Germany's Health Care System: A Suitable Option for a Measured U.S. Health Reform

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Introduction

In 2019, the United States spent 17% of its GDP on health care. This is over 8 percentage points higher than the Organization for Economic Co-operation and Development (OECD) average (Tikkanen & Abrams, 2020). Indeed, the U.S. spends 26% of its national budget on health care (McGraw, Lecture 5.1, 2020). Despite this enormous cost, the US has some of the poorest health outcomes amongst comparable countries. For example, the U.S.'s life expectancy is the lowest of comparable OECD countries at 78.6 years (Tikkanen & Abrams, 2020).

It thus comes as no surprise that Americans are pushing for health care reform. Medicare-for-All, in particular, has become popular and is based on single-payer health care systems such as in the UK and Canada. However, there are many different actors in the public policy process that influence health reform; no one actor makes the decisions in American politics. Therefore, to increase the chance of health reform success, diversifying policy options is necessary. Indeed, there are other nations, such as Germany, that utilize successful health care systems, but are often overlooked in the U.S. reform discussion. Analyzing Germany's health care system may prove useful to U.S. policymakers, as it is a multi-payer system that is based on principles that the U.S. tends to value culturally, such as private industry, competition and consumer choice. This fact may make such a reform option more politically feasible in the U.S. than a single-payer system. Specific policies that suit the U.S. economically should be considered for implementation. In order to be relatively politically feasible, this implementation process should begin with a non-profit administered public option.

Germany's Health Care System

Background

Germany's health care outcomes are statistically comparable to other OECD countries, and are significantly more effective than the U.S.'s in cost, health, and access. Germany's spending on health care in 2018 was comparable to other OECD countries at 11.2% of GDP, though it ranked as the third highest percentage. This percentage was significantly lower than the U.S.'s at 16.9% of GDP. Further, total health care spending in Germany was the fourth highest OECD per capita spending at just under $6,000 per capita, though this was also substantially lower than the U.S.'s $10,200 per capita spending. While Germany's total spending per capita was relatively high, out-of-pocket (OOP) spending for consumers was one of the lowest amongst OECD countries at $738 per capita. This was also substantially lower than the U.S.'s OOP spending of $1,122 per capita (Tikkanen & Abrams, 2020). Therefore, while the German government spends a relatively large amount on health care, this spending is significantly lower than what is seen in the U.S. Additionally, citizens in Germany are considerably more protected from OOP expenses than their counterparts in the U.S.

Germany's health indicator statistics are also similar to other OECD countries. Average life expectancy is similar to other comparable countries, though slightly on the lower side, at 81.1 years. In comparison, the U.S.'s life expectancy is the lowest of OECD countries at 78.6 years. Germany's percentage of those with chronic disease burden is approximately at the average of OECD countries at 17%, which is much lower than the U.S.'s 28%. Additionally, Germany's maternal mortality, a widely accepted key indicator of population health (Wilmoth et al., 2012), is relatively low compared to other OECD countries and is substantially lower than in the U.S. (3.2 deaths vs. 17.4 deaths per 100,000 live births) (OECD Data Lab, 2020). While there is certainly room for Germany to improve these indicators, they are both in line with other OECD countries and largely better than the U.S.'s indicators.

Germany most excels on the international stage in access to health care services (Schneider et al., 2017). Wait times for services, often a key concern amongst critics of universal health care, are very low compared to other OECD countries, and in some cases are even lower than in the U.S. For example, the percentage of consumers self-reporting waiting over two months for a specialist appointment was only 3% in Germany, which is slightly lower than the U.S.'s 6% and is one of the lowest amongst OECD countries. A key reason for these low wait times may be that Germany has one of the highest numbers of practicing physicians out of OECD countries, at 4.3 physicians per 1,000 population. This is nearly double the U.S.'s 2.6 per 1,000 population. Despite being slightly costlier than some comparable countries, Germany has one of the lowest reported experienced barriers to health care services due to cost at 7%, compared to the US's 33% (The Commonwealth Fund, 2020).

With these comparative statistics in mind, it is no surprise that this long-lasting health insurance system is often considered to be one of the most successful health insurance systems in the world. Germany's public health insurance system was implemented by Chancellor Otto von Bismarck in 1883 and was the world's first social health insurance system (Busse et al., 2017). While the system has changed substantially since its initial implementation, it has long been identified by its collaboration between public and private industry.

Like most comparable countries, Germany has achieved universal health insurance. Unlike the U.K. and Canada, however, the government does not directly supply its public insurance. Instead, 88% of the German population is enrolled in statutory health insurance (SHI), which is largely regulated by the government but is administered by private, non-profit insurers, popularly called "sickness funds" (Tikkanen et al., 2020). This insurance is very generous in its coverage, covering doctors, dentists, chiropractors, physical therapists, psychiatrists, hospital services, all prescriptions and more (Reid, 2010). Those with a specified level of income can opt out of SHI and can purchase their own private insurance, around half of which are for-profit (Tikkanen et al., 2020).

SHI is financed through wage contributions from both employees and employers at 7.3% each. However, earnings above $69,897 per year are exempt from contribution. The unemployed contribute through their unemployment entitlements, and the government contributes on behalf of those who are long-term unemployed. This revenue is pooled together and distributed to individual sickness funds using a risk-adjusted capitation formula. In addition, a supplementary wage contribution is also required and is based on the individual sickness fund and the consumer's income. In 2019, the average contribution was 1%. In addition to this payment, limited premiums (based on income) and copayments also apply to some services. Other OOP costs include deductibles, though the amount of the deductible varies by sickness fund (Tikkanen et al., 2020).

While public insurance is administered by non-profit insurers, it is regulated by a combination of government and private industry. At the federal level, the Federal Joint Committee (under the Federal Ministry of Health) decides which services will be covered by SHI and sets quality measures for providers contracted with SHI. The committee is made up of representatives from sickness funds, providers, patients, as well as unaffiliated members. Therefore, there is a significant degree of joint self-regulation by private industry in this area, though it is monitored by the federal government. Separately, prices for services and cost-containment strategies are negotiated between payer and provider associations with virtually no government oversight (Busse & Blümel, 2014). However, the Ministry of Health has begun to play a limited role for certain services, such as pharmaceuticals (Altenstetter, 2003).

Specific German Health Policies to Consider

Four major pillars of Germany's health insurance system include universal health insurance, business competition and consumer choice, relatively low costs (compared to the U.S.), and price transparency. Policies behind these pillars will be discussed and analyzed from an economic perspective to understand if U.S. policymakers should consider implementing such policies.

Universal Health Insurance

Germany achieved universal health insurance by mandating insurance coverage for the German population in 2007. In 2019, 88% of the population was covered through SHI sickness funds, and 11% were covered by private insurance. While SHI is specifically mandated for employed individuals earning under a specified annual salary, others are covered through SHI, including unemployed individuals and pensioners. Enrollees' children are also covered through their parents' insurance. Under SHI, every consumer has an equal right to medical care, and no one can be denied coverage (Tikkanen et al., 2020). The 1% of the population not covered by these terms, such as civil servants, refugees, and undocumented immigrants, receive health insurance through specific governmental schemes (Busse et al., 2017).

There are economic advantages for countries that provide universal health insurance. One of the main goals of health insurance is to shield consumers from high health care costs. When these costs aren't shielded, both consumers and providers are hurt (i.e., a negative externality). For consumers, this can result in spending less money on other products and even taking on debt, which, for those with lower incomes, can be even harder to pay back due to high interest rates. This result not only leads to less money spent on other products and services in the economy, but also may cause individuals to struggle financing necessities, such as food and housing. For providers, such as hospitals, this comes in the form of uncompensated care that hurts the provider's revenue. This lack of revenue can be passed onto consumer who can afford care and, if not, can lead to less investment in the hospital. It is economically beneficial for governments to support their entire population's ability to afford health care services, as this action works to decrease these negative externalities.

Low Costs Relative to the U.S.

The U.S.'s spending on health care is the largest amongst OECD countries, including Germany. As previously mentioned, in 2017, the U.S.'s per capita spending reached over $10,200. In comparison, adjusted for differences in cost of living, Germany's per capita spending was just under $6,000 (Tikkanen & Abrams, 2020). These lower costs are, at least in part, due to specific policy decisions by the government.

First, the German federal government only contracts with non-profit insurers to administer the public insurance. Therefore, the insurers' main goal is to pay consumer's medical bills, as they are not beholden to pay shareholders as in the case of for-profits (Reid, 2010). While non-profits are incentivized to make money in order to pay their staff, they do not have the same incentive to continually increase profitability and serve shareholders. This fact can keep costs relatively contained.

Second, the German federal government imposes spending caps (or, "budgets") on certain health care providers, such as hospitals (Busse et al., 2017). Ideally, these caps incentivize providers to reduce unnecessary care and therefore control costs (Barber et al., 2019). Capping spending and imposing budgets for certain sectors has almost certainly contributed to containing costs for public insurance.

In addition to these spending caps, copayments for consumers are capped (and some exemptions apply). The copayments are capped by federal legislation and apply to all sickness funds. For example, copayments cannot be more than 2% of a household's gross annual income. For those with chronic disease who meet certain requirements, this amount is capped at 1% (Tikkanen et al., 2020). Such measures seem to be successful, as Germany has one of the lowest out-of-pocket spending per capita amongst other comparable countries (Tikkanen & Abrams, 2020).

Germany also has significantly lower administrative costs than the U.S (Reid, 2010). While there are numerous factors that contribute to this lower cost, one recent policy implementation that has had a significant impact is the introduction of a universal digital health card in 2008. Such cards are used by all SHI consumers and encode information such as name, address, sickness fund, and details of coverage. Consumers can also decide to include their medical information and give permission for it to be shared with their physician (Tikkanen et al., 2020). These cards have decreased paperwork significantly and have reduced administrative costs even further (Reid, 2010).

Universal digital health cards also make sense from an economic perspective. Providers spend massive amounts of time on paperwork, which contributes to economic waste, as the concept of

opportunity cost indicates that providers may be giving up the opportunity to spend this money and time in ways that more directly benefit consumers, employees, and/or the provider's practice. For example, time and money spent filing paperwork could be spent on purchasing and utilizing a new technology that benefits consumers. Thus, making administrative costs more efficient can only benefit a nation's economy.

As explored above, keeping health care costs from reaching unaffordable levels has a positive economic impact on both individuals and the overall economy: less money spent on health care frees up more money for individuals to spend in other sectors of the economy. Similarly, this idea also translates to spending by the federal government. Last year, spending on public health programs and ACA subsidies made up 26% of the U.S. national budget (McGraw, Lecture 5.1, 2020). Decreasing this amount frees up money that can be spent on other programs shown to economically benefit Americans.

Insurer Competition and Consumer Choice

To some, government intervention in health insurance is problematic and means less market competition and consumer choice. To see this viewpoint in the U.S., we need only turn to arguments against Medicare-for-All. Opponents argue that government-supplied health insurance that sets prices and coverage terms for providers will artificially decrease payments to providers to such an extent that many will go out of business, thus decreasing competition as well as the incentive to innovate (Goldman & Leive, 2013).

Germany, however, has balanced government cost-containing and quality measures with continued health insurance competition and innovation. While governmental and non-governmental entities control costs and set coverage rules, the non-profit insurers still compete aggressively for enrollees. This competition is possible as consumers can choose between multiple sickness funds. In 2019, there were 109 sickness funds (Tikkanen & Abrams, 2020). Consumers can also fairly easily switch sickness funds, especially if their sickness fund raises their deductible (Busse & Blümel, 2014). Competition is further made possible because sickness funds, though required to provide certain coverage, are able to offer extra benefits or services to attract new consumers (Reid, 2010).

These measures have economic benefits. They foster healthy competition, which in turn allows for continued innovation. In order to attract consumers, these insurers have to be relatively sensitive to what consumers want and need. This regulated competition seems to greatly benefit consumers economically, as they are receiving insurance that is both sensitive to their needs and affordable.

Price Transparency

Price transparency is a key aspect of Germany's health care system, especially when compared to the U.S. An example of this transparency is the public releasing of negotiated rates for pharmaceuticals (Robinson et al., 2019). Another significant transparency measure is SHI's online directory (GOÄ) (Reid, 2010). The GOÄ is a product of the negotiations between industry associations that lead to set coverage and prices for SHI. All of these coverage rules and prices are published in an online directory available to providers. Therefore, providers can easily check if their recommended treatment is covered by SHI and how much it will cost the patient.

Transparency within a market is a key aspect of economics, as it is a tool to combat information asymmetry. Information asymmetry results from one party in a transaction having more information than the other party, which may lead to one party taking advantage of the other. In this case, where neither physician nor patients often know what the patient will end up paying for a medication, it is easy to see the benefit of addressing this market failure. While discussing treatment options with a patient, a provider can check coverage and costs. This knowledge can enable both provider and patient to make informed decisions that can lead to efficient and optimal actions and outcomes.

Considerations for Implementation

While there are many economically-sound policies that the U.S. could take from Germany, there are specific considerations that U.S. policymakers must contemplate when crafting these ideas into legislation and regulations. These considerations, including politics and cost, will drive how, and to what extent, policies from Germany's health care system could be implemented in the U.S. Despite many of these policies exhibiting traits that American culture generally tends to value, the reality is that such policies, especially taken together as a package, will likely face an uphill battle to implementation.

Congress

A policy option requires enough votes in Congress to become law. Due to the cost-containing policies such as price controls and, especially, the government's role in setting budgets for providers, the Republican Party is unlikely to support a legislative package that transitions the U.S. to Germany's system. For example, this past year, a bipartisan prescription drug pricing bill, pushed by Senate Finance Chairman Chuck Grassley (R-IA), was virtually dead on arrival due to many Republicans' opposition to modest price controls supported by Grassley himself (Huetteman, 2019). Therefore, it is unlikely such policy ideas will receive much, if any, Republican support.

Thus, it would be up to Democrats to push a German-model health reform package. This may lead to even less Republican support, if the history of the Affordable Care Act (ACA) passage is to repeat itself. With these possibilities in mind, Democrats would need to control both chambers of Congress and the presidency for a German-model health reform to succeed. They will also likely require a substantial majority in both chambers, and a moderate-leaning President. While there are price control measures that Democrats tend to support, Germany's model relies heavily on joint self-regulation by industry associations with limited government oversight. This likely will not appeal to more progressive Democrats, especially those who support a single-payer system. Therefore, the Democratic Party would need to have large majorities in both chambers, as some Democrats may resist this legislative package.

Interest Groups

Health care interest groups tend to be a significant roadblock to any major U.S. health reform, and a German-model health reform package would be no different. First, for-profit insurers will likely fight against such a reform, as they would be excluded from administering public insurance and this insurance scheme would become their competition. As 75% of Germans eligible to purchase private insurance instead keep their public insurance (Tikkanen et al., 2020), for-profit insurers in the U.S. would stand to lose significant profits.

Providers will also likely fight against such a reform. Under Medicare and Medicaid, providers have long contended that reimbursement rates are too low – in some cases so low that they lose money by treating enrollees (Rickert, 2012). Although providers would have significant input into how services are priced, spending caps and sector budgets set by the government would likely lead providers to become a powerful actor amongst the opposition.

Drug manufacturers, represented by PhRMA, would also likely be a powerful actor in the opposition group. PhRMA has been incredibly successful at protecting their interests in recent years, including preventing Medicare from negotiating drug prices. One of their talking points against any price controls is that such controls will limit their ability to research and provide new life-saving medication. These talking points, along with large amounts spent on lobbying (Evers-Hillstrom, 2019), have been very effective at influencing public and Congressional opinion in their favor.

Some consumer groups and even some government officials may push back against such a large reform. National agency staff who work directly on Medicare and Medicaid may be resistant to change, though they may also be able to transition to working on new health care regulation. Some consumer groups with financial stakes may also push back against such a reform. For example, AARP offers many Medicare Advantage plans, which would become obsolete in a full reform as Medicare would be replaced by an SHI-style public insurance.

These complex webs of interest groups are powerful, especially when they work together. An example of this can be seen through California's failed health care reform in '90's. In this circumstance, providers were a mixed bag of supporters and opponents. Hospitals, however, successfully opposed bills with hospital rate regulations. For different reasons, insurers were also a mix of supporters and opponents, and the opponents ultimately prevailed. Though they had different reasons for doing so, these interest groups and others banded together to create a campaign that helped defeat the reform legislation, despite the original presence of mass public support and a political appetite for reform. In fact, the opposition spent over three times the amount that proponents did. These campaigns were highly successful, as after these campaigns were implemented, polls showed that public support had drastically decreased. The health reform push ultimately failed (Oliver & Dowell, 1994). Supporters of a German-model national health reform must take into account these dynamics if they are to successfully pass such a reform.

Federalism

While regional governmental actors do have a role in health care decisions in Germany, it is very limited compared to the role of the federal government and industry associations. This is in contrast to the U.S., where states not only control their own Medicaid programs, but also in some cases oversee their own state ACA-style marketplaces. In fact, New Jersey has already created its own state marketplace to decrease reliance on the federal government (The State of New Jersey, 2020). As such, states are unlikely to support decreasing their autonomy, especially when it comes to decisions over coverage of politically charged health care services, such as abortion and contraception. From a federalism perspective, German-style reform would likely be legal for the federal government to pass and order implementation, as it would be set up in a similar fashion to the ACA: a federally regulated marketplace, without the issue of Medicaid expansion. However, federal policymakers will likely still have to account for and address some potential state and local-level pushback.

Cost

The goal of health insurance reform would be to increase the percentage of the U.S. population that has health insurance while decreasing and containing the exorbitant public funds spent on health care per capita. The German policies explored above are a mix of policies that will both cost and save money in different areas, but optimally together they would make the U.S. health care system more cost efficient.

First, in terms of a health insurance mandate, policymakers will need to be mindful of health insurance affordability after health reform implementation. While Germany's health care system succeeds in shielding consumers from high costs, this is not the case in the U.S., and policymakers must ensure this is the case before mandating insurance. If insurance is still relatively unaffordable for some consumers, it would be economically unwise to require these consumers to enroll in it, as this could cause unnecessary financial strain on some Americans.

Second, replacing the current U.S. health care system with a model that largely consists only of a public insurance market and a private insurance market will end health insurance programs such as Medicare and Medicaid. Spending on these public programs makes up 26% of the national budget (McGraw, Lecture 5.1, 2020). Further, in 2018 federal subsidies for health insurance totaled around $685 billion, 40% of which was spent on subsidizing Medicaid and CHIP (Congressional Budget Office, 2019). Cutting these programs would save the government a significant amount of money, which could be used to offset the costs associated with this health reform's implementation.

In terms of a public insurance market, contracting with non-profit insurers to administer public insurance is likely to save the government money in two ways. First, contracting out the actual delivery mechanism of health insurance will shift a significant amount of costs associated with administration onto the contracted insurers, and away from the government. Second, the non-profit nature of the insurers means that they do not have the incentive to search for ways to continually increase profits, which can lead to increased costs in the overall health care system. Therefore, such a model will likely save the government money in both the short- and long-term.

German cost-containing measures also present the opportunity for the government to save money in the long-term. Setting spending caps or sector budgets, when done properly, would almost certainly contain government spending costs on health insurance. However, it is unclear what entity would take on these costs. Ideally, providers would reduce unnecessary care, thus controlling costs. However, depending on how many consumers are still covered by private insurance, providers may not reduce unnecessary care to an optimal level and instead pass the cost onto those with private insurance. As all consumers would have the opportunity to enroll in public insurance, providers would be unable to increase prices for private enrollees too much, or they would risk consumers transferring to public insurance instead. Another important consideration for this policy is that there is also an incentive to under-provide care and refer complex patients to other health care providers (Barber et al., 2019). Policymakers would need to keep these considerations in mind when determining the size of caps and budgets.

Setting prices for services and medications covered under public insurance has also been shown to be an effective cost-containing measure in government spending on health insurance, as Medicare reimbursement rates are often cited to be lower than private insurance rates. However, some of these costs are likely passed to consumers with private insurance (or no insurance). This in turn can contribute to high premiums for private insurance plans, some of which the government provides subsidies for in the ACA marketplace. Germany's model of dual self-regulation for pricing likely addresses some of these concerns, as private industry has a larger role in setting the prices for public insurance than they do in the U.S., however there are still reports of possible uneven reimbursement rates (Ramos et al., 2018). Therefore, while these price controls likely save the government money compared to if the government paid the provider's asking price, policymakers must still be mindful of the reality of cost-shifting.

Replicating Germany's use of technology would also likely decrease health care costs in general. As explored above, the implementation of a universal digital health card significantly decreased providers' administrative costs. While it does appear to have taken around 1.6 billion euros to implement (Smart Card Alliance, 2006), the long-term administrative savings due to decreased paperwork will likely dwarf that original cost. In the U.S., for example, hospitals were estimated to have spent over $300 billion on administrative costs in 2017 (Himmelstein et al., 2020). For transparency, the GOÄ likely won't contribute to much direct savings in terms of government spending, as consumers' OOP costs are purposefully limited, thus shielding them from the cost of more expensive services they may not have chosen if they weren't shielded. However, allowing both patients and providers to view what is covered significantly decreases the chances of a patient consuming services that are not covered by their insurance. As explored above, this can have a positive impact not only the consumer's personal finances, but also on the economy as a whole.

While many of these measures would likely save the U.S. government money in both the short- and long-term, the cost of implementing a universal public insurance system should not be underestimated. While it is unclear how much an actual implementation in the U.S. would cost, it is unlikely that a program that provides the opportunity for every American to enroll in health insurance will decrease the amount of money the U.S. government spends on health care overall. Instead, the optimal outcomes of the policy would be to both decrease the amount the U.S. spends in comparison to the number of consumers and contain the relatively rapid increase in health care prices for services and medications.

Perhaps the largest roadblock to the government decreasing its overall spending, besides the expected growth in individuals utilizing public insurance, is that the actual price of health care services in the U.S. tend to be some of the highest in the world, a fact that implementation of a public insurance won't fully address. For example, the average cost of entry into an ER (i.e., not including extra charges such as blood tests or drugs) in 2017 was over $1,700 (Alltucker, 2019). Indeed, the hospital spending per discharge in 2017 was over $21,000 (compared to Germany's $6,500) (Tikkanen et al., 2020). While certain provisions of Germany's model will likely decrease hospital's administrative costs, thus, ideally, decreasing costs for consumers, these savings aren't likely to come to fruition immediately. Universal medical cards, for example, will likely take years to fully implement. Further, providers will play a significant role in the setting of prices. Therefore, it is unclear that even once savings are fully realized for

providers, that this would lead to a decrease in prices set, or simply a significant slowing of the annual increase in prices. These continued high prices mean that government will likely continue to pay a significant amount for health care, though the hope is that containing the increase in prices will also contain the increase in spending in the long-term and that spending will be more efficient (i.e., less spending per person).

Finally, another cost consideration for policymakers is that a major reform of the U.S.'s insurance sector will not address every issue that contributes to the international trend of increasing health care costs. There are other significant factors that have been increasing the cost of health care, including an aging population and advancing health care technologies. Therefore, it will be important for policymakers and the public to understand that more will need to be done to decrease costs and improve health outcomes, even if a German-model reform is successfully implemented.

Taxes and Public Opinion

The implementation of a German-model health reform will cost money. Although some of this cost will be offset by savings detailed above, it will still need to be paid for in some way, taxes being the most obvious choice. It would be unwise for policymakers to attempt to pay for this policy through means other than taxes, such as cutting other programs or increasing debt. Designated health care spending currently makes up 26% of the national budget, and as overall spending is unlikely to decrease, it is highly unlikely policymakers would be able to cut this amount from other sections of the budget without harming the country's population. Further, the U.S. has a rising national debt problem, an issue exacerbated by COVID-19. In fact, the U.S.'s debt as a percentage of GDP has passed the threshold that the World Bank considers to be the point at which countries experience substantial reductions in economic growth if sustained for too long (McGraw, Lecture 5.6, 2020). Using debt to fund this implementation would not only push the U.S. further past this threshold, but would also take away spending for other programs, as spending on interest would increase. Policymakers are thus left with utilizing taxes to raise revenue.

Unfortunately, taxes have never been popular with the American public. American employees only pay a tax of 1.45% of their paychecks on Medicare (IRS, 2020). It will likely decrease public support, therefore, if policymakers suddenly increased this tax to the amount Germans' pay (around 7%). Luckily, however, the public option would be available to everyone, not just a specific group of people. This fact would likely decrease some resentment that can build up from people who don't want to pay taxes for programs that don't benefit them directly.

Current public opinion on health reform can be seen through a recent Kaiser Family Foundation (KFF) poll, which tracked the change in attitude towards Medicare-for-All after hearing messages about how the reform would impact the current system (KFF, 2020). While Medicare-for-All is not a German-model health reform, many of the same messages will likely be used either for or against such a reform. For example, as expected, 60% of respondents would oppose Medicare-for-All if it would require most Americans to pay more in taxes. Further, 60% of respondents also would oppose Medicare-for-All if it would threaten the current Medicare program, which is a reality for a pure German-model reform. Lastly, 70% of respondents would oppose Medicare-for-All if it would lead to delays in people getting some medical tests and treatments. While, as discussed, this is not a reality for Germany, it will likely be a message that opposition groups utilize to decrease public support. Policymakers will therefore need to be aware of American's relationship with taxes, as well as other responses to certain messaging, and will likely need to attempt to address it through revamping a German-model implementation and/or running advocacy campaigns to keep public support from plummeting.

Recommendations

Recommendation #1 – Start with the Public Option

Due to considerations outlined above, it will likely be more politically feasible to slowly transition into Germany's health care model than to do a complete overhaul of the U.S.'s health care system. The public option is particularly favorable to begin this transition, as nearly 70% respondents

reported their support for a public option in KKF's public opinion poll (KFF, 2020). Choosing to begin with a public option also avoids pushback from the public and some consumer groups who would fight against cutting current public insurance programs, such as Medicare.

Instead of administering the public option themselves, the federal government could contract with non-profit insurers to administer the program instead. Washington State, for example, passed its own public option law and instead chose to contract with private insurers to administer the program. Next year, five insurers are set to administer the public insurance (The State of Washington, 2020). Just as important as it will be to contract with multiple insurers, however, it will be equally as important to only contract with non-profits for maximum cost-saving capabilities. Coverage requirements and payment schedules could be set much of the same way they are now through the Department of Health and Human Services (HHS), however industry groups could be given more power in that decision-making process. For example, an advisory group made up of provider, the non-profit insurers, and patient representatives could be created under HHS. This group would make annual recommendations based on pricing realities and proven outcomes to the regulatory agencies under HHS that would then set prices and coverage requirements under the public option.

Another important aspect of Germany's system are the spending caps and sector budgets. While policymakers may consider implementing such cost-containing techniques in the long-term, it is likely unwise to implement them in the short-term. First, it is unclear how much this program would actually cost. Even with a CBO report, it would likely be wise to wait a few years to see of cost outcomes and if such cost-containing measures are needed. Second, such caps would likely cause a shock to the health care system, which may not be a bad thing in the long-term, but also may not be appropriate with the implementation of a public option, which will likely cause its own shock waves.

Recommendation #2 – Invest in Health Care Technology

Investing in technologies similar to Germany's universal health card and GOÄ will likely be very important for offsetting some of the cost of implementing a public option in the long-term. Such technologies would also likely be an important step for the U.S. to set a standard for data-sharing in health care and transparency. A universal health card and, especially, an online catalogue similar to the GOÄ could be implemented for the public option. If these technologies are successful, they will not only decrease waste in the system, but will also likely prove to be a very attractive incentive for consumers to choose the public option market.

Recommendation #3 – Finance Primarily Through Payroll Taxes and OOP Costs

It may be optimal for the U.S. to primarily finance the public option through a mix of limited payroll taxes shared by both the employer and employee and OOP costs, just like Germany. While this decision would certainly increasing the difficulty of implementation, it is important for the long-term success of this policy that it has a relatively steady funding source that policymakers know work. This is a lesson learned from the ACA, as a number of its significant funding sources, such as the Cadillac tax and a tax on medical device companies, never came to fruition (Antos & Capretta, 2020). To limit the percentage of the payroll tax, the ceiling for the highest level of taxable income can be higher rather than lower.

OOP costs will also be an important aspect of financing this policy. It can help keep taxes relatively low and will optimally be significantly lower in costs than premiums, copayments, and deductibles for private insurance. Depending on how limited these OOP costs are, they will likely seem like a bargain to Americans, who are used to paying relatively large OOP costs. Therefore, it is unlikely that there would be significant pushback against this funding source, if it is low enough. Further, subsidies must exist for lower-income individuals. These subsidies can initially be based off of the income threshold for Medicaid expansion states, as this will help people in non-expansion states who can't afford a private insurance gain access to health insurance. Lastly, premiums could be based off of income, as they are in Germany. This helps to ensure that lower-income individuals who don't qualify for subsidies aren't overburdened with health care costs.

Germany also receives revenue through taxes on benefits received by short-term unemployed individuals. While U.S. policymakers may be attracted to this option on the basis of fairness, it is important to note that Germany's unemployment benefits are significantly more generous than the U.S. (European Commission, 2020). For the U.S., it therefore likely doesn't make much sense to tax this benefit, especially as the amount of benefits are largely decided by states. For those who are both short-term and long-term unemployed, it likely makes sense to instead subsidize their contributions, as Germany does for its long-term unemployed.

Instead, policymakers may consider a small increase on the capital gains tax. While it would need to be low enough not to disincentivize investment, or be too politically unpopular, it is a way of receiving tax revenue from very wealthy individuals who do not rely on payroll taxes for their income. It is important to note, however, that increasing capital gains taxes may be especially difficult to implement as it is the wealthiest individuals who can pump money into political campaigns that would stand to lose the most. Policymakers will need to be mindful of these facts and not rely too heavily on this type of revenue.

Just like Germany, these tax revenues can be distributed to public option health insurance plans based on a risk-adjusted capitation formula. Since health plans wouldn't be allowed to deny coverage to any individual, it will be important that the plans are properly compensated for the care they pay for.

Recommendation #4 – Expand if Successful

Some expansion will likely naturally occur if the program is seen as a success. For example, at the start of implementation, policymakers can allow self-insured employers to contract with a public option insurer to administer their own employee health insurance plan (KFF, 2019). Policymakers can also add in incentives for employers to send their employees into the public option marketplace. This could be done through allowing employers to keep some health insurance tax breaks by providing some subsidies for employees to enroll in a public or private insurance plan. If the public option is a success, seemingly small actions such as these could slowly increase the number of employed individuals receiving public health insurance.

Larger expansions that significantly simplify our health care system, however, should not be implemented immediately. Such expansions could include cutting Medicaid and/or Medicare and use those savings to subsidize consumers who can't afford OOP costs. Subsidies may also be used for public option plans that gain a sudden influx in patients with complex and expensive medical needs, as is often the case for Medicare and Medicaid. Either way, the public option is a concept that has never been tested before in the U.S., and thus policymakers should be patient as its outcomes and effectiveness are researched in both the short- and long-term. Further, health care has become a highly politicized issue, and attacks against the public option are likely, as there have been many attacks against the ACA since its implementation. Policymakers must ensure that the public option can not only withstand such attacks, but also continue to thrive during them, before the infrastructure that provides health insurance for millions of Americans is disbanded.

Recommendation #5 – Increase Health Care Workforce

For both the short- and long-term success of this program, it is imperative that policymakers both address the shortage of health care workers in certain areas of the country and prepare for more individuals to consumer health care services. To avoid dangerous (from a political and health care perspective) wait times for services, policymakers could create incentivizes that increase the American health care professional workforce, both and general and equitably.

Recommendation #6 – Invest in Decreasing Health Care Inequalities

While providing quality, affordable health insurance is certainly a large step towards decreasing health inequalities, it will not be a silver-bullet solution. After implementing their own German-model health policy, it will be essential for policymakers to continue fighting for different forms of health policy that will increase the U.S.'s health outcomes. For example, health disparities that are caused and

enhanced by issues related to housing, income, location, race, gender, sexuality and education all need to be addressed holistically. Only then will the U.S.'s health care system truly succeed.

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