yet still preserved access to nearly all doctors and hospitals for Medicare beneficiaries. So, just as we should think about using Medicare to achieve universal coverage, we should also think about expanding the use of Medicare prices to control costs and sustain a universal system.

The Case for Midlife Medicare

In her 2016 presidential campaign, Hillary Clinton had policies on nearly every issue confronting the country, while Trump had only a few simple positions. Clinton's nuanced command of the issues was admirable, but many voters were unsure what she would do as president, whereas everyone knew exactly what Trump was promising. If Democrats learn one thing from Trump's success, it should be *focus*. While candidates ought to have extensive and detailed knowledge, they need a small number of easily grasped focal ideas that define what their candidacy is all about. With that concern in

mind, I am suggesting only two focal points for an agenda in health care—making a new part of Medicare available to people at age 50 and controlling health-care prices. Although the details will be complicated to work out, people won't need to be experts to understand what they stand to gain from those policies.

Recent Republican alternatives to the ACA hit older adults in the individual market particularly hard. The legislation passed by Republicans in the House in May would have allowed insurers to charge older adults five times as much as younger adults (instead of three times as much under the ACA) and would have provided much smaller premium subsidies with little adjustment for income. According to the Congressional Budget Office, in a state that carried out the law without any special waivers, the House bill would have raised the net cost of insurance for a 64-year-old with an income at 175 percent of the federal poverty level from $1,700 to $16,100—an 847 percent increase. In September, Republicans in the Senate fell one vote short of passing their own repeal-and-replace legislation, which would have converted all premium subsidies as well as funds for the Medicaid expansion into block grants to the states. Under that bill, if Republican-led states adopted the same principles that their representatives in the House supported, older adults now getting marketplace coverage would also have faced such radical increases in premiums that many of them would have become uninsured. Since Republicans keep promising to carry out their policies one way or another—through federal legislation, administrative waivers, and state policies—the threat to older adults has not disappeared.

Older adults are particularly concerned about health insurance because of the onset of health problems in midlife. Moreover, as the economists Anne Case and Angus Deaton have shown, rates of illness and death have been increasing in recent decades for Americans in midlife, especially for non-Hispanic whites with a high school education or less. The human costs of deindustrialization are being recorded in their lives. For many of them, finally becoming eligible for Medicare at age 65 is a moment of tremendous financial relief.

The idea of moving that age up to 55 through an early "buy-in" to Medicare has been around since President Clinton proposed it in 1998. In 2017, a group of Democratic senators, led by Debbie Stabenow of Michigan, introduced a bill for a Medicare buy-in beginning at age 55, while a group of Democrats in the House proposed a buy-in starting at age 50. But reform efforts haven't focused on the potential of the buy-in idea, and there has been no recent effort to cost out the different ways of designing it. The term "buy-in" may suggest an option wholly financed by premiums, but since many of the people interested in early access to Medicare will have retired before age 65 because of health problems, a program entirely financed by premiums would be unaffordable.

Midlife Medicare, as I imagine it, would be a new part of Medicare for people aged 50 to 64, financed by general revenues as well as by premiums. The general revenue would be set roughly to offset adverse selection and to match the value of subsidies in the ACA, scaled up for a standard Medicare plan, including pharmaceutical coverage. (Like

Medicare Part B, it would not draw on the Medicare Trust Fund.) The program would be open to older adults who do not have employer-sponsored insurance and were not offered it, and it would consequently be smaller and more fiscally manageable than a single-payer plan. Yet it would still be an important breakthrough not only for the people who would enroll in it but for others as well because it would significantly reduce costs for the remaining, younger pool in the

SEN. DEBBIE STABENOW, D-MICH., SPEAKS DURING THE SENATE FINANCE COMMITTEE MARKUP OF THE "TAX CUTS AND JOBS ACT" ON WEDNESDAY, NOV. 15, 2017. SOURCE: AP IMAGES.

individual market.

Focusing on Midlife Medicare would respond to political realities that advocates of "Medicare for all" have hoped to elide. Shifting all Americans into a federally financed program, as I mentioned earlier, would require a staggering increase in taxes. Advocates say that because of savings people would pay less than they do now in premiums, but this argument ignores several problems. First, many people such as seniors and veterans who are satisfied with their coverage would see the new taxes as an extra burden. Second, employees with health benefits would have to trust that their employers would pass along savings in the form of higher wages and that the resulting wage increases would offset the new taxes—an impossible calculation for them to make. Third, a single-payer plan would require people to give up their current private coverage, and as long experience has shown, Americans are fearful of doing so, especially once a mobilized private health-care industry has had a chance to raise anxieties about change. Single-payer proposals have

gone down to defeat in state referenda three times in recent decades: 73 percent to 27 percent in California in 1994, 79 percent to 21 percent in Oregon in 2002, and 80 percent to 20 percent in Colorado in 2016—all blue states, and the margins were not even close.

General expansions of Medicare, such as Jacob Hacker's proposal for a new part of Medicare open to everyone (including employee groups), would also raise concerns about open-ended costs and risk alienating a crucial group—seniors. Many of the elderly see Medicare as their own program, earned through taxes they have paid over their working years, a view they have long been encouraged to hold by Medicare advocates. Midlife Medicare would have a far better chance of winning seniors' support. The leading organization representing seniors, AARP, welcomes all Americans 50 years of age and older as members and seeks to represent them as a single constituency. People aged 50 to 64 have also paid Medicare taxes over their working years and can equally be said to have earned Medicare benefits. Since Social Security already has a provision for obtaining pension benefits early (at age 62), the idea of early eligibility is a familiar one. Public opinion data on a Medicare buy-in for 55- to 64-year-olds are encouraging. According to an April 2017 YouGov survey, seniors approve a Medicare buy-in at nearly as high a rate (71 percent) as all age groups combined (82 percent).

Americans who resist publicly financed health care in the abstract often seem more willing to support it when the issue is more specific to an age group. That is how we got Medicare and CHIP. Age-based public programs may not be ideal, but they are not an intolerable compromise. They have the political virtue of creating an identifiable group of beneficiaries whose problems are readily understood and whose families can be mobilized to defend their rights.

Like "senior" Medicare itself, Midlife Medicare would likely receive support from those too young to enroll who would see it not just as someone else's protection but as someday their own. People with an employer-sponsored plan would know that if they decide to retire early, they could continue to get good health coverage. By removing older adults from the individual market—in effect, siphoning off much of the high-cost population—Midlife Medicare would also make premiums for younger people more affordable. An additional step, eliminating the two-year waiting period for Medicare currently facing people already deemed eligible for Social Security Disability Insurance, would contribute to still-lower premiums in the individual market for the population age 49 and younger.

Politically, Midlife Medicare represents a possible point of convergence between the left and center in the Democratic Party. Advocates of Medicare-for-all might support an extension of Medicare to age 50 as a first step toward their larger goal, while others could see it as a positive step on its own. Even if Midlife Medicare didn't lead to any further expansions of Medicare, it could help show how to make the rest of the system work better. Here it's important to understand why the Medicare program works better than the ACA and how the latter might be fixed with the benefit of Midlife Medicare's example.

Several different ideas for expanding Medicare are now in circulation. A key distinction among them is whether they involve expanding Medicare as a plan or Medicare as a program. The distinction is crucial.

When most people think of expanding Medicare, they think of expanding access to the public Medicare plan, as in Sanders's single-payer, "Medicare for all" bill. But the Medicare program is not actually a single-payer; a third of beneficiaries use it to sign up for one of the many private Medicare Advantage plans. Medicare is now a framework for choice of plan—a marketplace for public-private competition. Expanding use of that framework has distinct advantages over the ACA marketplaces, even if the latter included a public plan.

It's not only Sanders's single-payer bill that calls for expanding the use of Medicare as a plan rather than Medicare as a program. Some public-option proposals do the same. Senators Michael Bennet and Tim Kaine have proposed a new Medicare plan, which they call Medicare "X," for "extra," that would be offered as an option in the ACA's individual marketplaces, beginning in 2020 with counties that have one or no private plans, extended three years later to all individual marketplaces, and the following year to small business. The Medicare-X plan would meet the ACA's requirements for essential health benefits and be financed through premiums, supported by the same subsidies as other marketplace plans.

Medicare-X has advantages over public options that are supposed to be "like Medicare" but unconnected to the Medicare program itself. If stand-alone public plans had to negotiate rates with providers, the plans might not have much bargaining power, and even if they used Medicare rates, many providers might refuse to participate. But participation in Medicare-X at Medicare rates could be required of providers who want to continue participating in "senior" Medicare, as nearly all would. If Bennet and Kaine's proposal had been part of the ACA, it might have averted some of the problems in the marketplaces today. But, as an adjustment to the ACA, it also reflects some of the law's limitations.

To appreciate those limitations, consider the differences between the framework for choice of plan in the Medicare program and in the ACA. The key differences have to do with how plans pay health-care providers, and how much consumers pay for different plans. The federally set provider prices for public Medicare also effectively cap what private Medicare Advantage plans pay providers. In Medicare Advantage, out-of-network providers are paid no more than Medicare rates and are prohibited from billing beneficiaries for any additional amount (so-called "balance billing"). As a result, in-network providers have an incentive to offer insurers even lower prices in order to get an increased number of patients.

The result is that the Medicare market is similar to European health systems that have multiple insurance funds but more unified payment rates. Even though the cap on out-of-network charges in private plans may seem a small detail of Medicare, it achieves a large effect in protecting Medicare beneficiaries from rising costs.

The other key aspect of Medicare is the dominant role of Medicare's public plan. Public Medicare doesn't just offer an "option"; public Medicare's costs are the basis (or "benchmark") for determining how much beneficiaries pay for Medicare Advantage plans. But while public Medicare covers roughly 80 percent of expected average costs for beneficiaries, the benchmark in the ACA marketplaces is the second-lowest-cost "silver plan," which covers only 70 percent of expected average costs. For the same level of coverage, ACA beneficiaries pay a lot more themselves. The difference has had a huge impact on the plans in the ACA marketplaces that consumers choose. The system has driven enrollees toward plans with relatively high deductibles and narrow networks and generated only ambivalent support for the program. In addition, the complete cut-off of subsidies for people with incomes above four times the poverty level has also created a significant group of middle-class people who don't have their premiums capped and often resent the ACA for forcing them into a risk pool and plans that require them to pay more for insurance than they previously did.

In contrast to the insurer monopolies in many ACA marketplaces, the terms established by Medicare give seniors access to both an affordable public plan and a variety of private options. The Medicare system works as well as it does because it has both a dominant public plan and price regulation on the private side. In contrast, Kaine and Bennet's Medicare-X proposal calls only for a public plan as an option in the ACA marketplaces, not the price regulation that enables private plans to compete in Medicare Advantage. Insurers will argue that they cannot compete with Medicare-X under those circumstances, and they're probably right. Although it may seem ideologically inconsistent, insurers need price regulation (that is, of providers) in order to compete with a public plan that sets rates.

Midlife Medicare would have all the features that enable Medicare to work better than the ACA—the strong public Medicare plan, the use of that plan as a benchmark, and provider price regulation in private Medicare Advantage options. All those elements would come as part of the now-established Medicare structure. Reformers could also try to introduce these features into the ACA marketplaces if the ACA survives the Trump era.

But regardless of what happens with the ACA, one idea deserves wider consideration as a general cost-control measure: using Medicare rates to cap out-of-network charges in private insurance.

The New Case for Regulating Prices

Health-care reformers and political leaders need to take a new look at an old idea—price regulation in health care. As of

1980, more than 30 states regulated hospital rates, but during the following two decades nearly all of them eliminated rate-setting in the belief that managed care and the free market would solve the problem of high health-care costs. Instead, prices and costs have continued to rise to far higher levels than in other peer countries, and waves of consolidation in the health-care industry have created monopoly provider systems in many areas. Relying on the market to limit health-care costs was never likely to work, but it is even more implausible today than it was before.

The new case for price regulation isn't based only on the growth of monopoly power in health care. After 30 years of unregulated private rates and regulated Medicare rates, the evidence is in: Medicare has held down prices more effectively than private insurance. The use of Medicare rates as a cap on out-of-network charges in Medicare Advantage has also demonstrated the value of a limited but strategic intervention to control costs without imposing uniform price controls. A legitimate concern about traditional price regulation is that it would lock in the fee-for-service payment system. But a cap on out-of-network fees still allows insurers to work out contracts that reward in-network providers for better performance. Out-of-network caps can be a spur to moving the entire health-care system away from fee-for-service. The Obama administration began moving public Medicare itself toward alternative payment methods, and while those methods have so far not yielded big savings for Medicare (and are being eroded under Trump), they have created the basis for a payment system that combines cost containment with incentives for improvements in the quality of care.

Capping out-of-network charges would also hardly be an unpopular idea. At a time when deductibles have been rising and patients are often hit by "surprise" medical bills (for example, from an out-of-network physician at an in-network hospital), provider payment caps would directly address problems that even the relatively well-insured are facing. The out-of-network caps then would also constrain in-network costs, since they would reduce the bargaining power of the monopoly systems.

Out-of-network prices could be limited in two general ways. Direct regulation based on Medicare rates would be the stronger approach. Commercial rates for hospital care today vary from roughly 130 percent to 200 percent of Medicare; one estimate puts the average for hospital prices at about 175 percent of Medicare. According to a study of private insurance claims by Yale University's Zack Cooper and colleagues, applying Medicare rates to all private insurance would reduce total private spending on inpatient hospital care by 31 percent. If the cap were set at 110 percent of Medicare, spending would drop by 24 percent; if at 130 percent of Medicare, spending would fall by 11 percent. Hospitals have generally been doing very well lately, with average margins of around 7 percent; nonprofit hospitals are a very profitable business. Even so, simply extending Medicare rates would be too severe. A somewhat higher cap—perhaps varying by region, and gradually tightening over time—would be an effective way to keep costs down.

A second approach would be to require hospitals to follow Medicare's relative prices and post a single figure indicating where they stood in relation to Medicare. For example, one hospital might choose to offer care at Medicare rates, another at 130 percent of Medicare, and a third at 200 percent of Medicare. Insurers have not had success in controlling costs by providing their subscribers with tools for price transparency. As I suggested earlier, many patients are not in a position to shop around. But a simplified system based on Medicare ratios might have a significant impact, if only because of the force of public opinion on the institutions charging the highest prices. If it's too difficult to reinstitute rate-setting, requirements for simple transparency would be a good second choice.

Whenever Democrats get another shot at health reform, that effort will have to fit within a larger national agenda and other demands facing the country. My proposals for Midlife Medicare and price regulation are a guess about what might be both desirable and feasible at that point. If the ACA marketplaces survive in a weakened form, Midlife Medicare could help reduce the burdens on them and demonstrate how a restructured marketplace with a strong public plan can work. If Republicans have succeeded in destroying the ACA, it may be hard to persuade people to revive that model, and Midlife Medicare could offer another practical way forward, as CHIP did in the wake of the defeat of the Clinton health plan.

Since the lower health-care costs of other countries are mainly the result of more effective price restraint, we could get a lot of the benefit of single-payer from adopting caps on provider payment. But price regulation doesn't have to wait for a change in national politics. State governments could undertake that function as they once did, focusing now on out-of-network charges as a key point of leverage. State experiments with different strategies for regulating health-care prices could then prove valuable for policy at the national level.

Of course, the struggle over preserving the gains of the ACA isn't over. States may be able to step in to make up for some of the Republican sabotage at the national level. But it is also not too soon to think about the alternatives that lie ahead when new opportunities for reform emerge.

This article was published as part of a special report on health care reform, co-produced with *The American Prospect*.

Paul Starr, Contributor

Paul Starr is co-founder and co-editor of the The American Prospect. and professor of sociology and public affairs at Princeton University. A winner of the Pulitzer Prize for General Nonfiction and the Bancroft Prize in American history, he is the author of seven books, including most recently Remedy and Reaction: The Peculiar American Struggle over Health Care Reform (Yale University Press, revised ed. 2013).