



HEALTH CARE CHOICES 20/20: *A Vision for the Future*

Lower Costs | Personalized Care That Puts You and Your Doctor in Charge
Better Coverage | Secure Safety Nets for the Vulnerable

Health Policy Consensus Group



Executive Summary

The nation faces a clear choice between two paths for America's health care future: One is largely controlled by the government and strewn with empty promises. The other is controlled by you and doctors, leading to more choices, lower costs, and improved quality and access.

The first path builds on failure. Approaches like a public option—"Medicare for All" on the installment plan—double down on Obamacare's failures, especially its soaring costs and tightening restrictions on access to the doctors and hospitals you want and need.

Make no mistake: No matter how their ideas are packaged, the left's ultimate goal is Medicare for All—legislation sponsored by a majority of House Democrats that would outlaw your existing coverage and put you in a system where all of your choices are controlled by government.

The second path reflects American values—an innovative, patient-focused approach that gives you more control and better choices at lower costs. It's a path that frees patients and doctors to make health care decisions and empowers innovators to produce better solutions at lower prices. It makes insurance and care more affordable while better protecting those with pre-existing conditions and chronic health challenges. And it's a path that helps you: independent estimates show it will lower premiums by up to 24 percent, cover nearly 4 million more people through private coverage, and improve access to medical providers by 8 percent.

The American people know we need real change. You want to be in charge of your health care without asking Washington politicians or health insurance bureaucrats for permission.

Here's how the Health Care Choices 20/20 proposal makes you better off in at least 10 ways.

The proposal:

1. **Empowers you to keep your health coverage and doctors when you change or lose your job.** The COVID-19 pandemic has exposed the need for people to have secure, portable health coverage. Congress should codify and improve the Trump Administration's Health Reimbursement Arrangement rule that allows employers to offer and employees to use tax-free dollars to buy insurance they can keep if they lose or change jobs. Our plan would also let low-income patients use the value of their existing government coverage to enroll in better, private health plans, including employer-sponsored coverage.
2. **Saves you money on health care and drugs by making the prices of health care transparent.** Medical care is one of the few services where you don't know the price until weeks or months after you receive it. Congress should codify the Administration's transparency rules so you can compare prices and obtain the best value—and share in the savings.
3. **Eliminates your risk of surprise medical bills through transparency and truth in advertising.** Too many patients face high medical bills they did not expect and did not agree to pay. Transparent prices and truth in advertising are the first steps to resolving that problem.
4. **Benefits you financially when you choose lower-cost, high-quality care.** Prices for the same medical services can vary by thousands of dollars. You should be able to benefit if you choose a lower-cost alternative that better

suits your needs. Congress should permanently eliminate regulatory barriers that prevent you from shopping for value, and it should allow you to put any savings you receive into a health savings account.

5. **Gives you better options, lower premiums, and better access to care if you get sick, have a pre-existing condition, and need financial help.** Today, Congress sends money to insurance companies and imposes burdensome mandates that drive up the cost of coverage for everyone. Instead, Congress should give regulatory relief to states so they can reform their insurance markets. And it should convert the subsidies that currently go to Medicaid expansion and health insurance tax credits into formula grants to the states to support coverage for lower-income and vulnerable patients. The grants would be distributed through the Children's Health Insurance Program, with built-in life protections so taxpayer money can't be used to fund abortions.
6. **Gives you access to specialized plans and care if you have a chronic illness.** Health insurance plans can perform better when they don't try to be all things to all people. Instead, we should encourage plans that include centers of excellence catering to patients with specific medical problems, such as heart disease or diabetes. Congress should clear away barriers that block this option.
7. **Gives you more options to get insurance and care tailored to your needs and those of your family.** Government rules that dictate every detail of insurance policies keep consumers from selecting plans that make the most sense. Congress should codify the Administration's rules on Association Health Plans and short-term policies, expanding the range of options for consumers to get coverage that meets their needs, including the ability to choose a direct primary care doctor or join a health care sharing ministry.
8. **Makes it easier for you to manage your own health care dollars.** Millions of Americans with high health costs are not eligible to contribute to health savings accounts, including seniors on Medicare. Congress should create broad, flexible access to these accounts so anyone can use them in conjunction with more versatile plans, including those that provide high-quality care for chronic illness.
9. **Makes telehealth permanent so you can talk "virtually" with medical care providers.** Telehealth allows patients to have access to their doctors without long waits, trips to emergency rooms, and the risk of exposure to other sick patients in a doctor's office. Regulators cleared away barriers to telehealth during the pandemic, and the number of virtual doctors' visits has soared in just a few months. Congress and the states should make this temporary relief permanent and relax other barriers to unleash the full potential of new care delivery options.
10. **Removes barriers to innovation and competition.** Policymakers at the federal and state levels have imposed burdensome mandates and regulations that discourage competition, interfere with patients' access to the care of their choosing, and reward big businesses and special interests at the expense of patients. Examples include

certificate-of-need laws that create barriers to entry and rules that prevent providers from practicing at the top of their education and training. Congress and the states should lift those barriers to foster innovation and provide more and better options for consumers to get lower prices and better quality through competition.

The debate today is between those who want to exert even more government control over the health care sector and those, like us, who favor giving patients more choice and control and allowing the creativity we have seen in the COVID-19 crisis to flourish.

We want a system that encourages innovation and competition to provide consumers the best care at the lowest cost. We welcome the opportunity to work with policymakers to shape the better, brighter health care future we believe can be ahead.

THESE RECOMMENDATIONS WERE DEVELOPED BY THE HEALTH POLICY CONSENSUS GROUP, which includes medical professionals, state and national health policy experts, and leaders of organizations from around the country who are determined to give Americans relief from high costs, cover more people more effectively, increase competition to provide more coverage options, and do a better job of protecting the sick.

For more information, please visit: HealthCareChoices2020.org.

Introduction

America's health sector has been tested mightily during the COVID-19 crisis. It has shown its flexibility and adaptability in saving countless lives, quickly mobilizing research and manufacturing capacity to develop treatments and vaccines and pivoting to telemedicine in a matter of days, enabling medical professionals to do everything from providing routine care to performing virtual triage in order to protect medical staff and patients from possible COVID-19 exposure.

The pandemic has also exposed how government red tape gets in the way of a rapid response and interferes with patients being able to quickly and efficiently get the care they need from those they trust most. Much can be accomplished when governments enable medical innovators rather than obstructing their progress. The Trump Administration, state leaders, and Congress—on a bipartisan basis—have waived hundreds of rules in a race to fight the virus.

We should never go back.

Instead, both the Administration and Congress should make these sensible temporary changes permanent and build on them with additional reforms and flexibility that will promote creative health care and health coverage options.

President Donald Trump's recent executive order¹ takes a step in this direction by directing the federal government to continue these deregulatory efforts “with the same vigor and resourcefulness” deployed in the initial phases of the COVID-19 response.

Changes should continue to empower private sector and state and local innovators. The federalist approach in the pandemic response has empowered states and localities with the flexibility to meet the unique challenges of diverse communities, with the federal government playing a supportive role.

When liberated from counterproductive rules and regulations, providers and suppliers inside and outside the health sector are quickly creating new and better solutions. Countless companies big and small have repurposed their manufacturing facilities to produce needed medical supplies, and pharmaceutical companies are operating at warp speed to develop treatments and vaccines. Medical providers and health plans have quickly moved to adopt new procedures. Liberated from outdated laws and regulations, they could do much more to produce better outcomes, lower costs, and more consumer choices to make health care and coverage more accessible.

Entrenched problems in our system remain and demand solutions. We must build on the lessons learned in the crisis to provide much greater flexibility to states, localities, and innovators on a permanent basis. These goals should guide our continuing response to the pandemic and also to creating broader changes in our health sector going forward.

In particular, the crisis has shown how important it is for citizens to be able to have health coverage that they own and can keep even if they lose or change jobs. Tens of millions of Americans

1. Executive Office of the President, “Regulatory Relief to Support Economic Recovery,” Executive Order No. 13924, 85 *Federal Register* 31353, May 19, 2020, <https://www.federalregister.gov/documents/2020/05/22/2020-11301/regulatory-relief-to-support-economic-recovery> (accessed August 21, 2020).

lost their jobs as a result of the COVID-19 economic shutdown. People need jobs to be restored, and they also need health coverage that is more secure and affordable going forward.

Making health care and coverage more affordable means addressing how government policies contribute to inflated prices. They often distort the market by protecting special interests and creating mountains of mandates and regulations, blocking medical providers from finding ways to deliver care more efficiently, and making it harder for innovators to enter the market and offer more attractive and affordable options. The Affordable Care Act (ACA, also known as Obamacare) has exacerbated these problems. The high costs of health insurance premiums price many people out of the market, especially those who don't qualify for subsidies. Even for those with coverage, deductibles and copayments can be so high that many can't afford to access care.

Those enrolled in public programs are often frustrated as well. Many Medicaid recipients, for example, struggle to find physicians who can afford to accept the program's low payment rates, and many find it especially difficult to get appointments with specialists to treat serious health problems. Policy changes are needed to prioritize the needs of the most vulnerable so they too can choose from the best private coverage options rather than being locked into restrictive government-controlled programs.

People are hurting, and they often feel powerless against this system. These and other frustrations are generating interest in plans to further expand the federal government's power over our \$3.6 trillion health sector.² That would

be a disaster. Such a system would inevitably increase costs, stifle innovation, reduce quality, and limit access to quality care—especially for the sick and vulnerable, including people with pre-existing conditions.

Thankfully, policymakers can take another path—one that builds on the reality that when innovators are liberated from counterproductive rules and regulations, they can create new options to make health care more affordable and accessible. The Health Care Choices proposal described in this paper, developed by the Health Policy Consensus Group, provides a policy path with meaningful reforms and achievable steps that would result in the financial security and peace of mind that America's patients are demanding while lowering costs, increasing choices, and supporting innovation.

Options for All—Without the Government Taking Over

Americans know we need real change with better coverage that puts you, and not the government, in charge of your health care. Everyone should be able to obtain affordable, portable health coverage and choose from a wide range of options, with extra support available for those with lower incomes and high health costs. Getting there, in our view, requires a fresh approach that respects our country's diversity and that reflects the very different preferences and needs of Americans.

Today, virtually all people lawfully present in the United States have access to health coverage. Most lower-income people who are uninsured

2. Micah Hartman et al., "National Health Care Spending in 2018: Growth Driven by Accelerations in Medicare and Private Insurance Spending," *Health Affairs*, December 5, 2019, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01451> (accessed August 21, 2020).

are eligible for free coverage but are not enrolled.³ In addition, there are many options to access care directly, including Federally Qualified Health Centers and free clinics throughout the country.

Our health reform solutions offer targeted approaches to the very real problems that exist in our health sector, starting with the burden of high health costs that are driving millions of people out of the market. According to the Kaiser Family Foundation, 45 percent of uninsured nonelderly adults say they were uninsured because the cost is too high, making cost the most common reason cited for being uninsured.⁴ Making health coverage and health care more affordable will mean millions more people can obtain coverage for themselves and their families.

The plan we are offering would lower premiums, cover more people more effectively, increase competition to provide more coverage options, and do a better job of protecting the sick.

The Burden of Health Costs

Paying for health care is a significant financial burden for American families and individuals, both in direct and indirect costs. The average price of a health insurance policy for a family receiving coverage through the workplace is now \$20,576.⁵ While the worker contribution of this amount is technically “only” \$6,015, the employer contribution of \$14,561 is part of the worker’s overall compensation package.⁶ Higher health costs mean American workers receive less take home pay.

For what they pay for health insurance, a family could pay for a year of college tuition or buy a new compact car every year.⁷ Some families pay more for health insurance than they do for their mortgage payment or rent and nearly twice as much as they do for groceries.⁸

Costs rose in other markets as well. Average premiums in the individual health insurance

3. Jennifer Tolbert et al, “Key Facts About the Uninsured Population,” *The Kaiser Family Foundation*, December 13, 2019, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.01451?journalCode=hlthaff> (accessed August 20, 2020). The Kaiser Family Foundation breaks down the numbers to show that most of the estimated 27.9 million people who were uninsured in 2018 had access to health insurance coverage. More than half of the uninsured in 2018 were eligible for financial assistance through either Medicaid or subsidized premium assistance under the ACA but weren’t signed up. Another 3.3 million declined offers of employer-sponsored coverage. More than 2 million had incomes greater than 400 percent of the federal poverty level and presumably have the means to purchase coverage if it were affordable. The great majority of the remaining uninsured are undocumented immigrants.
4. Ibid.
5. Kaiser Family Foundation, “2019 Employer Health Benefits Survey,” September 25, 2019, <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/> (accessed December 17, 2019).
6. Ibid.
7. For school year 2017-2018, the average out-of-state tuition and required fees was \$25,657. See National Center for Education Statistics, “Table 330.20. Average undergraduate tuition and fees and room and board rates charged for full-time students in degree-granting postsecondary institutions, by control and level of institution and state or jurisdiction: 2016-17 and 2017-18,” *Digest of Education Statistics*, November 2018, https://nces.ed.gov/programs/digest/d18/tables/dt18_330.20.asp (accessed December 17, 2019). The November 2019 Kelley Blue Book value for compact cars ranged from \$18,585 to \$21,920. See KBB Editors, “Compact Cars,” Kelley Blue Book, November 22, 2019, <https://www.kbb.com/articles/car-news/best-compact-cars/> (accessed December 17, 2019).
8. The average monthly mortgage payment in the United States is \$1,030. See Justin Pritchard, “What Is the Average Monthly Mortgage Payment?,” *The Balance*, updated March 12, 2019, <https://www.thebalance.com/average-monthly-mortgage-payment-4154282> (accessed December 17, 2019). In 2018, average monthly rent in the United States was \$1,025 (for a one-bedroom rental). See Abodo, “[REPORT] America’s 2018 Rental Market in Review: Renters Finally Get Relief,” January 1, 2019, <https://www.abodo.com/blog/2018-annual-rent-report/> (accessed December 17, 2019). In 2018, the mean expenditure on food at home was \$4,464. See Bureau of Labor Services, “Table 1502. Composition of consumer unit: Annual expenditure means, shares, standard errors, and coefficients of variation, Consumer Expenditure Survey, 2018,” <https://www.bls.gov/cex/2018/combined/cucomp.pdf> (accessed January 8, 2020); Tanza Loudonback and Liz Knueven, “What Average Americans Spend on Groceries Every Month in 22 Major Cities,” *Business Insider*, March 5, 2020, <https://www.businessinsider.com/what-americans-spend-on-groceries-every-month-2019-4> (accessed December 17, 2019).

market more than doubled between 2013 and 2018—with premiums tripling in some states. Deductibles rose by an average of 21 percent between 2014 and 2019.⁹ Additionally, health insurance premiums for small businesses have risen 48 percent over the last decade, far outpacing wages and inflation.¹⁰

People who receive little or no subsidy for health insurance are increasingly likely to be uninsured. Census data show that from 2017 to 2018, nearly 75 percent of the increase in the uninsured was among people with incomes above 300 percent of the federal poverty level where any subsidies can be swamped by costly premiums.¹¹ The answer is not more and bigger subsidies that chase and contribute to rising costs.

As costs have risen, choices have fallen. Even with recent actions by the Trump Administration to increase choices, the number of

counties in which just one insurer participated in Obamacare exchanges is still greater in 2020 than it was in 2014 (25 percent versus 16 percent).¹² Additionally, it has become harder for people to see the doctors they prefer with their health plans' narrow and restricted networks, and many find that the best hospitals are not in their networks.¹³ People want and need better options, especially those with chronic conditions.

A Long-Standing Problem

Even before enactment of the ACA in 2010, the nation's health sector was being pushed toward greater government control rather than toward consumer choices in a more competitive market. This trend accelerated under the ACA, which contains scores of provisions that touch nearly every part of the health sector.

9. As measured by average premiums paid per enrollee—that is, total premiums divided by total enrollees. See Edmund F. Haismaier and Meridian Baldacci, "Premiums, Choices and Government Dependence Under the Affordable Care Act: A State by State Review," Heritage Foundation, March 12, 2020 (accessed October 7, 2020).

10. In 2008, \$4,501 was the average total single premium per enrolled employee in firms that offered health insurance and had fewer than 50 employees. In 2018, the same figure measured \$6,667. 2008 data: See Agency for Healthcare Research and Quality, "Table I.C.1 (2008). Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics: United States, 2008," https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2008/tic1.pdf (accessed January 8, 2020). 2018 data: Agency for Healthcare Research and Quality, "Table I.C.1 (2018). Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics: United States, 2018," https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2018/tic1.pdf (accessed January 8, 2020). Inflation-adjusted median wages grew about 4 percent from 2009 to 2019. Emmie Martin, "Here's How Much More Americans Are Earning in 2019 Than They Did in 2009," CNBC, August 2, 2019, <https://www.cnbc.com/2019/08/02/how-much-americans-earn-in-2019-compared-to-2009.html> (accessed December 17, 2019). The U.S. cumulative rate of inflation from November 2009 to November 2019 was 19 percent. See U.S. Bureau of Labor Statistics, "CPI Inflation Calculator," <https://www.usinflationcalculator.com/> (accessed December 20, 2019).

11. According to Census estimates, the number of uninsured persons increased between 2017 and 2018 by a net 2 million persons (which incorporates the reduction of 66,000 in the uninsured population below the poverty level), and 1.5 million of that 2 million net increase were individuals with household incomes above 300 percent of the poverty level. Calculations based on Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," Current Population Reports, p. 12, Table 4, November 2019, <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf> (accessed August 21, 2020).

12. In 2014, 515 counties had only one insurer offering on the ACA exchange, compared with 776 counties in 2020. The number of counties with only one insurer offering exchange coverage peaked at 1,622 (52 percent) in 2018. Figures calculated using data from Rachel Fehr, Rabah Kamal, and Cynthia Cox, "Insurer Participation on ACA Marketplaces, 2014-2020," Kaiser Family Foundation, November 21, 2019, <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-aca-marketplaces-2014-2020/> (accessed December 18, 2019).

13. In 2019, 72 percent of exchange plans were health maintenance organizations or exclusive provider organizations, compared with 48 percent of plans in 2014. 2019 data: Elizabeth Carpenter and Chris Sloan, "Health Plans with More Restrictive Provider Networks Continue to Dominate the Exchange Market," Avalere Health, December 4, 2018, <https://avalere.com/press-releases/health-plans-with-more-restrictive-provider-networks-continue-to-dominate-the-exchange-market> (accessed December 18, 2019). 2014 data: Avalere Health, "2017 Health Insurance Exchange Snapshot," January 2017.

One Patient's Experience

“JANET” REPORTED TO US that when she was diagnosed with Hepatitis C in 1999, she enrolled in Colorado’s high-risk pool.

“My premiums in 2010 were \$275/month with a total out of pocket of \$2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question,” she said. “My \$600,000 transplant was covered 100% with a \$2,500 out of pocket maximum!”

When Obamacare went into effect, Colorado’s high-risk pool was shut down. “I was forced into the regular marketplace.” Her premiums rose to \$450 right away, and eventually she was paying \$1,100 a month with a deductible of \$6,300.

But her anti-rejection meds weren’t covered along with the cost of other necessary care. She now is spending \$19,500 a year out of pocket before her insurance kicks in.

Too many families report that their ACA plans do not provide them access to hospitals that specialize in

the cancer care they need, the surgeries they require, or the medicines they must have.

Like Janet, they have “coverage” under the ACA, but access to care is often inferior to the state high-risk pool or other coverage they had before. We must do better for those who are most vulnerable and most need quality care.

Unlike the ACA, the Health Care Choices proposal provides dedicated changes to help patients like Janet. States would be able to set up new, better-funded risk mitigation programs, such as reinsurance, that help those with the greatest medical needs to get the care they need. Regulatory barriers would be removed that keep plans from specializing in treating those with chronic conditions. And people with chronic illness would be better able to manage their health care spending in accounts they own and control.

Wharton School Professor Mark Pauly explains in a recent study that the federal government shapes a much larger share of spending than the portion it finances directly. He finds that the share of “government-affected” health care spending in 2016 totaled nearly 80 percent—“not leaving much in the unfettered, market-based category.”¹⁴ In addition to the health programs it runs directly, the federal government also exerts its control through regulations and mandates on allegedly private plans, including detailed

directives for coverage in the employer market, which insures at least 157 million Americans.¹⁵

In the health sector, government officials, not patients, too often determine what services can or must be covered, how much will be paid, and who is eligible to both deliver and receive these services. Third-party payment systems and the resulting lack of price and benefit transparency lead to significant distortions in the market.

Patients are at the bottom of the health care totem pole. The more government gets involved,

14. Mark Pauly, “Will Health Care’s Immediate Future Look a Lot like the Recent Past?,” American Enterprise Institute, June 7, 2019, <https://www.aei.org/wp-content/uploads/2019/06/Will-Health-Cares-Immediate-Future-Look-a-Lot-Like-the-Recent-Past.pdf> (accessed August 20, 2020). Pauly points out that even though the federal government influences, regulates, and subsidizes most forms of coverage, it then delegates more of the operational delivery decisions to the private sector, making programs such as Medicare Advantage and the Medicare Prescription Drug Benefit somewhat more efficient and effective and possibly less costly than if they were operated by the government.

15. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population,” 2018, <https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed August 21, 2020).

the more those offering services throughout the health sector are forced to respond to legislative and regulatory demands of government rather than to the needs and preferences of patients. The growing presence of government in health care is not the solution to our problems; it *is* the problem. We need a health care system that is more responsive to consumer demand and allows competition from new and smaller entrants.

Patients are looking for choice, access, affordability and security. Instead they are finding fewer choices, limits on where they can receive care, rising costs, and confusion.

Freeing the health sector from excessive regulation and micromanagement would liberate innovators and medical professionals to compete in responding to consumer needs by providing better results at lower costs, just as we see in other sectors of the economy. Change must come from the bottom up as consumers are empowered to make choices in a competitive marketplace that is catering to them and where innovators are rewarded for providing better care at a lower price. That is the change the Health Care Choices proposal would bring.

Americans will have a choice: One path leads to a vibrant health sector with greater incentives to respond to their needs and with dedicated resources to take better care of the most vulnerable. The other leads to more and bigger government, controlled not by consumers but by rigid rules and government bureaucrats that lock in the status quo and ever rising costs.

“Medicare for All,” “Medicare for More,” “Public Option,” “Obamacare for More:” Paths to Failure That Double Down on Existing Mistakes

Intense and justified frustration with the status quo is creating political volatility, uncertainty, and the circumstances for sudden, dramatic change.

Progressives believe their time has arrived. Proponents of government-run health care hope to capitalize on this frustration and the panic caused by COVID-19 to turn control over the U.S. health sector to government.

Their plans to impose their vision have been in motion for decades. After the failure of former President Clinton’s Health Security Act in 1994,¹⁶ they decided to regroup, rebrand, and adopt an incremental strategy to further expand government’s role.

In 2008, progressive journalist Ezra Klein said organizations on the left were pursuing a “sneaky strategy, the point of which is to put in place something that over time the natural incentives within its own market move it to single payer.”¹⁷

In 2013, then-Senate Majority Leader Harry Reid publicly acknowledged that Obamacare was not “going to work forever” and that the country would “absolutely” have to abandon private insurance in favor of a government-run system.¹⁸

This strategy is no longer covert. Numerous nationally prominent Democrats have called for the end of any private insurance and a

16. Health Security Act, S. 1757, 103rd Cong., 1st Sess.

17. Ezra Klein, “The Deceptive Strategy Underlying Obamacare,” NetRoots Nation Conference, July 2008, timestamp 1:43, https://www.youtube.com/watch?v=FEliqqE_DI4 (accessed December 18, 2019).

18. Editorial, “Harry Reid Says Obamacare a Step Toward Single-Payer System,” *Las Vegas Sun*, August 10, 2013, <https://lasvegassun.com/news/2013/aug/10/reid-says-obamacare-just-step-toward-eventual-sing/> (accessed December 18, 2019).

complete government takeover of one-sixth of the American economy.¹⁹ They have misleadingly rebranded this effort as “Medicare for All”—misleading because the legislation would end Medicare for more than 61 million beneficiaries, including those on traditional Medicare as well as those enrolled in the popular private Medicare Advantage plans.²⁰

Others, in the name of political incrementalism, propose ideas to expand government’s role. Some suggest creating a “public option” that would have a government plan “compete” with private plans.²¹ In reality, rather than compete, these public option proposals would drive out private competition and coverage and put access to quality patient care at risk. Former Vice President Joe Biden suggests that Obamacare’s

basic structure can be fixed through infusions of additional taxpayer cash or adding new federal programs.

Both approaches would simply obscure the existing system’s failures and lead over time to the same government takeover as Medicare for All.²²

Public Option Schemes: Expanding Government Control and Jeopardizing Access and Care

Public option legislative proposals would provide a glide path to single payer, government-controlled health care, such as Medicare for All. Representative Jan Schakowsky (D-IL), who has co-authored legislation to advance a public option, notes:

19. According to the Centers for Medicare and Medicaid Services (CMS), “As a share of the nation’s Gross Domestic Product, health spending accounted for 17.7 percent.” See CMS, “National Health Expenditure Data: Historical,” December 17, 2019, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical> (accessed December 18, 2019).
20. Gretchen Jacobson et al., “A Dozen Facts About Medicare Advantage in 2019,” June 6, 2019, Kaiser Family Foundation, <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/> (accessed August 20, 2020). See also Robert E. Moffit, “Total Control: The House Democrats’ Single-Payer Health Care Prescription,” Heritage Foundation, July 22, 2019, <https://www.heritage.org/health-care-reform/report/total-control-the-house-democrats-single-payer-health-care-prescription> (accessed August 20, 2020). Medicare enrollment data from the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, “The 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” April 22, 2020, p. 6. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf> (accessed August 20, 2020).
21. See for example, Robert E. Moffit and Nina Owcharenko Schaefer, “The Public Option: Single Payer on the Installment Plan,” Heritage Foundation, February 4, 2020, <https://www.heritage.org/health-care-reform/report/the-public-option-single-payer-the-installment-plan> (October 15, 2020).
22. In July 2020, a group describing itself as the “Biden-Sanders Unity Task Force” issued a 110-page paper outline a range of policies. Among these were recommendations to expand the ACA. While the recommendations largely track with those posted on former Vice President Biden’s campaign website, it also offers some additional details. The document says that the public option will come in several forms, including “at least one plan choice without deductibles.” The document also says that public option plans will “cover all primary care without any copayments.” It adds that the “lowest income Americans not eligible for Medicaid will be automatically enrolled in the public option at no cost to them, although they may choose to opt out at any time.” The public option “will be administered by the traditional Medicare program, not private companies.” CMS actually contracts with private companies to administer the traditional Medicare program, so it’s not clear whether the task force envisions a similar or different administrative method for the public option. The public option would control costs, according to the document, “by negotiating prices with doctors and hospitals, just like Medicare does on behalf of older people.” CMS does not negotiate prices with doctors and hospitals. It establishes those prices and updates them through an annual rulemaking process. At the time this paper was written, it is unclear whether Vice President Biden views this document as his policy position or as a good-faith effort among a task force of his supporters and those of Senator Bernie Sanders (I-VT) to achieve a consensus between two politicians who take different views on Medicare for All. “Achieving Universal, Affordable, Quality Health Care,” Biden-Sanders Unity Task Force Recommendations, undated, pp. 28–37, <https://joebiden.com/wp-content/uploads/2020/07/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf> (accessed July 9, 2020).

I know that many of you here today are single payer advocates, and so am I.... Those of us who are pushing for a public health insurance option don't disagree with the goal.... This is a fight about strategy for getting there and I believe we will.²³

Under a public option, a government plan would be offered to “compete” alongside private plans. Although proponents of the public option argue that this approach would preserve choice and competition, the reality is that these proposals²⁴ are designed to have the exact opposite effect. These public option proposals—whether creating a new government plan or expanding an existing government plan—would drive out private competition and coverage and would put access to care at risk.²⁵

Drive out private competition and coverage. Despite what supporters purport, the public option would not expand choice. By design, the public option would drive out private competition by providing government privileges to the public option over other private options that would not be able to compete.

By shifting costs to taxpayers and health care providers, the public option would create the illusion that the government plan is less costly than private options. Over time and with the

power to set rules and prices that favor the public option, private entities would find it difficult to compete, driving more individuals toward the government plan. For example, under one public option proposal, job-based coverage would drop by 22.6 million, and individual coverage would drop by 12.6 million.²⁶

Put access to care and treatments at risk. Like Medicare for All, the public option relies on government-set payment rates for medical care and services. Government payment rates do not typically resemble a market rate, and so-called government negotiations mean little when the main purchaser of medical benefits and services is the government. Government doesn't negotiate prices; it sets prices. As a result, fewer providers would be willing to participate, and patient access to care would be at risk.

Existing government programs underscore this risk. In Medicaid, government payment rates are on average less—often much less—than what private plans pay.²⁷ The result is fewer providers who are willing to participate, which results in patients having less access to needed providers and care. An advisory commission that provides recommendations on Medicaid found that only 68 percent of general practice physicians accept new Medicaid patients, while 91 percent accept

23. Representative Jan Schakowsky, Health Care for America Rally, 2009, timestamp 5:25, https://www.youtube.com/watch?v=W_MtLyDfXJA&feature=youtu.be&t=327 (accessed June 23, 2020).

24. As of the time of this writing, public option proposals include legislative bills such as Medicare for America, the Choose Medicare Act, the Medicare X Act, the CHOICE Act, Medicare at 50 Act, and the State Public Options Act.

25. Moffit and Owcharenko Schaefer, “The Public Option: Single Payer on the Installment Plan.”

26. Lane Koenig et al., “The Impact of Medicare-X on Coverage Healthcare Use and Hospitals,” KNG Health Consulting, March 12, 2019, p.ii, <https://www.aha.org/guidesreports/2019-03-11-impact-medicare-x-choice-coverage-healthcare-use-and-hospitals> (accessed December 18, 2019).

27. In 2016, Medicaid fee-for-service programs on average paid providers only 72 percent of what Medicare paid (across all services), and Medicare itself pays less than the private sector. Kaiser Family Foundation, “Medicaid-to-Medicare Fee Index,” 2016, <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed December 18, 2019); Daria Pelech, “An Analysis of Private-Sector Prices for Physician Services,” Congressional Budget Office, June 26, 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/presentation/52818-dp-presentation.pdf> (accessed December 18, 2019).

new privately insured patients.²⁸ Separately, a report by Avalere Health found that 24 of the top 50 Medicare Part B (non-vaccine) drugs were not on the Veterans Affairs' health benefits formulary.²⁹

Public option advocates claim that their plan is less radical than Medicare for All. But patients will ultimately face the same results—loss of existing coverage, less access to providers, worsening quality of care, and less innovation. Simply put, the public option is Medicare for All on the installment plan.³⁰

Obamacare for More: A Flawed Approach, Building on Failure

Some, including Democratic presidential candidate Joe Biden, want the federal government to “build on Obamacare.” The ACA is a seriously flawed program, and its structure will not be improved by pouring even more taxpayer money into it.

For example, the ACA requires insurers to issue policies to any applicant—a policy called “guaranteed issue.”³¹ In an attempt to keep people from gaming the system, the law also imposed an individual mandate, with a tax penalty on those who remained uninsured (a mandate that is still

on the books but was zeroed-out in the 2018 Tax Cuts and Jobs Act). The approach rested on the theory that, if mandated to purchase coverage, healthy people would pay higher premiums for health insurance that would in turn subsidize medical care for less healthy people. Young adults, the law's architects believed, would so want to avoid the tax penalty that they would pay disproportionately high premiums.

That theory proved false. Young adults largely spurned the deal, leaving insurers with a losing proposition. Insurers had to continue to issue policies to people in poor health at rates that were too low to finance their care. Insurers lost money. Many stopped selling ACA policies. Others, like the program's ill-fated co-ops, went out of business entirely, causing millions of people to scramble to find replacement policies. Despite the tens of billions of dollars that the federal government has paid to issuers of ACA policies, enrollment in the individual market has been shrinking since 2016.³²

Insurers that continued to sell ACA policies did three things that disadvantaged those with high medical bills. First, they raised premiums. Since government subsidies that are paid to insurers rise dollar-for-dollar with premiums, insurers have profited by raising rates. But

28. Kayla Holgash and Martha Heberlein, “Physician Acceptance of New Medicaid Patients,” Medicaid and CHIP Payment and Access Commission, January 24, 2019, p. 6, <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf> (accessed December 18, 2019).

29. Milena Sullivan and Ekemini Isaiah, “The VA National Formulary for Top Medical Benefit Drugs Is Narrower Than Current Medicare Part B Drug Coverage,” Avalere Health, August 13, 2019, <https://avalere.com/insights/the-va-national-formulary-for-top-medical-benefit-drugs-is-narrower-than-current-medicare-part-b-drug-coverage> (accessed December 18, 2019).

30. For a detailed examination, see Moffit and Owcharenko Schaefer, “The Public Option: Single Payer on the Installment Plan.”

31. John Goodman and Devon Herrick, “How Obamacare Made Things Worse for Patients with Preexisting Conditions,” *The Daily Signal*, January 14, 2020, <https://www.dailysignal.com/2020/01/14/how-obamacare-made-things-worse-for-patients-with-preexisting-conditions/> (accessed February 14, 2020).

32. Doug Badger, “Congressional Proposals to Increase Federal Health Care Spending: A Flawed Approach, Building on Failure,” Heritage Foundation, September 4, 2019, <https://www.heritage.org/health-care-reform/report/congressional-proposals-increase-federal-health-care-spending-flawed> (accessed February 14, 2020).

patients must pay their share of the premiums based upon the higher cost. Second, insurers increased cost-sharing requirements, such as deductibles and co-insurance. Third, and most ominously for people with complex medical needs, they narrowed provider networks, often requiring policyholders to obtain care from those who charged the lowest rates, limiting access to higher quality providers. No Obamacare plan in Texas, for example, includes the M. D. Anderson Cancer Center in its network, meaning that policyholders with cancer in that state can't get care at one of the world's leading oncology treatment centers.³³

The consequence for those with pre-existing medical conditions is that their coverage costs too much, and they often have very limited access to preferred doctors and hospitals. The consequence for everyone in the individual market: higher premiums, some that exceed their monthly rent payments or mortgages.³⁴ These high costs drive more and more people who were

previously insured out of the market.³⁵ Millions of people who once had affordable policies are dropping their insurance because they can't afford it. Coverage rates are falling among people who are not eligible for premium subsidies.³⁶ In 2018, the only income group that showed a statistically significant increase in uninsurance rates were those with incomes above 300 percent FPL, according to the Census Bureau.³⁷

Nonetheless, in June 2020, the House of Representatives passed legislation (H.R. 1425) to increase federal premium subsidies paid to insurance companies and make millions more higher income people eligible for these subsidies.³⁸

Universalizing the ACA's tax credits—creating "Obamacare for All"—is bad policy. Obamacare has more than doubled premiums for health insurance.³⁹ That has forced millions of people who once had affordable coverage to drop their insurance.⁴⁰ "Obamacare for All" would not provide people with more affordable options but would drive up costs. Government subsidies add

33. Goodman and Herrick, "How Obamacare Made Things Worse for Patients with Preexisting Conditions."

34. Robert Moffit, "As Obamacare Premiums Continue to Rise, Time to Look at Real Health Care Solutions," *The Daily Signal*, September 28, 2018, <https://www.dailysignal.com/2018/09/28/as-obamacare-premiums-continue-to-rise-time-to-look-at-real-health-care-solutions/> (accessed August 21, 2020).

35. Doug Badger, "Obamacare Is Uninsuring the Insured," *National Review*, August 10, 2017, <https://www.nationalreview.com/2017/08/obamacare-coverage-losses-uninsured-middle-income-medicare-medicaid-affordable-care-act/> (accessed August 21, 2020).

36. Ashlee Semanskee, Larry Levitt, and Cynthia Cox, "Data Note: Changes in Enrollment in the Individual Health Insurance Market," Kaiser Family Foundation, July 31, 2018, <https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/> (accessed August 15, 2019).

37. Berchick et. al., "Health Insurance Coverage in the United States: 2018," p. 12, Table 4. The Census Bureau surveys of uninsurance for 2019 yielded conflicting results. The Current Population Survey (CPS ASEC) survey showed an overall statistically significant decline in uninsurance across income levels. It also found that decline to be statistically significant for households with incomes under 100 of percent FPL and for households with incomes of at least 400 percent of FPL. The American Community Survey, by contrast, showed statistically significant increases in uninsurance across each income level. Katherine Keisler-Starkey and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2019," U.S. Census Bureau, September 2020, Appendix Tables A-1 and A-2, pp. 18-19.

38. Patient Protection and Affordable Care Enhancement Act, H.R. 1425, 116th Cong., 2nd Sess., <https://www.congress.gov/bill/116th-congress/house-bill/1425/text?q=%7B%22search%22%3A%5B%22hr+1425%22%5D%7D&r=1&s=4> (accessed August 21, 2020).

39. CMS, "Data on 2019 Individual Health Insurance Market Conditions," October 11, 2018, <https://www.cms.gov/newsroom/fact-sheets/data-2019-individual-health-insurance-market-conditions> (accessed August 21, 2020).

40. Edmund Haislmaier, "2017 Health Insurance Enrollment: Little Net Change, but Large Drop in Non-Group Coverage," Heritage Foundation, October 30, 2018, <https://www.heritage.org/health-care-reform/report/2017-health-insurance-enrollment-little-net-change-large-drop-non-group> (accessed August 21, 2020).

fuel to the fires of health costs, leading to higher and higher premiums.

The costs of these subsidies fall on taxpayers. According to the Congressional Budget Office (CBO), households with incomes above 400 percent FPL (i.e., those in the top two income quintiles) supplied 87 percent of federal income tax revenues in 2016.⁴¹ Instead of driving health care premiums higher and then increasing premium subsidies, we should pursue market-based policies that will make insurance more affordable while empowering people to choose coverage that works for them.

H.R. 1425 would vastly enlarge Obamacare entitlement spending. This approach overlooks substantial evidence that federal spending on subsidies is inefficient and insufficiently targeted. More spending won't cure these deficiencies. The costs of existing subsidies are rising even as a shrinking number of people benefit from them, a trend CBO expects to continue. Over the next decade, CBO projects that the number of subsidized beneficiaries will drop by roughly one-fourth, even as annual spending

on federal subsidies is projected to rise by more than one-third.⁴²

The trend of increased federal spending to subsidize a diminishing number of beneficiaries suggests a misallocation of federal resources. In effect, government is picking up the cost of premium increases that are caused, at least in part, by government policy. The combined effect of the ACA's regime of mandates, subsidies, and penalties has been to drive up the cost of premiums.⁴³ These premium increases led to a decline in the number of unsubsidized people with individual insurance coverage.⁴⁴ That led to a sicker and more expensive insurance pool, which has led to higher premiums. Since subsidies increase dollar-for-dollar with premiums, and since those subsidies are paid by the government to insurance companies, insurers that sell ACA-compliant products have perverse incentives to raise premiums.⁴⁵

Expanding Obamacare would double down on these perverse incentives, dumping more federal cash into a failed enterprise.

41. CBO, "The Distribution of Household Income, 2016," July 2019, <https://www.cbo.gov/system/files/2019-07/55413-CBO-distribution-of-household-income-2016.pdf> (accessed December 18, 2019).

42. CBO, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029," May 2019, Tables 1-1 and 2-1, https://www.cbo.gov/system/files/2019-05/55085-HealthCoverageSubsidies_0.pdf (accessed December 19, 2019).

43. Edmund Haislmaier and Doug Badger, "How Obamacare Raised Premiums," Heritage Foundation, March 5, 2018, <https://www.heritage.org/health-care-reform/report/how-obamacare-raised-premiums> (accessed August 21, 2020).

44. Haislmaier, "2017 Health Insurance Enrollment."

45. The Trump Administration announced in October 2017 that it would comply with a federal court ruling that it was unconstitutional for the federal government to continue to make cost-sharing reduction subsidy payments to insurance companies. These payments were designed to compensate insurers for providing richer coverage for people with incomes between 100 percent and 250 percent FPL. Insurers were still required to provide this more generous coverage but would no longer be compensated for it. Insurers, with the support of state regulators, adopted a strategy known as "silver loading," increasing the premiums for the benchmark silver plans sold on the exchanges to cover the additional higher costs of insuring people with incomes between 100 percent and 250 percent FPL. This raised premiums for silver plans sold on the exchange (but not off the exchange), which, in turn, increased federal premium subsidy payments to insurance companies. "Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments," U.S. Department of Health and Human Services, October 12, 2017, <https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html>. See also University of Pittsburgh, "Silver Loading and Switching: Unintended Consequences of Pulling Health Policy Levers," June 20, 2019, https://www.eurekaalert.org/pub_releases/2019-06/uop-sla061719.php.

Medicare for All: A Radical and Jarring Change for the Worse

The leading Medicare for All proposals sponsored by Senator Bernie Sanders (I-VT) and Representative Pramila Jayapal (D-WA) would abolish virtually all private and public coverage arrangements and replace them with a single, government-run health plan that would be centrally controlled and directed by the federal government. The plan has strong support among those who believe in a vanishing role for choice and private competition in the health sector.

Outlaw private coverage. A government-run, single-payer health system would fail the first test of preserving the coverage that millions of people already have and value. About 157 million Americans receive health coverage through the workplace as either an employee, a retiree, or a dependent.⁴⁶ Proponents of Medicare for All who want to eliminate private insurance are ignoring that nearly 7 in 10 people with employer coverage “give their health plan a grade of ‘A’ or ‘B,’ and large shares say the words ‘grateful’ or ‘content’ with the way they feel about” it.⁴⁷

End Medicare as we know it. A government-run, single-payer system would end Medicare as we know it. Today, more than 52 million older adults and 9 million others with disabilities rely on Medicare for their health coverage.⁴⁸ They value Medicare, and many believe their access would be undermined if nearly 264 million more Americans were competing with them for services from the same providers.⁴⁹

Medicare for All would take away the private coverage that 22 million seniors, or one-third of Medicare enrollees, have voluntarily chosen under Medicare Advantage, and it would dramatically change the program for seniors in the traditional Medicare program for seniors in the traditional Medicare program.⁵⁰

Medicare Advantage deploys private insurers to provide better access and better-coordinated care to seniors.⁵¹ Government workers do not have the ability to develop creative programs to personalize care to meet the needs and preferences of millions of individual patients, so they delegated that job to private Medicare Advantage plans that compete to attract seniors

46. Kaiser Family Foundation, “Health Insurance Coverage of the Total Population, 2018.”

47. See Liz Hamel et al, “Kaiser Family Foundation/LA Times Survey of Adults with Employer Sponsored Insurance,” May 2, 2019, <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-executive-summary/> (accessed October 6, 2020). Another poll from June 8, 2020, also shows that these basic views remain largely unchanged in the wake of the COVID-19 pandemic. See Emily Swanson and Ricardo Alonso-Zaldivar, “Poll: Pandemic Does Little to Alter US Views on Health Care,” June 8, 2020, <https://apnews.com/12c5c9873cfd9e8a5cd5787694204b9f> (accessed June 24, 2020).

48. The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, “The 2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,” 2020, April 22, 2020, p. 10, Table II. B1. <https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf> (accessed July 21, 2020).

49. Figure estimated by subtracting actual 2018 Medicare enrollment in the Medicare Trustees’ 2020 report, Table V.B3., from the Census estimate of the 2018 total population in Berchick et al., “Health Insurance Coverage in the United States, 2018,” p. 3, Table 1.

50. Gretchen Jacobson et al., “A Dozen Facts About Medicare Advantage in 2019,” Kaiser Family Foundation, June 6, 2019, <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/> (accessed December 18, 2019); Meridian Baldacci, “Single-Payer Health Care: Rhetoric Versus Reality,” Heritage Foundation, April 25, 2019, <https://www.heritage.org/health-care-reform/report/single-payer-health-care-rhetoric-versus-reality> (October 15, 2020). Medicare Advantage enrollment data from CMS, “Medicare Advantage/Part D Contract and Enrollment Data,” January 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData> (accessed January 17, 2020).

51. For example, see Meridian Baldacci and Robert Moffit, “Expanded Health Benefits for Seniors: The Trump Administration’s Changes to Medicare Advantage’s Supplemental Benefits,” Heritage Foundation, October 1, 2018, <https://www.heritage.org/medicare/report/expanded-health-benefits-seniors-the-trump-administrations-changes-medicare> (accessed December 19, 2019).

with added benefits, better networks, and value-based pricing.

Diminished quality. A government-run, single-payer system would be a major step backward in terms of providing reliable access to care. Countries with government-centric systems often struggle with delays and denials of care. The Fraser Institute in Canada finds that the median wait time for medically necessary treatment in Canada in 2019 was 20.9 weeks. The wait is considerably longer for some specialty services.⁵²

A recent study by U.K. researchers found that patients in the National Health Service (NHS) are much less likely to receive surgery for seven abdominal conditions, such as appendicitis to perforated ulcers and abdominal aortic aneurysms.⁵³ The result: The number of deaths in the hospital were significantly higher in England for all seven types of abdominal emergencies analyzed in the study than in the United States.

In addition, nearly a quarter of a million British patients have been waiting more than six months to receive planned medical treatment from the NHS, according to a recent report from the Royal College of Surgeons.⁵⁴ More than

36,000 patients have been in treatment queues for nine months or more.⁵⁵

Shortages and disruptions. Such a change to a Medicare for All system in the United States would create a perfect storm of shortages and disruptions. A report from the Association of American Medical Colleges finds that, even under our current health system, there will be a shortage of nearly 122,000 physicians by 2032,⁵⁶ a problem that could be exacerbated by the difficulty many private practice physicians have in keeping their practices open following the COVID-19 economic shutdown. At the same time, the demand for physicians is expected to grow even faster as baby boomers age, and rural areas will be hit especially hard, according to the report. The payment cuts envisioned under Medicare for All are likely to exacerbate this trend as more physicians close their practices or otherwise withdraw because of the payment reductions.⁵⁷

A budget disaster. Medicare for All risks incomprehensibly large deficit spending well into the future. Federal spending would increase by at least \$32 trillion over 10 years if the United States were to adopt a single-payer health care system.⁵⁸ Even doubling individual and corporate

52. Wait time “between referral from a general practitioner and receipt of treatment.” Bacchus Barua and Mackenzie Moir, “Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report,” December 10, 2019, <https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2019-rev17dec.pdf> (accessed December 18, 2019).

53. Vishwadha Chander, “Fewer Emergency Surgeries, More Deaths in British Hospitals vs. U.S.,” Reuters, October 15, 2019, <https://www.reuters.com/article/us-health-surgery/fewer-emergency-surgeries-more-deaths-in-british-hospitals-vs-u-s-idUSKBNIWU2H5> (accessed December 18, 2019).

54. Royal College of Surgeons, “NHS Hospitals Need Plan to Tackle Backlog of Patients, Warns RCS,” March 14, 2019, <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/nhs-stats-march-2019/> (accessed December 18, 2019).

55. Ibid.

56. Association of American Medical Colleges, “The Complexities of Physician Supply and Demand: Projections from 2017 to 2032,” April 2019, https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf (accessed December 18, 2019).

57. Ibid.

58. Charles Blahous, “The Costs of a National Single-Payer Healthcare System,” Mercatus Center, July 30, 2018, <https://www.mercatus.org/publications/government-spending/costs-national-single-payer-healthcare-system> (accessed December 18, 2019).

taxes would be insufficient to finance this spending increase.⁵⁹

Jeopardize life-saving innovation. Perhaps most important, Medicare for All would jeopardize the future discovery of new life-saving medical innovations. Research shows that countries with government-centric health systems restrict access to new medicines and other medical technologies and impose price controls on drugs that are available, drying up the capacity of companies to invest in new medical research.

One study recently surveyed access to new drugs in a number of countries that have government-dominated health systems. It found that people in France, for example, have access to only 48 percent of new drugs introduced between 2011 and 2018. Americans, by contrast, have access to 89 percent of those innovative medications. Nor is France an exception. The Swiss have access to only 48 percent of newly developed drugs, the Belgians 43 percent, and the Dutch 56 percent, with much more limited access to new drugs in other countries.⁶⁰

The United States has been the birthplace of the majority of the world's biomedical innovations over the past half-century. U.S. hospitals and physicians offer top quality care where Americans have access to the latest medical diagnostics. Medicare for All would jeopardize our nation's status as a recognized leader in medical innovation. A report from the Council of Economic Advisers shows that as many as 100 fewer drugs would enter the market over the next decade if progressives' price controls were implemented.⁶¹

Better path is needed. Rather than dramatically expand the role of government, policymakers should pursue targeted solutions that build on the strengths of our current system, empower patients and their families, expand choices of affordable coverage and care, and increase transparency.

A Clear Choice

In 2021, America could take one of two radically different paths for health reform.

One path would quicken, perhaps dramatically, our march toward a government-dominated health sector if the proponents of “Medicare for All,” “Medicare for Some,” the “Public Option” or “Obamacare Fixes” prevail.

The other path would move power and control away from Washington and toward an innovative, consumer-focused health sector that gives patients and doctors more control, with better options and better protections for the most vulnerable.

We believe America's true health reform debate is not an argument between one group that cares about people and one that does not. It is an argument between competing visions for how to deliver the best quality health care to the most people in the most efficient way.

There is a clear disagreement among policy experts. One side genuinely believes that total government control is the best way to fix our system. We strenuously disagree; we believe that competition, choice, and innovation will

59. Ibid.

60. Doug Badger, “Examination of International Drug Pricing Policies in Selected Countries Shows Prevalent Government Control over Pricing and Restrictions on Access,” Galen Institute, March 2019, p. 15, Table 2, <https://galen.org/assets/Badger-Report-March-2019.pdf> (accessed December 18, 2019).

61. Council of Economic Advisers, “House Drug Pricing Bill Could Keep 100 Lifesaving Drugs from American Patients,” December 3, 2019, <https://www.whitehouse.gov/articles/house-drug-pricing-bill-keep-100-lifesaving-drugs-american-patients/> (accessed December 18, 2019).

lead to the best quality, the best outcomes, and the most cost-efficient system to meet Americans' diverse needs.

Our Approach: A Fresh Vision to Empower Patients

The American people need and deserve a fresh approach to health reform. Politicians in Washington have frequently failed to offer initiatives that win broad support. They default to policies and programs that put and keep Washington officials and favored industry players in charge.

That is a fundamentally flawed approach. Health care delivery is local. Insurance is priced and sold at state and local levels, reflecting our nation's diverse populations and markets. It does not work for Washington politicians to impose sweeping regulations on our nation with its top-down, one-size-fits-all approach.

One key reason Obamacare failed to fix long-standing problems: Congress attempted to impose on the nation a solution that, allegedly, had worked in Massachusetts and assumed it could also work in states as diverse as Michigan, Maine, and Mississippi. That assumption has proven false. Washington politicians must resist the temptation to micromanage markets or impose solutions on the nation as a whole.

Washington's misguided approach has created many of the problems in our health care system. If more federal government involvement were the answer, our health sector would have been fixed long ago. The solution is not yet another Washington-centric answer.

Instead, Washington policymakers should empower leaders who are closer to the actual delivery of care to offer innovative solutions. Reform should liberate consumers, private innovators, and state leaders. Consumers should have control over resources and transparency in their options in order to force the market to respond to their needs, not to those of government bureaucracies. Innovators should be empowered to respond to diverse and changing demands for creative options for care and coverage. And state leaders should have the freedom to create the right market conditions to facilitate this innovation and to reform safety net programs and tailor them to the needs of their local markets and citizens. Reform should create space for real change that reflects all of this diversity.

Achieving these goals will require policymakers to address a range of policies, including reversing the mistakes of Obamacare while also addressing problems that pre-date that law.

Key Principles

We encourage policymakers to put three essential principles at the heart of reform:

1. **Personalized Care That Puts You and Your Doctor in Charge.** Liberty is an inalienable human right, and Americans want personal freedom and liberty in their lives and in their health care. Ninety-four percent of Americans agree that health policy should empower people—not government bureaucrats or insurance companies—to make decisions for themselves and their families.⁶²

62. Elizabeth Fender and Marie Fishpaw, "Public Opinion on Health Care Policy," Heritage Foundation, April 23, 2019, <https://www.heritage.org/health-care-reform/report/public-opinion-health-care-policy>.

2. **Lower Costs, Better Coverage, and Better Safety Nets.** Americans want lower costs, better coverage arrangements that meet their needs, and assurance that they and their loved ones can get the care they need when they get sick or hurt. The best way to do that is by allowing the market to create innovative options, with a strong and focused safety net for the vulnerable that supports their ability to access the care they need.
3. **Increased Choices and Lower Costs.** Private actors and states are inherently better able than the federal government to deliver on the first two principles. Innovations such as telemedicine, direct primary care, expanded HSAs, and price transparency that give patients more information and greater control can lead to the creation of more choices and usher in a new era of personalized health care.

Importantly, this approach provides a pathway to facilitate the creation of a competitive market that is responsive to patients. Markets, when combined with effective safety nets, are far more effective and compassionate than the heavy hand of government. Healthy markets can provide more choices of more affordable health insurance and better access to care while

encouraging innovative solutions in medical treatment and care delivery.

Building on Emerging Success

National, state, and private innovators already have taken steps in this direction that are beginning to bear fruit. The Trump Administration has taken actions to create a healthy and transparent health care market. State lawmakers have used regulatory flexibility granted by the Trump Administration to begin to reform their private health coverage markets and to introduce innovative safety net programs to better provide for the needs of those with high health costs. And doctors are offering innovative care arrangements that provide reliable access to primary care. These are producing real results—including more affordable policies and expanded coverage options that will result in hundreds of thousands of people gaining coverage by 2029, according to government estimates.⁶³

While progress is being made, much more needs to be done to enable more creative solutions. And for that to happen, Congress must act. Congress should build on these emerging successes and empower all patients to access these innovations and many others that would come in a market that is not suffocated by excessive regulation.

63. The Trump Administration has addressed short-term, limited duration plans; health reimbursement accounts (HRAs); and association health plans (AHPs). Because of these actions, the Administration projects net coverage gains: 0.2 million Americans by 2028 from the short-term rule, 0.8 million Americans by 2029 from the HRA rule, and 0.4 million Americans in 2023 and later years from the AHP rule. For estimate, see HHS, “U.S. Departments of Health and Human Services, Labor and the Treasury Expand Access to Quality, Affordable Health Coverage Through Health Reimbursement Arrangements,” June 13, 2019, <https://www.hhs.gov/about/news/2019/06/13/hhs-labor-treasury-expand-access-quality-affordable-health-coverage.html> (accessed August 24, 2020). For rules, see “Short Term, Limited-Duration Insurance,” 83 *Federal Register* 38212, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>; “Health Reimbursement Arrangements and Other Account-Based Group Health Plans,” 84 *Federal Register* 28888, June 20, 2019, <https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans>; “Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Health Plans,” 83 *Federal Register* 28912, June 21, 2018, <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans> (all accessed August 20, 2020).

Towards that goal, the Health Policy Consensus Group's proposal offers a fresh approach that moves away from today's Washington-centric system and, instead, devolves power and control toward newly empowered patients so they can access more choices of better quality, more affordable care and coverage.

Benefits of Our Proposal

Our vision of a patient-centered health sector requires removing federal barriers that are blocking innovation. States should have broad authority to reform their health insurance markets, especially focusing on doing a better job than the ACA has done of providing coverage and care for people with chronic and pre-existing conditions. Medical professionals should be able to create innovative ways of treating these individuals with the care they deserve rather than focusing on complying with red tape.

Our plan helps you. Independent estimates show it will lower premiums by up to 24 percent, result in nearly 4 million more people purchasing insurance, and improve access to medical providers by 8 percent.⁶⁴ The plan will:

1. Empower you to keep your health coverage and doctors when you change or lose your job.
2. Save you money on health care and drugs by making the prices of health care transparent.
3. Eliminate your risk of surprise medical bills through transparency and truth in advertising.
4. Benefit you financially when you choose lower-cost, high quality care.
5. Give you better options, lower premiums and better access to care if you get sick, have a pre-existing condition and need financial help.
6. Give you access to specialized plans and care if you have a chronic illness.
7. Give you more options to get insurance and care tailored to your needs and those of your family.
8. Make it easier for you to manage your own health care dollars.
9. Make telehealth permanent so you can talk "virtually" with medical providers – including by phone, email, video conference and other innovative delivery arrangements
10. Remove barriers to innovation and competition.

Actions Needed

To realize these changes, federal and state government policymakers need to remove existing legal and regulatory barriers and conflicting requirements. Under the Health Care Choices proposal, Congress should:

1. Empower you to keep your health coverage and doctors when you change or lose your job. For decades, employer-sponsored health insurance

64. Douglas Holtz-Eakin and Christopher Holt, Center for Health and Economy, "Estimate of the Health Care Choices Proposal," October 22, 2020 <https://healthandeconomy.org/the-health-care-choices-proposal-2/> (accessed November 3, 2020).

has been the centerpiece of the private health sector, covering more than 157 million Americans.⁶⁵ But in our changing economy, more options are needed for coverage that is portable, flexible, and affordable. Americans need more security and control over their health spending decisions with resources they can draw on in times of a medical or economic crisis.

People should be able to have health insurance that can travel with them, even as they move from job to job, place to place, and in and out of the labor market. This could include traditional types of health insurance as well as innovative coverage options such as short-term plans, direct primary care arrangements, and health care sharing ministries.

Congress also should remove government barriers that inhibit choice and portability. For decades, most Americans have had little to no choice in their coverage arrangements. Instead, their employer or the government picks their plan for them. While this works for many, millions of others are being left behind.

As a first step, the Trump Administration improved regulations governing Health Reimbursement Arrangements (HRAs).⁶⁶ The HRA changes allow employers who don't have the ability or means to provide traditional employer-sponsored insurance to, instead, reimburse their employees' premiums for coverage they obtain in the individual health insurance market. In essence, this equalizes the tax advantages between traditional group insurance offered by employers and direct employer contributions that workers use to

purchase individual-market coverage. Those with private individually owned insurance are then better able to keep their plans even if they move or change jobs because the policies are connected to them and not their employers. The COVID-19 pandemic has shown how important it is for people to be able to keep their insurance if they lose or are furloughed from their jobs.

Recommendation: Congress should codify the Administration's Health Reimbursement Arrangement rule and allow individuals more options in the types of insurance they are able to purchase with HRA funds.⁶⁷

Lower-income Americans also have limited ability to choose the coverage they may prefer and instead are usually assigned to programs picked for them by government officials, such as Medicaid managed care plans. Today, people receiving coverage through the ACA, the Children's Health Insurance Program (CHIP), and Medicaid can obtain subsidized coverage only if they are enrolled in these government programs. Yet many program enrollees have trouble finding doctors, particularly specialists, to see them because of these programs' low payment rates. To facilitate choice and portability, Congress should also allow families and individuals to direct government subsidies to the private coverage of their choice.

Recommendation: Congress should allow recipients who are eligible for ACA subsidies,

65. Kaiser Family Foundation, "Health Insurance Coverage of the Total Population."

66. "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 84 *Federal Register* 28888, June 20, 2019, <https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans> (accessed August 20, 2020).

67. To achieve these goals, Representative Dan Bishop (R-NC) introduced H.R. 5224—Increasing Health Coverage through HRAs Act, 116th Congress (2019-2020), <https://www.congress.gov/bill/116th-congress/house-bill/5224?s=1&r=2> (accessed August 20, 2020).

The Health Care Choices Proposal would:¹

- **Reduce costs.** The Health Care Choices Proposal is estimated to lower premiums up to 24 percent. Key changes to advance that goal include (1) eliminating Obamacare's failed entitlement spending scheme, which increases taxpayer payments to insurance companies every time they raise prices; (2) unwinding federal mandates so private actors can innovate (including the 3:1 age band rating, essential health benefits, single risk pool requirement, and others); and (3) ensuring that people who are sick or have pre-existing conditions can access care without driving up premiums for everyone else.
- **Expand private coverage.** The Health Care Choices 2020 proposal is estimated to increase the number of insured by almost 4 million, while also expanding private coverage. The proposal gives people more choices and fosters innovation. It would repeal heavy-handed federal mandates that constrict the type of coverage Americans can buy and provide additional flexibility to allow private innovation in coverage options. The proposal provides incentives for states to open their markets to more choices of affordable coverage.
- **Help those most in need and provide security for sick, low-income patients.** Today, Obamacare's subsidy structure enriches insurance companies while fueling higher costs. The proposal changes this and instead provides dedicated resources to states so they can target assistance to those with low-incomes, pre-existing conditions and high health costs. This change focuses subsidies on those who need them most. Like the successful welfare reform of 1996, the proposal repeals a failed program and replaces it with formula grants to states that will enable them to target assistance to those in need to ensure the most expensive patients are protected in ways that do not raise costs for everyone else. The proposal is estimated to improve access to providers by 8 percent.
- **Ensure that all Americans can choose a private health plan.** The proposal would give the millions of Americans locked into Obamacare exchanges and government-run Medicaid and CHIP programs a better option on the private market through "premium support." It would take the value of their subsidy and apply it to a plan of their choice.
- **Protect life.** Funding for these grants to the states would run through the existing CHIP, which permanently prohibits federal taxpayer dollars from being used to pay for abortions thanks to longstanding life protections embedded in the existing law.

1. All coverage and cost estimates in this text box are from an analysis by Douglas Holtz-Eakin and Christopher Holt, Center for Health and Economy, "Estimate of the Health Care Choices Proposal," October 22, 2020 <https://healthandeconomy.org/the-health-care-choices-proposal-2/> (accessed November 3, 2020).

Medicaid, and CHIP to have the option of applying the value of their subsidy to a private coverage arrangement of their choice—much like Medicare beneficiaries do today through private Medicare Advantage programs. This would empower recipients receiving financial assistance to obtain private health insurance, including employer-sponsored coverage if offered.

2. Save you money on health care and prescription drugs by making the prices of health care transparent. Americans today have more information about the price and quality of televisions than they do about the health insurance and medical care that consume a much greater share of their budgets. Most physicians and hospitals do not provide price lists, and if they do, the information can be opaque and inaccurate.

When pricing information is available, research shows that prices vary widely both within and across geographic areas. According to the Foundation for Government Accountability, “The same x-ray on the same kind of machine in different locations can vary in price from a couple hundred dollars to thousands. Surgery by the same doctor but in different facilities can range from a few thousand dollars to tens of thousands.”⁶⁸

In addition, patients facing elective procedures find it difficult or even impossible to learn in advance the price of their expected care and their share of the bill. This lack of information keeps consumers from benefitting from the kind of price visibility and competition that provide higher quality and lower prices in other sectors of the economy.

Studies show that when consumers have access to information, they can save money. There is much room for improvement in ensuring that consumers have access to meaningful price information.⁶⁹ One state that excels is New Hampshire: People who shopped for care using a New Hampshire price website saved 36 percent.⁷⁰ In another example, a Georgia patient

was quoted a price of \$40,000 for a surgical procedure at a hospital in her home state. She contacted the Surgery Center of Oklahoma, which said it would do it for \$3,500. The patient went back to her Georgia hospital asking for a better price, which agreed to do it for \$3,500.⁷¹ There are many other examples of the benefits of transparency to employer coverage where transparent prices help patients choose better quality, more affordable care.⁷²

Both government policy and provider inertia have contributed to the lack of robust price information. Scholar Brian Blase notes that “it is increasingly clear that insurers lack the same incentives as ... consumers to obtain the lowest possible cost for quality care. Insurers and third-party administrators often receive payments that are a function of total spending, which creates an incentive for them to prefer higher spending.”⁷³

President Trump and the Department of Health and Human Services (HHS) recently announced steps to address these challenges,⁷⁴ following up on the President’s 2019 executive order on transparency, requiring hospitals to post prices online in a consumer-friendly

68. Foundation for Government Accountability, “Right to Shop: Frequently Asked Questions,” <https://thefga.org/research/right-to-shop-faqs-health-insurance/> (accessed December 19, 2019).

69. Catalyst for Payment Reform, Amy Y. Gu, ed., “2020 Report Card on State Price Transparency Laws,” May 5, 2020, <https://sourceonhealthcare.org/press-release-2020-report-card-on-state-price-transparency-laws/>.

70. Brian Blase, “How Price Transparency Would Revolutionize Healthcare,” *New York Post*, October 12, 2019, <https://nypost.com/2019/10/12/how-price-transparency-would-revolutionize-healthcare/> (accessed December 19, 2019).

71. Grace-Marie Turner, “Three Cheers for Transparency,” *Forbes*, November 15, 2019, <https://www.forbes.com/sites/gracemarieturner/2019/11/15/three-cheers-for-transparency/#541b17921349> (accessed February 14, 2020).

72. Brian Blase, “Transparent Prices Will Help Consumers and Employers Reduce Health Spending,” Galen Institute, September 27, 2019, https://galen.org/assets/Blase_Transparency_Paper_092719.pdf (accessed December 19, 2019).

73. Ibid.

74. HHS, “Trump Administration Announces Historic Price Transparency Requirements to Increase Competition and Lower Healthcare Costs for All Americans,” November 15, 2019, <https://www.hhs.gov/about/news/2019/11/15/trump-administration-announces-historic-price-transparency-and-lower-healthcare-costs-for-all-americans.html> (accessed December 20, 2019).

format and requiring insurance companies to provide cost estimates to enrollees before receiving care.⁷⁵

Industry groups have challenged these efforts, claiming they could lead to increased prices. In reality, as Blase has argued, “The notion, advanced by providers and insurers that negotiated prices are a trade secret and that the status quo should remain in place, is noxious and works for them but not for the rest of society. They’re economically justified in fearing sunlight and competition, but that’s exactly what is needed to reform health care. Concerns from some economists that collusion could result from price transparency appear unjustified. Local markets right now are characterized by a limited number of providers, particularly hospitals, who engage in repeated interactions. They already tend to have knowledge of each other’s payment rates, particularly relative to each other. Moreover, hospitals and other providers already provide consumers with pricing information in the Explanation of Benefits documents when they bill patients.”⁷⁶

Transparent prices will help cost-conscious purchasers hold insurers and providers accountable for pricing decisions and lead to lower costs. Consumer need to be able to access information about both price and quality to assess value. Policymakers should clear barriers hindering consumers’ access to this meaningful price and quality information.

Recommendation: Federal changes should respect and build on existing state laws that encourage price transparency, and states should be encouraged to examine their own laws to facilitate consumer shopping for price and value.

Recommendation: Congress should codify the Administration’s two rules on Medicare price transparency to provide market certainty and help consumers and employers be better shoppers of care. Federal and state authorities should go beyond these rules and require providers and facilities to provide a good-faith estimate before an item or service is actually delivered.⁷⁷

3. Eliminate your risk of surprise medical bills through transparency and truth in advertising. Surprise medical bills are a source of frustration for many Americans. Patients take their insurance companies and medical facilities at their word when they say that a hospital is in-network. What their insurers and hospitals don’t tell them is that, even though the hospital is in-network, it permits non-network doctors who practice there to balance bill patients.

Surprise bills arise when patients who seek treatment from a network doctor at a network hospital receive a bill from a non-network physician who participated in the procedure—an anesthesiologist or a radiologist, for example. Patients can also be presented with surprise medical bills when they are transported to non-network emergency rooms.

75. CMS, “Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public,” 45 C.F.R. Part 180, <https://www.hhs.gov/sites/default/files/cms-1717-f2.pdf> (accessed December 20, 2019); CMS, “Transparency in Coverage,” 26 C.F.R. Part 54, 29 C.F.R. Part 25900, and 45 C.F.R. Parts 147 and 158, <https://www.hhs.gov/sites/default/files/cms-9915-p.pdf> (accessed December 20, 2019).

76. Blase, “Transparent Prices Will Help Consumers and Employers Reduce Health Spending.”

77. A good-faith estimate will show the full comprehensive price that a patient will be billed for the expected medical visit, procedure, or service.

These bills can amount to many thousands of dollars.⁷⁸ Patients are generally held responsible for 100 percent of the difference between what the non-network doctor charges and what their insurer pays, a practice known as “balance billing.”

Recommendation: Congress should end surprise medical bills through transparency and truth in advertising to protect and empower patients.⁷⁹ Specifically, Congress should require insurers and medical providers to give patients accurate and honest information *before* they receive medical care and penalize entities that provide consumers with false and misleading information. It should protect patients from facing balance bills for any medical services provided at a hospital that is in their network and should place penalties on an insurer who represents a facility—and a facility that represents itself—as being in-network if it permits doctors who practice there to balance bill patients. And, the practice should end for patients in need of emergency medical assistance when they don’t have the capacity to shop for care at a network facility.

4. Benefit you financially when you choose lower-cost, high quality care. Once patients have access to pricing information, some will choose

lower-cost care and treatments. Patients should be able to share in any savings when they choose this care, but some government mandates limit their opportunities to do so. These barriers should be removed.

For instance, the ACA’s Medical Loss Ratio (MLR) rules require insurers to spend at least 80 percent⁸⁰ of premium revenue on medical care for enrollees or give enrollees premium refunds equal to the differences. However, that mandate makes no allowance for a savings plan. If an insurer gives an enrollee part of the savings from choosing a lower-cost provider, it is unclear whether, under the MLR rule, the insurer must report that payment as medical care, an administration expense, or a refund of premium income.⁸¹ The Trump Administration took steps to address this issue when they proposed, as part of a price transparency rule on November 15, 2019, that “savings” payments should be accounted in the MLR calculation in a manner that does not discourage their adoption.

Recommendation: Congress should codify the Trump Administration’s November 15, 2019, rulemaking provisions clarifying that “savings” payments should be counted in the MLR calculation in a manner that does not discourage their adoption.⁸²

78. Chad Terhune, “His \$109K Heart Attack Bill Is Now Down to \$332 After NPR Told His Story,” National Public Radio, August 31, 2018, <https://www.npr.org/sections/health-shots/2018/08/31/643342598/his-109k-heart-attack-bill-is-now-down-to-332-after-npr-told-his-story> (accessed August 20, 2020).

79. Doug Badger and Brian Blase, “A Targeted Approach to Surprise Medical Billing,” Galen Institute, December 2019, https://galen.org/assets/A_Targeted_Approach_To_Surprise_Medical_Billing.pdf (accessed August 20, 2020).

80. The requirement is 85 percent in the case of a large group plan.

81. While some insurers are starting to offer tools that let patients receive savings, existing regulations “scare off others out of a fear of making less money.... However, following consultation with federal officials one state Department of Insurance was informed that incentive payments would count as medical spending, and not be classified as an added administrative cost.” Foundation for Government Accountability, “Right to Shop,” <https://thefga.org/wp-content/uploads/2016/12/Right-to-Shop-FAQ-1.pdf> (accessed December 20, 2019).

82. MLR is intended to control overhead costs, including profit. If an insurer spends less than 80 percent of premiums (85 percent in the large group market) on medical care, then it must rebate premium to the insured. A “savings payment” accomplishes the same thing, only in advance. The customer gets the money up front, rather than having to wait for an MLR calculation to receive his or her rebate. To put it another way, if the insurer doesn’t get to keep the money, it should not count against the insurer in measuring MLR.

There are other barriers as well to insurers being able to reward patients who choose lower-priced care. For example, some insurers are experimenting with a new model, called “referencing pricing.” Here, the insurer sets a fixed, transparent rate it will pay for a service, and the patient can choose where to get a surgery or treatment. For example, the average cost of a knee replacement in Florida is about \$37,000. But rates for the procedure vary from \$28,000 to \$45,000.⁸³ Under reference pricing, an insurer can offer to pay the average amount (\$37,000) for the procedure. The patient then has the option of going to the most expensive facility and paying the additional \$8,000 or getting the surgery at the least expensive facility and saving up to \$9,000.⁸⁴

WellPoint (Anthem) in California took this approach, setting the amount it would pay for hip and knee replacements to \$30,000 for its CalPERS enrollees. Patients could choose to get the procedure done at any hospital that met or exceeded a certain quality metric, but if the cost exceeded their insurer’s \$30,000 reimbursement rate, they paid the difference themselves. This experiment had a dramatic effect, bringing down

the cost of surgery across California.⁸⁵ Patients had outcomes comparable to or better than non-CalPERS members, including lower 30-day general infection and complication rates.⁸⁶ This impact would be magnified if the insurer could deposit a portion of the savings in the patient’s health savings account.⁸⁷ If a patient found the service for \$28,000, for example, she could get a \$2,000 reward.⁸⁸

This reform can also benefit patients more broadly by encouraging price shopping. According to Blase, “If enough people become shoppers, higher-priced facilities will begin to lower their prices to avoid losing customers. This happened in California earlier this decade when the state adopted a reference pricing model for state employees. The result: a 9 to 14 percentage point increase in the use of low-price facilities and a 17 to 21 percent reduction in prices.” And a spillover effect will occur, meaning that even people who did not shop still benefit. “They benefit because providers lowered prices for everyone, not just the active shoppers. In California, about 75 percent of these price reductions spilled over to populations that were not participating in the reference pricing model.”⁸⁹

83. Florida Health Price Finder, “Knee Replacement,” <https://pricing.floridahealthfinder.gov/#care-bundles/TK001-knee-replacement-FL-florida> (accessed December 20, 2019).

84. Employer-sponsored plans could choose to split some portion of the savings between the enrollee and the sponsoring company, and such decisions would vary by sponsoring company and, in the case of individual insurance plans, by insurer.

85. John Goodman, “Stunning Results from California,” Independent Institute, August 7, 2013, <https://blog.independent.org/2013/08/07/stunning-results-from-California> (accessed December 20, 2019).

86. Anthem, “Study: CalPERS Members Had Similar to Better Outcomes at Facilities Charging Less for Hip and Knee Replacements,” June 24, 2013, <https://www.anthem.com/press/california/study-calpers-members-had-similar-to-better-outcomes-at-facilities-charging-less-for-hip-and-knee-replacements/> (accessed January 22, 2020).

87. Congress might also consider allowing savings to go to alternative savings vehicles.

88. Marie Fishpaw and John C. Goodman, “A Health Plan for President Trump,” *National Review*, August 1, 2019, <https://www.nationalreview.com/2019/08/health-care-plan-transform-dysfunctional-system/> (accessed June 11, 2020).

89. Blase, “Transparent Prices Will Help Consumers and Employers Reduce Health Spending.”

Recommendation: Individuals should be able to benefit from savings when they choose the most cost-effective care. If employers were to offer reference pricing that allows enrollees to receive a rebate if they choose lower cost care, they should be able to keep the savings. Congress should ensure they can put the savings in their HSAs without the money counting toward their maximum annual contributions.

Recommendation: To encourage consumers to seek better value in their health spending, health insurers and private employers who sponsor health insurance should explore offering a “reference pricing model” that ensures that employees can share in savings when they choose lower-cost care. Government employers should adopt this change in their sponsored plans, as well (e.g., the Office of Personnel Management and health benefit programs sponsored by state governments). Ideally, insurers and employers will combine this change with expanded, consumer-friendly price transparency tools.

5. Give you better options, lower premiums and better access to care if you get sick, have a pre-existing condition and need financial help. The ACA’s goal was to help people access coverage even if they have high health costs or pre-existing medical conditions. The heavy-handed strategy it used to do that has caused a cascade of distortions in the health sector.

Congress should replace the ACA’s strategy with policies that put the interests of patients

first, prioritizing those with the greatest medical need. This will require replacing the current Washington-knows-best approach with one that devolves power to individuals and families and empowers states to reset market conditions so people have more choices of more affordable care and coverage, with stronger safety nets so people with costly health conditions can access needed care.

This approach builds on emerging successes enabled by the Trump Administration. Several states have obtained federal waivers that provide them limited relief from some of Obamacare’s strictures. These waivers enable them to divert federal money to more directly finance care for people with greater medical needs and higher costs.

States that obtained these waivers reduced premiums in their individual markets at no cost to the federal government. In seven waiver states, premiums fell by a median of 7.5 percent. Premiums rose by a median of 3.09 percent in the 44 states and the District of Columbia that did not obtain waivers. An additional five states are seeking waivers in 2020. Premiums are estimated to fall by 5.9 percent to 19.8 percent in these states.⁹⁰

These results are instructive. States that obtained these waivers were able to divert federal funds to subsidize care for the sickest people. The waivers show that giving states such flexibility helps not only those in greatest medical need but also benefits those in the individual market by making premiums more affordable.

90. See Doug Badger, “How Health Care Premiums Are Declining in States That Seek Relief from Obamacare’s Mandates,” Heritage Foundation, August 13, 2019, <https://www.heritage.org/health-care-reform/report/how-health-care-premiums-are-declining-states-seek-relief-obamacares> (accessed October 15, 2020); Doug Badger and Edmund Haislmaier, “State Innovation: The Key to Affordable Health Care Choices,” Heritage Foundation, September 27, 2018, <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices> (accessed October 15, 2020) and Doug Badger, “Obamacare Caused Premiums to Spike. Here’s How States Are Lowering Them Again,” *The Daily Signal*, September 10, 2019 (accessed October 15, 2020).

Recommendation: Congress should build on the successes of state waivers under Section 1332 of the ACA by directing federal funds to states and giving them more flexibility to improve care options for high-cost patients with pre-existing and chronic medical conditions. States experimenting with this approach have achieved lower premiums and more coverage options and have been able to focus resources on helping high-risk, high-cost patients. These early adopter states have shown this approach is successful. Instead of paying federal funds directly to insurers on an entitlement basis, Congress should distribute funds to states as fixed allotments through the Children’s Health Insurance Program, which provides built-in life protections so taxpayer money can’t be used to fund abortions.

To further protect the vulnerable, Congress should stipulate that states must devote a portion of their federal allotment to help those with high anticipated medical costs and also to those with low incomes. States should have significant latitude in how they structure these arrangements to assure that consumers have more and better choices. To help those with pre-existing conditions, states could, for example, establish high-risk pools, “invisible” high-risk pools, reinsurance, or other risk adjustment arrangements that better allocate resources to

plans and programs, including those that provide specialized care for people with chronic illness and other pre-existing conditions.

6. Give you access to specialized plans and care if you have a chronic illness. Federal law today makes it hard for patients to seek care and coverage arrangements targeted to their individual needs. Instead, it requires standardized health plans, emphasizing uniformity in benefits rather than allowing for specialization. Standardized health plans often make it difficult for people with chronic conditions, such as diabetes or heart disease, to have health coverage organized around providing specialized care for their particular needs.

There are many reasons for this, but among the biggest problems are federal regulations that inhibit variation in designing plans to meet the specific needs of patients. The ACA requires every policy offered in an exchange to provide the standard benefit package, typically turning them into one-size-fits-all (or one-size-fits-none) plans. The ACA also prohibits doctors from creating new physician-owned hospitals, which studies⁹¹ have shown outperform traditional hospitals on quality outcomes. According to a study published by the Journal of the American College of Surgeons, physician-owned surgical hospitals outperform other hospitals in the Medicare value-based purchasing program.⁹² More than 40

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91. See, for example, P. M. Courtney et al., “Reconsidering the Affordable Care Act’s Restrictions on Physician-Owned Hospitals: Analysis of CMS Data on Total Hip and Knee Arthroplasty,” *Journal of Bone and Joint Surgery, American Volume*, Vol. 99, No. 22 (November 15, 2017), pp. 1888–1894, <https://www.ncbi.nlm.nih.gov/pubmed/29135661> (accessed December 20, 2019); Azeem T. Malik et al., “Posterior Lumbar Fusions (PLFs) at Physician-Owned Hospitals: Reconsidering the Restrictions of the Affordable Care Act (ACA),” *Spine Journal*, Vol. 19, No. 9 (September 26, 2019), pp. S62–S63, <https://www.sciencedirect.com/science/article/abs/pii/S1529943019303286> (accessed December 20, 2019); Azeem T. Malik et al., “Anterior Cervical Discectomy and Fusions (ACDFs) at Physician-Owned Hospitals: Is It Time to Reconsider the Sanctions of the Affordable Care Act (ACA)?,” *Spine Journal*, Vol. 19, No. 9, Supplement (September 2019), p. S20, <https://www.sciencedirect.com/science/article/abs/pii/S1529943019302384> (accessed December 20, 2019); Junyoung Ahn, Scott Blumenthal, and Peter B. Derman, “Physician-Owned Hospitals in Orthopedic and Spine Surgery,” *Annals of Translational Medicine*, Vol. 7, Suppl. 5, p. S162 (September 2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6778271/> (accessed December 20, 2019).
92. Adriana G. Ramirez et al., “Physician-Owned Surgical Hospitals Outperform Other Hospitals in Medicare Value-Based Purchasing Program,” *Journal of the American College of Surgeons*, Vol. 223, No. 4 (October 2016), pp. 559–567, <https://www.sciencedirect.com/science/article/pii/S1072751516307207?via%3Dihub> (accessed December 20, 2019).

How the Health Care Choices Formula Grants Would Work

THE HEALTH CARE CHOICES 2020 proposal grants states broad authority to reform their individual health insurance markets, provided they offer better options for care for people with pre-existing or chronic illnesses and high health care costs. “Better” means outcomes such as those we have seen in states experimenting with this concept during the past few years that have produced lower premiums and more coverage options with dedicated resources to help high-risk, high-cost patients.

The proposal would repeal the ACA’s open-ended subsidies to states for enrolling childless, non-disabled, working age adults in Medicaid as well as the entitlements to subsidies for individual health insurance premiums and cost-sharing reduction subsidies and redirect these resources as formula grants to the states, coupled with new flexibility and incentives. The money would go to states through the CHIP program with its built-in life protections. States would use the grants to provide assistance to those with low incomes and high health costs and also to stabilize their individual and small group health insurance markets so coverage can be more affordable and choices can be improved for millions of people who are being pushed out of the insurance markets because of costs.

By replacing spending through the ACA with these formula grants, states can better help low-income and sick residents to access the care they need from the doctors and health coverage options they choose in ways that will strengthen—not undermine—private markets.

Congress should follow these guidelines to assure that people have more choices of care and coverage and that the vulnerable are protected:

- At least 50 percent of the formula grant goes toward supporting people’s purchase of private health coverage.
- At least 50 percent goes to provide coverage for low-income people (the two categories will overlap).
- A portion of the grant goes to offset the costs of high-risk patients to make sure they get the care they need without driving up premiums for everyone else in the market.
- Anyone eligible for financial assistance under the grant can take the value of their premium

assistance to purchase private coverage they believe better meets their needs.

- The grant would be distributed through the Children’s Health Insurance Program, which provides protections against taxpayer money being used to fund abortions.
- Funds to finance the grants would be based upon spending, as of a fixed date, on ACA subsidies (both tax credits and cost-sharing payments) and Medicaid expansion.
- States would get regulatory relief from federal mandates imposed by the ACA, allowing states to implement the rules that work best for their markets. ACA requirements involving single risk pools, minimum loss ratio requirements, and the 3:1 age ratio would not apply in states receiving federal allotments. Essential health benefit mandates would be replaced with more flexible standards used in other government health programs. Nullifying these mandates along with new flexibility to the states would allow states to create market conditions that will result in reduced premiums, allow lower premiums for younger and middle-income enrollees, and in combination with risk mitigation, assure that the sick get the coverage they need.

The proposal assumes funds are at or near the current spending baseline, and restructures that spending to provide states with incentives to use the money more efficiently. Allocation formulas among the states should reflect need in that state, as Congress assesses it during legislative development. We recommend the funding formula treat fairly the needs of low-income, high-risk patients in all states, with special care to treat fairly those in states that did not expand Medicaid.

Legislative action is needed to unleash the innovation and energy that are pent up in our health sector. The Health Care Choices 2020 proposal would help revive the individual and small group health insurance markets that have been so damaged by the ACA. Our plan would provide states with flexibility to use existing resources to assist people who need help in purchasing health insurance, especially those with pre-existing conditions, and empower states with new flexibility to create more and more affordable options for coverage.

percent of physician-owned hospitals received the top five-star rating in a 2015 release by the Centers for Medicare and Medicaid Services, compared to only 5 percent of general hospitals.⁹³

Further, Congress has enacted so-called anti-kickback and Stark restrictions to prevent physicians from financially benefitting from their referrals, but these restrictions have had the unintended consequence of hampering the adoption of innovative payment arrangements, care coordination, and patient engagement efforts. For instance, they prevent doctors from providing services to patients such as transportation, health coaching, or financial aid for medicines that their patients need but can trigger fraud and abuse penalties.⁹⁴

Recommendation: Congress should clear away barriers in the ACA's federal regulations governing health insurance that prohibit the creation and sale of coverage arrangements designed specifically to treat people with chronic conditions, such as diabetes and heart disease. This will facilitate development of coverage options that focus⁹⁵ on care for specific serious and chronic health conditions such as cancer and diabetes and thus encourage creativity and competition in treating those with these illnesses.

Recommendation: Congress should repeal the moratorium on new or expansions of physician-owned hospitals in order to broaden access to quality, innovative, patient-centered care. Care provided at facilities such as the Surgery Center of Oklahoma is typically a fraction of the cost of care at big community hospitals. These patient-focused facilities give patients paying cash for medical care an alternative to receive quality, affordable surgeries and other medical treatments.

Recommendation: Congress should clarify that anti-kickback and Stark restrictions are not intended to limit innovative payment arrangements, care coordination, and patient engagement options.

7. Give you more options to get insurance and care arrangements such as direct primary care and health care sharing tailored to your and your family's needs. Under Obamacare, choices declined in the individual market. In 2019, half as many insurers offered plans through ACA exchanges as offered plans in the pre-ACA individual market.⁹⁶ Through a series of rulemakings, the Trump Administration has made more options available to individuals and small firms. While these regulations are important, they are subject to judicial

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93. Grace Marie Turner, "Lift the Ban on Physician-Owned Hospitals," *Forbes*, November 6, 2015, <https://www.forbes.com/sites/gracemarieturner/2015/11/06/lift-the-ban-on-physician-owned-hospitals/#5311bcd11531> (accessed August 24, 2018). CMS later after publication of this piece released an updated star rating approach that expanded the number of hospitals that qualify for top five-star ratings.
94. HHS, Office of the Inspector General (OIG), "Comparison of the Anti-Kickback Statute and Stark Law," <https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf> (accessed December 20, 2019).
95. Robert S. Galvin, "Consumerism and Controversy: A Conversation with Regina Herzlinger," *Health Affairs*, 2007, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.26.5.w552> (accessed October 15, 2020).
96. Haismaier and Baldacci, "Premiums, Choices, and Government Dependence Under the Affordable Care Act." Calculations are based on federal and state information on exchange participation and National Association of Insurance Commissioners data for pre-ACA market participation (accessed through Mark Farrah Associates subscription service). Insurer offerings are counted based on parent companies. Data for 2013 includes only insurers with 1,000 or more covered lives in the applicable state. Figures for 2019 do not include data for insurers selling exclusively off the exchange.

challenge and reversal by a new administration. Congress should write these regulations into law and go further with additional reforms to facilitate additional coverage options including health care sharing, direct primary care, more-affordable major-medical insurance (sometimes called catastrophic coverage), and other options.

Direct primary care. DPC is a health care arrangement where patients contract directly with a physician for primary care services, which many combine with insurance to protect against major medical expenses. Direct primary care is an example of an innovative care delivery model offering patients reliable access to primary care at lower costs than traditional arrangements. The great majority of DPC fees are between \$51 and \$99 a month, as of 2018. DPC practices typically serve households earning \$70,000 or less.⁹⁷ This can be a cost-effective option for families in all income categories. For example, at Epiphany Health, a DPC practice in North Port, Florida, a family of four pays only \$155 a month for full-service access.⁹⁸ Moreover, Epiphany Health has also found it can negotiate lower prices for services from other care providers for their members. Rather than paying more than \$1,100

for an MRI,⁹⁹ for example, Epiphany Health patients pay \$225 for an MRI and \$175 for CT scans.¹⁰⁰ Regrettably, options such as DPC are not typically available to Medicare patients because of federal restrictions that discourage physicians from entering into private agreements with their Medicare patients for direct primary care services outside of the Medicare program.

Health care sharing. Health care sharing is another example of an innovative and growing health care model. Like direct primary care, health care sharing offers alternative arrangements to traditional health insurance. More than 1 million Americans are estimated to be participating in health care sharing, where members agree to pay fellow members' bills for medical care.¹⁰¹ Monthly costs for a family under some health care sharing arrangements can average less than \$500, depending on the family.¹⁰² Compare that to Obamacare, where the average premium for a family bronze plan, which has an average deductible in excess of \$13,000, is \$1,253 a month in plan year 2020.¹⁰³

While these more creative arrangements are available and growing in popularity, federal regulatory barriers hinder their growth.

97. *Concierge Medicine Today*, "What Is Concierge Medicine?," updated March 2020, <https://conciergemedicinetoday.org/what-is-concierge-medicine-concierge-medicine-definition-concierge-medicine-defined/> (accessed July 8, 2020).

98. Lee S. Gross, "Reducing Health Care Costs: Improving Affordability Through Innovation," testimony before Committee on Health, Education, Labor and Pensions, U.S. Senate, November 28, 2018, <https://www.help.senate.gov/imo/media/doc/Gross2.pdf> (accessed December 19, 2019).

99. "Expensive Imaging: New Data Reveal MRI Prices highest in the US," *Radiology Business*, May 11, 2018, <https://www.radiologybusiness.com/topics/healthcare-economics/expensive-imaging-new-data-reveal-mri-prices-highest-us> (accessed January 16, 2019).

100. Gross, "Reducing Health Care Costs."

101. Mike Obel, "Why Health Care Sharing Ministry Memberships Now Top 1 Million," *Fox Business*, June 26, 2018, <https://www.foxbusiness.com/features/why-health-care-sharing-ministries> (accessed December 19, 2019).

102. Michael Leonard, "4 Best Health Sharing Plans as an Alternative to Insurance," *Well Kept Wallet*, updated January 14, 2020, <https://wellkeptwallet.com/health-sharing-plans/> (accessed February 14, 2020).

103. CMS, "Plan Year 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States," October 22, 2019, p. 5, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceReport.pdf> (accessed January 22, 2020). See also eHealth, "Lower Premiums but Higher Out-of-Pocket Costs for 2020 ACA Consumers," <https://news.ehealthinsurance.com/insights-blog/lower-premiums-but-higher-out-of-pocket-costs-for-2020-aca-consumers>.

In particular, federal law does not allow participants in these arrangements to pay charges with proceeds from an HSA. In June 2019, President Trump issued Executive Order 13877 directing the Secretary of the Treasury to propose a rule that would allow expenses related to direct primary care and health care sharing ministries to be treated as eligible medical expenses under the tax code.¹⁰⁴ In June 2020, the Internal Revenue Service published proposed regulations that would treat HSA disbursements as eligible medical expenses for direct primary care and health care sharing.¹⁰⁵

While this proposed rule, if finalized, would mark an improvement over existing policy, it does not permit people with these arrangements to make HSA contributions. Under federal tax law, only certain health insurance policies are HSA-compatible. That is, an individual must be enrolled in a policy that conforms to certain federal rules in order for that individual (and the individual's employer) to be able to *contribute* to an HSA. Currently, these alternative care arrangements are not HSA-compatible. Legislation is needed to accomplish that.

Recommendation: Congress should go further and allow people who participate in direct

primary care and health care sharing to contribute to HSAs and to use proceeds from those accounts to pay for these arrangements.¹⁰⁶

Recommendation: Congress should remove restrictions on physicians that discourage them from entering into private agreements with their Medicare patients for direct primary care services outside of the Medicare program. These limitations discourage some direct primary care physicians from accepting new Medicare patients.

Short-term insurance. The Administration used its rulemaking authority to give individuals and small businesses additional health insurance options when it finalized a rule¹⁰⁷ in 2018 to expand access to short-term, limited duration insurance (STLDI). The Obama Administration had limited these policies to three months of coverage and prohibited their renewal, which severely limited options for consumers.¹⁰⁸ Under the Trump Administration's new rule, short-term plans can be offered for up to 364 days and can be renewed for up to three years, subject to state regulation.¹⁰⁹ The rule has been challenged in court, and both a district court judge and an

104. Executive Order 13877 of June 24, 2019.

105. Internal Revenue Service, "Proposed Regulations Address Direct Primary Care Arrangements and Health Care Sharing Ministry Memberships," IR-2020-116, June 8, 2020, <https://www.irs.gov/newsroom/proposed-regulations-address-direct-primary-care-arrangements-and-health-care-sharing-ministry-memberships>.

106. Senator Bill Cassidy (R-LA) has introduced bipartisan legislation to accomplish this goal for people who participate in DPC arrangements. "S. 2999-Primary Care Enhancement Act of 2019," 116th Cong., 1st Sess., <https://www.congress.gov/bill/116th-congress/senate-bill/2999/text?r=19&s=1> (accessed August 20, 2020). Representative Mike Kelly (R-PA) introduced legislation to provide for similar treatment of health care sharing ministries. "H.R. 2177- Faith in Health Savings Accounts Act of 2019," 116th Cong., 1st Sess., <https://www.congress.gov/bill/116th-congress/house-bill/2177> (accessed August 20, 2020).

107. Short Term, Limited-Duration Insurance, 83 *Federal Register* 38212, August 3, 2018, <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance> (accessed August 20, 2020).

108. Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 *Federal Register* 75316, October 31, 2016, <https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance> (accessed August 20, 2020).

109. Brian Blase and Doug Badger, "The Value of Short Term Health Plans: Rebutting the Energy and Commerce Democratic Staff Report," *Health Affairs*, August 17, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200813.226193/full/> (accessed August 20, 2020).

appeals court panel have upheld the Administration's rule.

Short-term plans are helpful to people with gaps in employment and to early retirees who no longer have employer-sponsored health insurance and need to maintain coverage before they qualify for Medicare. These plans also help young people who don't have coverage through their parents' insurance, people who are unemployed or are otherwise leaving the workforce temporarily to attend school or training programs, the self-employed, entrepreneurs starting new businesses, and others without access to employer insurance who earn too much to qualify for assistance.

Because they have more flexibility to respond to consumer needs, short-term plans offer a greater variety of benefit packages compared to ACA plans. CBO anticipates that "the majority of people who enroll in STLDI as a result of the most recent regulations will enroll in plans that do provide insurance coverage."¹¹⁰ In other words, these are not "junk" plans, as critics claim.

Short-term plans have been available for more than two decades and are not subject to the benefit requirements and pricing restrictions contained in the ACA, so rates can be set in an actuarially appropriate manner where

the premiums better match risk. Premiums for short-term health plans are typically less than half of those of ACA plans for equivalent insurance protection.¹¹¹

They also rely on underwriting, which means they function more like actual insurance to provide protection against more serious illnesses or accidents. Because of the Trump Administration's changes in rules on short-term policies, the plans can be renewed so people can have this insurance protection beyond the previous 90-day limit and for up to three years. The guaranteed renewable feature of short-term plans is an important part of this consumer-friendly health insurance option. The plans can also be combined with other insurance—an outgrowth of a part of the Trump executive order that permits a separate type of insurance, sometimes called "change-of-health-status insurance"—to bridge the gap between the three-year periods.¹¹²

Short-term plans are not a panacea for everyone, but they offer a valuable option for many, especially when, as considered in this proposal, they are offered along with other plans such as change-of-health-status insurance. People with expensive, pre-existing chronic conditions who do not qualify for or want a short-term plan will, under this proposal, be able to obtain care and coverage through other state-government run

110. Congressional Budget Office, "CBO's Estimates of Enrollment in Short-Term, Limited-Duration Insurance," September 25, 2020, <https://www.cbo.gov/publication/56622> (accessed October 16, 2020).

111. Chris Pope, "Renewable Term Health Insurance: Better Coverage Than Obamacare," Manhattan Institute, May 16, 2019, <https://www.manhattan-institute.org/cheaper-health-insurance-alternatives-to-obamacare-for-low-medium-risk-patients> (accessed December 19, 2019).

112. As John Goodman explains: "This is an outgrowth of a part of the Trump executive order that permits a separate type of insurance, sometimes called 'change-of-health-status insurance,' to bridge the gap between the three-year periods. Say the enrollee is in a short-term plan and gets cancer. Health-status insurance protects her against this bad outcome. It pays any extra cost that arises because of a change in medical condition, leaving the enrollee free to pay the same premium a healthy person would pay. By stringing together these two types of insurance, we now have the possibility of a market that healthy people can buy into and that is guaranteed to be renewable (regardless of health condition) indefinitely into the future. Going forward, expect to see insurance companies enter this market and offer plans that look very much like traditional Blue Cross insurance before there was Obamacare—with reasonable premiums and a full menu of benefits. It will be the closest thing we have ever had to genuine free market health insurance." For more see John C. Goodman, "Short-Term Insurance Is Not the Problem. It's the Solution." *Forbes*, June 29, 2020, <https://www.forbes.com/sites/johngoodman/2020/06/29/short-term-insurance-is-not-the-problem-its-the-solution/#777bddd05d5c> (accessed August 6, 2020).

programs designed for them. This proposal's goal is to ensure that both groups have better options than under the current system.

Recommendation: Congress should codify the Trump Administration's rule on Short-Term Limited Duration Plans so that a future administration or activist judges can't strike them from the books and so that people can rely on this coverage being available. Congress should also allow workers to use their HRA funds to purchase short-term insurance as an alternative to ACA-compliant plans. When combined with other reforms in this proposal, these changes will open new opportunities for people to purchase coverage they can keep over the long term, assuring them protection against acute or chronic illnesses they may develop.

Association Health Plans. Smaller and medium-sized businesses should have more freedom to organize into groups to obtain more affordable health insurance for their employees. The Trump Administration created new health insurance options through its Association Health Plans (AHP) rule. The goal is to expand the ability of small businesses to band together to buy coverage, including across state lines, to get the economies of scale big companies obtain. Codifying the rule would also put to rest the current legal challenges that are blocking implementation of the AHP rule.

Recommendation: Congress should codify the Trump Administration's rule on Association Health Plans so that employers and workers can obtain more and more affordable coverage options and a future administration or activist judges can't strike this option.

Broader regulatory relief. Congress should also provide broader regulatory relief from federal mandates that limit the kinds of products that insurers can sell. Insurers should be able to offer coverage that allow more innovative products that meet the needs of individuals and families, and the ACA's sweeping approach limits that ability today. To ensure vulnerable patients with pre-existing conditions can continue to access care and coverage, such reforms should be linked to changes to federal subsidies for protecting the vulnerable so the sick can get the coverage they need without insurers charging the healthy unfairly high premiums.

Recommendation: Congress should take steps to remove barriers to the growth of innovative coverage arrangements, beginning with allowing states to get regulatory relief from ACA coverage mandates that make it more difficult for them to allow, and for people to obtain, more innovative insurance products that can better meet their needs. Under the formula grant in the Health Care Choices 20/20 proposal, states that receive allotments also would get relief from some of the ACA's cost-driving regulations. They would have more flexibility in determining which benefits insurers must offer, they would no longer be required to charge young adults unfairly high premiums, they could deviate from federal Medical Loss Ratio requirements (which advantage incumbent insurance companies by keeping out new market entrants), and insurers within their borders would not be bound by the single risk pool requirement. States could also allow insurers to offer discounts or other incentives to individuals who choose to remain continuously covered.

8. Make it easier for you to manage your own health care dollars. Health savings accounts allow

people to use tax-free dollars to pay for medical care and to save for future health care expenses.

More than 22 million people have HSAs, but millions more are barred from establishing such accounts because of federal rules.¹¹³ Today, very few policies offered in the individual market can be integrated with HSAs. Patients can establish and contribute to HSAs only if their insurance policies meet certain other criteria in addition to having the federally stipulated high deductible.¹¹⁴ These criteria restrict plans from covering most services or treatments before the deductible.¹¹⁵ For example, a patient can't have an HSA if his or her policy provides a separate deductible for prescription medicines or covers a few physician visits below the deductible. Patients also can't use an HSA for coverage of arrangements such as DPC and health sharing ministries. Further, current law restricts seniors' ability to have private coverage with an HSA after they turn 65.¹¹⁶

Congress should take several key steps to build on the success of HSAs and remove government barriers to their growth.

Recommendation: Allow everyone to have a health savings account, regardless of how their insurance is structured. Congress should broaden the universe of policies that can be coupled with HSAs to give people more coverage options and allow them to use HSAs to pay for a broader

range of medical services, as well as premiums. To provide the added flexibility, Congress should stipulate that any plan with an actuarial value of 80 percent or less would be HSA-compatible, regardless of how the policy structures its cost sharing.¹¹⁷

Recommendation: Congress should clarify that funds can be used for direct primary care and health care sharing ministries and also to help others finance their health care needs by stating these expenditures are qualified expenses for HSA purposes.

Recommendation: Congress should allow account holders over 65 to choose private coverage with a health savings account, and to continue to contribute to their HSAs. Many seniors continue to work and benefit from employer-sponsored coverage. They should be permitted to enroll in HSA-compatible insurance, and they and their employers should be able to contribute to their accounts.

Recommendation: Congress should allow account holders to save more money and align contributions limits with average deductibles. Annual HSA contributions are limited to \$3,550 for an individual and \$7,100 for a family in 2020.¹¹⁸ These limits are not keeping pace with rising deductibles and catastrophic protections. For 2020,

113. Cathryn Donaldson, "More Americans Choose a Health Savings Account with a Consumer-Directed Plan for Their Financial Security," America's Health Insurance Plans, <https://www.ahip.org/more-americans-choose-a-health-savings-account/> (accessed December 19, 2019).

114. Internal Revenue Service, "Publication 502 (2018), Medical and Dental Expenses (Including the Health Coverage Tax Credit)," January 9, 2019, <https://www.irs.gov/publications/p502> (accessed December 19, 2019).

115. *Ibid.*

116. Internal Revenue Service, "Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans," March 4, 2019, <https://www.irs.gov/pub/irs-pdf/p969.pdf> (accessed December 19, 2019).

117. Edmund F. Haismaier, "Obamacare's Cost Sharing is Too High, Even for HSAs," Heritage Foundation, June 1, 2018, <https://www.heritage.org/health-care-reform/report/obamacares-cost-sharing-too-high-even-hsas> (access date).

118. Alicia Adamczyk, "These Are the New HSA Limits for 2020," CNBC, June 4, 2019, <https://www.cnbc.com/2019/06/03/these-are-the-new-hsa-limits-for-2020.html> (accessed February 18, 2020).

the average deductible for family coverage under an ACA Bronze plan is \$ 13,394. The average out-of-pocket maximum for such policies is \$15,462.¹¹⁹ Congress should increase HSA limits to allow people to use tax-free dollars to pay deductibles and out-of-pocket costs. Congress could start by doubling allowed contribution limits so they better match the average deductibles for plans.

9. Make telehealth permanent so you can talk “virtually” with medical care providers—including by phone, email, video conference—and other innovative delivery arrangements. In a 21st century world of instant communications, access to medical care has been stuck in the 20th century. Patients should be able to “visit” their doctors from home—expediting care, avoiding long waits and even unnecessary and expensive emergency room visits. Patients can often receive quality care for a fraction of the cost of an in-person visit through portals facilitated by technology.

While federal and state governments took steps during the COVID-19 response to remove barriers to telehealth, the relief is temporary. The federal government should permanently codify pandemic-related regulatory relief, such as permanently removing federal barriers to telemedicine so patients can receive care without leaving their homes. Some states have suspended the requirement that out-of-state doctors must get a new, state-specific license before they can practice in a different state. Relaxing these rules allowed medical providers from across the country to help patients in New York City and other epicenters of the pandemic, for example.

Additional barriers need to be removed as well. Common restrictions, according to the Center for Connected Health Policy, include the types of services and providers that can be reimbursed, whether someone has to have an in-person visit with a physician first, and whether patients can access telemedicine from their own home. Moreover, the definition of *telehealth* varies from state to state, with some states offering far more flexibility to providers and patients than others.

Recommendation: State and federal policy-makers should make telehealth options for consumers permanent beyond the duration of the pandemic.

Recommendation: States and the federal government should also ensure that the definitions surrounding telemedicine are current and broad enough to facilitate innovation as new tools are approved by the FDA and as medical professionals determine which patients can benefit. One model to follow is Georgia, which enacted legislation that expanded the state’s definition to be broad and flexible enough to facilitate future innovation and inventions. Specifically, Georgia defined *telehealth* to be all-inclusive with the following definition: “the use of information and communications technologies, including, but not limited to, telephones, remote patients monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health-related education, public health, and health administration.”¹²⁰

119. eHealth, “ACA Market Unsubsidized Price Analysis: 2020 OEP,” October 2019, https://news.ehealthinsurance.com/_ir/68/20199/ACA_Market_Unsubsidized_Price_Analysis_OEP_2020.pdf (accessed December 19, 2019). This is the most recent data available.

120. Marie Fishpaw and Stephanie Zawada, “Telehealth in the Pandemic and Beyond: The Policies That Made It Possible, and the Policies That Can Expand Its Potential,” Heritage Foundation, July 20, 2020 (accessed July 22, 2020).

Recommendation: Federal and state policy-makers should clarify that physicians and other medical providers can treat patients via telemedicine regardless of the patient's location. States should loosen requirements that block virtual consultations, such as requiring an in-person visit before a provider can see a patient via telemedicine or limit patients to seeing providers licensed in the state in which the patient lives. Congress should codify the Administration's waivers that allow Medicaid and Medicare patients to access care virtually and allow physicians to practice telehealth across state lines.

Recommendation: Policymakers should make more flexible payment policies for government programs that pay for telehealth. During the initial pandemic response, policymakers largely adopted policies that provided payment parity for services provided via telehealth or in an office (an approach designed to facilitate quick adoption). Going forward, state and federal policymakers could look to Utah's permanent reimbursement law, which permits providers to request reimbursement from health insurers covering state and local government workers for "medically appropriate telemedicine services at a commercially reasonable rate" as model policy. This reimbursement strategy is flexible and

allows providers and payers to negotiate specific reimbursement amounts for different telemedicine services to best serve individual patients.

10. Removing barriers to innovation and competition. Policymakers at the federal and state level have imposed burdensome rules and regulations that interfere with patients' access to care of their choosing, discourage competition, and are used by big businesses and special interests to benefit themselves at the expense of patients.

Government policies that discouraged competition¹²¹ and encouraged consolidation¹²² among hospitals and providers have led to highly concentrated markets. Hospital mergers have produced markets dominated by a handful of large hospital systems, restricting consumer choices and dampening price competition. An estimated 77 percent of Americans in urban areas live in highly concentrated urban markets.¹²³ Spurred at least in part by the ACA's policies, trends in consolidation—both in terms of hospital mergers and the acquisition of physician practices—have intensified.¹²⁴

Hospitals have used the power they've gained under these policies to engage in practices that leave consumers facing higher costs and fewer choices. Hospital consolidation has increased prices with no evidence that it improves quality.

121. For example, at the federal level the ACA extended and intensified restrictions on physician-owned hospitals. That provision protects large hospital systems from having to compete against new hospitals established by physicians in their community. Physician-owned hospitals offer consumers additional choices in where they receive medical care and reduce health care costs through additional competition.

122. The ACA placed great emphasis on "accountable care organizations" (ACOs), generally hospital-based entities that would be responsible for providing medical care to a group of seniors. A senior who was assigned to an ACO would have his or her care provided and coordinated by the ACO entity. If Medicare spent less on that senior's medical care in a given year than the average for a similarly situated senior, then the ACO would share in the government's savings. The ACO program motivated many hospital systems to buy up physician practices. If they were going to be measured on the amount of care they provided to a Medicare beneficiary, they understandably wanted to control as many aspects of the care as they could. The program thus encouraged greater provider consolidation, although it didn't end up saving the government money.

123. HHS, Treasury and Labor, "Reforming America's Healthcare System Through Choice and Competition," December 2018. <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf> (accessed August 21, 2020).

124. *Ibid.*, pp. 23–28 and 20.

One study shows price increased as much as 40 percent after one hospital system acquired another.¹²⁵ A retrospective study by the Federal Trade Commission (FTC) of four hospital mergers turned up evidence that hospitals themselves view such activity as increasing their “negotiating clout” over insurers, resulting in higher prices.¹²⁶ This vertical integration restricts the health care choices available to patients even as it increases the costs of medical care.

The adverse effects of market concentration manifests itself in a variety of ways, including anti-competitive contracting clauses, price opacity, state-enforced barriers to entry, and guild-like protectionist laws and regulations. A recent *Health Affairs* piece shows how state medical boards, for example, have impeded the expansion of telemedicine, barred non-physician clinicians from practicing to the top of their education and training, and used their regulatory authority to impede innovation.¹²⁷

The Health Care Choices 20/20 proposal contains provisions that would deal with some of these adverse effects, including provisions to expand telemedicine, make prices transparent to patients, and end surprise medical bills. Congress should also do more to roll back policies that block competition in hospital markets.

Recommendation: Enable physicians to provide better quality care by repealing the moratorium ban on physician-owned hospitals. The ACA

extended and intensified restrictions on physician-owned hospitals. That provision protects large hospital systems from having to compete against new hospitals established by physicians in their community. Physician-owned hospitals offer consumers additional choices in where they receive medical care and reduce health care costs through additional competition. Congress should remove this barrier to entry.

Recommendation: Encourage states to address anti-competitive laws that drive up prices and reduce consumer choices. Thirty-six states and the District of Columbia have imposed certificate-of-need laws, “which require health care providers to obtain certificate-of-need permits from their licensed state health regulatory authorities before they expand their facilities and services.... [I]n 2009, overall health care costs were approximately 11 percent higher in states with certificate of need laws than those without them—\$7,230 per capita in the former compared to \$6,5265 in the latter.’ By restricting new construction of provider facilities, these programs reduce competition, prevent the market from working on its own and are subject to political influence.”¹²⁸ Both the Justice Department and FTC have long identified these laws as anti-competitive. The laws generally do not control costs or improve quality, and they restrain provider entry and innovation in health care delivery.¹²⁹ Federal taxpayers are on the hook for

125. Ibid, p. 21.

126. Ibid, pp. 22–23.

127. Eli Y. Adashi, Barak D. Richman and Reuben C. Baker, “The New State Medical Board: Life in the Antitrust Shadow,” *Health Affairs*, January 6, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20191226.86148/full/> (accessed August 21, 2020).

128. Republican Study Committee, “A Framework for Personalized, Affordable Care,” <https://rsc-johnson.house.gov/sites/republicanstudycommittee.house.gov/files/documents/%28online%29%20FINAL%20RSC%20Health%20Care%20Report-%20Removed%20Story.pdf> (accessed July 9, 2020).

129. Robert E. Moffit, “How State Leaders Can Begin Undoing Obamacare’s Damage.” Heritage Foundation, January 25, 2018, <https://www.heritage.org/health-care-reform/commentary/how-state-leaders-can-begin-undoing-obamacares-damage> (accessed July 10, 2020).

these state decisions thanks to programs such as Obamacare and Medicaid, which give states more money as they spend more money. To address this, Congress should encourage states to repeal these laws. Further, Congress could consider adjusting a portion of the Health Care Choices formula grant to states based on whether they keep these laws in place.

Recommendation: Allow medical providers to practice at the top of their education and training. Most states impose rules that do not allow well-trained advanced-practice nurses, physician assistants, and other medical professionals to practice at the top of their education and training. The Trump Administration relaxed Medicare rules that apply to non-physicians as part of its response to the pandemic in order to improve access to care for patients. The changes helped address staffing shortages by allowing facilities to assign personnel to cities and facilities facing the greatest medical needs. Congress should make these changes permanent, and states should repeal rules and laws that impose obstacles to the highest and best use of medical resources.

Recommendation: Medicare should pay the same for services provided in a hospital-based setting as it does for the same service provided in a physician's office or an ambulatory surgical setting. Medicare today often pays more for a medical service provided in a hospital setting than it does for that same service provided at an ambulatory surgical center or physician's office. While providers in different settings may

choose to charge different prices for the same service, taxpayers should not be forced to pay more for the same procedure based on the site of care. Providers should face equal incentives to use taxpayer money most efficiently. Congress should start by codifying the Administration's initial efforts to require Medicare payments to be site neutral¹³⁰ and go beyond it to ensure that Medicare is reimbursing the same amount for a service regardless of the setting in which it is provided.

Recommendation: Enable more price transparency by ending gag clauses in contracts between plan administrators and medical providers. Contracts between group health plan administrators and hospitals often contain clauses that prevent the administrator from disclosing hospital prices to the plan sponsor. That means that employers, who are paying the claims, aren't allowed to know the prices the hospitals are receiving for these claims. This practice should end.

Recommendation: Enable consumers to shop for care by ending anti-steering clauses in contracts. Contracts between medical providers and health plans and issuers often contain clauses that prevent insurers from steering enrollees to providers that offer the best value. That means an insurer can't tell an enrollee that it would cost less to get scheduled care at, for example, a freestanding ambulatory surgical center than at a hospital outpatient department. In addition to other provisions of the proposal requiring price transparency, this would allow insurers to inform their customers about where to find the best

130. Robert King, "Appeals Court Rules HHS Has Authority to Implement Site-Neutral Payments, Dealing Blow to Hospitals," *FierceHealthcare*, July 17, 2020, <https://www.fiercehealthcare.com/hospitals/appeals-court-rules-hhs-has-authority-to-implement-site-neutral-payments-dealing-blow-to> (accessed August 28, 2020)

value when they're scheduling medical care. This practice should end.

Recommendation: Enable patients to reduce out-of-pocket spending for medical procedures by ending anti-tiering clauses. Contracts between medical providers and health plans and issuers often contain clauses that prevent insurers from creating cost-sharing tiers for such providers. These are somewhat analogous to drug formularies. Pharmacy benefit managers can put one drug in a therapeutic category in a preferred tier, where patient copays are lower than for other drugs in that same therapeutic category. This practice should end so plans and issuers have the same latitude with respect to providers, charging lower copays for those that agree to lower prices. This change, coupled with price transparency, would help consumers reduce their out-of-pocket spending for medical procedures.

Recommendation: Enable patients to access more affordable care by ending all-or-nothing clauses. Hospital conglomerates often include campuses in a variety of settings, including rural towns. An insurer that wants to contract with

a rural affiliate of such a conglomerate can be contractually required to contract with all its affiliates. This immunizes the conglomerate from price competition, resulting in higher medical premiums and out-of-pocket costs for patients. This practice should end so insurers can better establish networks that offer consumers more affordable prices.

Recommendation: Direct the FTC and Justice Department to report routinely the extent and effects of hospital consolidation and the role of state medical boards in restraining competition. A large body¹³¹ of academic research documents consolidation of hospital markets and their effect on health care prices and quality. These studies find that such consolidation restrains competition in ways that directly affect prices without improving quality. Similarly, the antitrust regulators have in the past undertaken studies of the practices of state medical boards, resulting in the courts restricting some of their anti-competitive practices. Congress should direct these agencies to conduct a fresh, thoroughgoing and comprehensive analysis of the extent of hospital consolidation, updated annually and reported to Congress.

131. See "Reforming America's Healthcare System Through Choice and Competition," U.S. Departments of Health and Human Services, Treasury and Labor, November 2018, pp. 20-21. Footnotes 51 and 52 of that document cite the following studies: The Gaynor M, Town R. The impact of hospital consolidation—update. Robert Wood Johnson Foundation, The Synthesis Project. Policy Brief No. 9. June 2012, at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261. Other studies include Haas-Wilson D, Garmon C. Hospital mergers and competitive effects: two retrospective analyses. *Int J Econ Bus.* 2011;17, 30 (post-merger review of Agency methods applied to two hospital mergers; data "strongly suggests" that large price increases in challenged merger be attributed to increased market power and bargaining leverage); Dafny L. Estimation and identification of merger effects: an application to hospital mergers. *J Law Econ.* 2009;52(3):523, 544 ("[H]ospitals increase price by roughly 40 percent following the merger of nearby rivals"); Capps C, Dranove D, Hospital consolidation and negotiated PPO Prices. *Health Aff.* 2004 Mar-Apr;23:175, 179 ("Overall, our results do not support the argument that efficiencies from consolidations among competing hospitals lead to lower prices. Instead, they are broadly consistent with the opposing view that consolidations among competing hospitals lead to higher prices."); see also, e.g., Farrell J, Pautler P, Vita M. Economics at the FTC: retrospective merger analysis with a focus on hospitals. *Ref Indus Org* 2009;35(4):369 (Mergers between not-for-profit hospitals can result in substantial anti-competitive price increases). These effects are not limited to for-profit hospitals: mergers between not-for-profit hospitals can also result in substantial anti-competitive price increases. Farrell J, Pautler P, Vita M. Economics at the FTC: retrospective merger analysis with a focus on hospitals. *Ref Indus Org* 2009;35(4):382 (corroborating Michael G. Vita MG, Sacher S. The competitive effects of not-for-profit hospital mergers: a case study. *J Indus Econ.* 2001;49:63).

Policymakers should address other structural dynamics in taxpayer-funded health programs that drive up the cost of care. Consumer-centered reform doesn't stop by addressing the problems discussed above. Additional reforms are needed, including reforms to Medicare, Medicaid, prescription drug pricing, and nonprofit hospitals. Such ideas are outside the scope of this project, which primarily focuses on ways to lower costs for patients and to improve choices and security in the private insurance market. The Health Policy Consensus Group encourages policymakers to continue to examine these and other important matters.

A Clear Choice

The debate today is between those who want to exert even more government control over our health sector and those, like us, who favor giving patients more choice and control and allowing the creativity we have seen in the COVID-19 crisis to flourish—a system that encourages innovation and competition to provide consumers the best care at the lowest cost. We welcome the opportunity to work with policymakers to shape the better, brighter health care future we believe can be ahead.

Appendix I

Why Congress Should Repeal ACA Entitlements and Replace Them with the Health Care Choice 2020 Proposal to Provide Fixed Federal Allotments to States

Despite the tens of billions of dollars that the federal government has paid to issuers of individual policies, enrollment in the individual market has been shrinking since 2016.¹³² A number of insurers abandoned the ACA money after incurring substantial losses. Those that remain have swung to profitability by increasing premiums.¹³³ Since government subsidies that are paid to insurers rise dollar-for-dollar with premiums, insurers have profited by raising rates. Subsidy increases have shielded recipients, especially those earning less than 250 percent of FPL, from rate hikes. Nevertheless, the number of people receiving subsidies has declined even as the average value of the subsidies has grown,

a trend that CBO expects to persist through the next decade.¹³⁴ In 2018, only half the people eligible for subsidies claimed them.¹³⁵

Meanwhile, millions of people who once had affordable policies are dropping their insurance because they can't afford it. Coverage rates are falling among people ineligible for premium subsidies.¹³⁶ In 2018, the only income group that showed a statistically significant increase in uninsurance rates were those with incomes over 300 percent of the federal poverty level, according to the Census Bureau.¹³⁷

The ACA has reduced the number of uninsured primarily by making nondisabled, non-aged, childless adults eligible for Medicaid.¹³⁸ The Medicaid expansion, in addition to being costly, has been marred by fraud. States have enrolled people who are not eligible for the program to maximize their receipt of enhanced federal matching funds.¹³⁹ California is a prime

132. Badger, "Congressional Proposals to Increase Federal Health Care Spending."

133. Rachel Fehr, Cynthia Cox, and Larry Levitt, "Individual Insurance Market Performance in Early 2019," Kaiser Family Foundation, June 27, 2019, <https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-early-2019/> (accessed August 15, 2019).

134. Badger, "Congressional Proposals to Increase Federal Health Care Spending."

135. Doug Badger and Jamie Bryan Hall, "Why Millions Are Still Uninsured Despite Government Intervention," *The Daily Signal*, October 28, 2019, <https://www.dailysignal.com/2019/10/28/whmillions-are-still-uninsured-despite-government-intervention/> (accessed February 14, 2020).

136. Semanske, Levitt, and Cox, "Data Note: Changes in Enrollment in the Individual Health Insurance Market."

137. Berchick et al., "Health Insurance Coverage in the United States, 2018."

138. Edmund Haislmaier, "2017 Health Insurance Enrollment: Little Net Change, but Large Drop in Non-Group Coverage," Heritage Foundation, October 30, 2018, <https://www.heritage.org/health-care-reform/report/2017-health-insurance-enrollment-little-net-change-large-drop-non-group> (accessed August 21, 2020).

139. Brian C. Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center, November 2019, https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v2_2.pdf (accessed February 14, 2020). Almost every expansion state enrolled far more people than projected, but no state went so far beyond its projections as California. California failed to verify proper eligibility in 2014 and 2015 before enrolling residents in Medicaid. One HHS OIG study found that more than half of expansion and non-expansion enrollees that they reviewed who came onto the program in that time frame were not eligible or had not had their eligibility properly assessed. ("California Made Medicaid Payments on Behalf of Non-Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements," HHS OIG, December 2018, <https://oig.hhs.gov/oas/reports/region9/91702002.asp>). See also CMS, "2019 Estimated Improper Payment Rates for Centers for Medicare and Medicaid Services (CMS) Programs," CMS Fact Sheet, November 18, 2019, <https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs>; HHS OIG, "California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements," February 2018.

example. The federal government will pay half the cost of coverage for a Medi-Cal recipient who is disabled, aged, pregnant, or under age 18. But because of Obamacare's Medicaid expansion, the federal government paid 100 percent of the costs incurred by a nondisabled adult from 2014 to 2016, a figure that was gradually reduced to 90 percent in 2020. That motivated California and other expansion states to prioritize enrolling able-bodied childless adults, since the federal government paid more for this new group than for the more vulnerable low-income individuals already covered by Medicaid and who often languish on waiting lists awaiting care.

The Health Care Choices 20/20 proposal would eliminate this misallocation of subsidies so that taxpayer money is spent in a way that best benefits patients. It would begin by repealing the Obamacare premium subsidies to insurance plans and misdirected Medicaid expansion spending and replacing it with a program of fixed federal allotments to states.

To qualify for allotments, states must, among other guidelines, develop plans that would make affordable health insurance broadly available. States would also be required to devote a portion of their allotments to care for those with pre-existing medical conditions. They would have flexibility on how to direct that assistance, including financing high-risk pools, invisible high-risk pools, risk adjustment or reinsurance arrangements. Unlike existing law, which allocates federal tax credits on the basis of income, states would have to direct federal money to those in most need, including those with lower incomes and those with the greatest medical needs.

Recipients of public assistance would also be given flexibility and choice. Unlike under current law, which balkanizes the poor into various programs—Medicaid, CHIP, premium subsidies

for exchange-based coverage—these recipients would be able to direct the value of their assistance to the coverage of their choice. Individuals would have greater flexibility to, for example, fund personal accounts or support the purchase of job-based coverage for those eligible.

People who want to keep their plans could do so. Those who get subsidies and want to make a change would have new options. Medicaid recipients would no longer be forcibly enrolled in state-contracted health maintenance organizations if they preferred to instead apply the value of their Medicaid benefits to private coverage or health insurance sponsored by their employers. Nor would members of the same family have to be assigned to different programs—Mom to Medicaid, Dad to the exchange, children to CHIP. Instead, the family could combine the value of the assistance to enroll in a single health plan.

Since the Health Care Choices funds would flow through the CHIP statute, federal money could not be used to purchase insurance that included abortion coverage.

States that receive allotments would also get relief from some of the ACA's regulations that have driven up premium costs. They would have more flexibility in determining which benefits insurers must offer. They would no longer be required to charge young adults unfairly high premiums. They could deviate from federal minimum loss ratio requirements, which advantage incumbent insurance companies by keeping out new market entrants. And insurers would not be bound by the single risk pool requirement. Giving states more flexibility would help repair the damage the ACA inflicted on individual markets and make insurance more affordable for their residents.

Finally, Congress will have to set allocation formulas that determine how much funding

each state gets. The proposal assumes that funds are at or near current spending baseline and restructures that spending to provide states with incentives to use the money more efficiently. Allocation formulas among the states should reflect the needs of the vulnerable in that state. As Congress assesses this question during legislative development, we recommend the funding formula treat fairly the needs of low-income, high-risk patients in all states, with special care

to treat fairly those in states that did not expand Medicaid. Congress also could consider the merits of including in the allocation formula provisions that would adjust payments to states, on a budget neutral basis, based on their success in opening up their health insurance markets to greater competition, increased choices, and better protections for the vulnerable and that encourage innovation to respond to changing patient and consumer needs.