



Blueprint for America

EDITED BY

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TRANSFORMATIONAL HEALTH CARE REFORM

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The Affordable Care Act (ACA), frequently referred to as Obamacare, has pushed health care in the United States onto a drastically different, far more government-dominated pathway. In place now are a costly expansion of already failing entitlement programs, harmful new tax burdens, and unprecedented regulatory authority of the federal government over health insurance and the health care industry. These changes were instituted while ignoring, even doubling down on, the fundamental problems with the existing system—the perverse incentives that have caused runaway costs and excluded millions of Americans from the world’s best medical care.

Years after the initial rollout of the ACA, the American people, the health care industry, and the courts still struggle to navigate the law. Time is of the essence. Under the new regulatory environment, consolidation has accelerated within virtually all of the important sectors of health care, including hospitals and physician practices, pharmaceutical companies, and insurers. This reduces competition, hurts consumers, and raises prices to patients by thousands of dollars per year.¹ Further implementation of the ACA will undoubtedly accelerate the development of a two-tiered health care system seen in other nationalized systems, and reverse

the superior access and outstanding quality of care that distinguish American health care from the centralized systems that are failing the world over.

Meanwhile, Americans will increasingly require medical care at an unprecedented level, as the population ages and risk factors like obesity continue to compound. To meet these demands, technological advances in clinically relevant molecular biology, medical devices, and targeted pharmaceuticals offer great promise for new treatments and breakthrough cures. Yet the current trajectory of the health system, particularly under the ACA, threatens both the sustainability of the system and the essential climate for the innovation necessary to reach its potential.

I propose a comprehensive, six-point plan for reforming US health care (for a more detailed discussion, see Scott W. Atlas, *Restoring Quality Health Care: A Six-Point Plan for Comprehensive Reform at Lower Cost*, Hoover Institution Press, 2016): it would fundamentally transform the system by empowering consumers and instilling appropriate incentives to induce market-based competition, while reducing the federal government's authority over health care. My plan centers on instilling incentives for lower-cost insurance coverage and broadly expanded, universal health savings accounts. The plan restores the original purpose of health insurance: to protect against the risk of significant and unexpected health care costs. With these reforms, the plan enhances the availability and affordability of twenty-first-century medical care for all Americans, ensures continued innovation, and reduces health care costs by trillions of dollars over the decade. These savings will promote increased economic activity into other areas of the economy. Perhaps most importantly, the reforms in this plan reflect the key principles held by the American people about what they value and expect from health care in terms of access, choice, and quality.

This essay will examine the status of American health care in light of the ACA and then outline key reforms needed to meet the significant health care challenges facing the nation. Six major re-

forms are proposed, each with its underlying rationale: 1) expand affordable private insurance; 2) establish and liberalize universal health savings accounts to leverage consumer power; 3) introduce appropriate incentives with rational tax treatment of health spending; 4) modernize Medicare for the twenty-first century as the population ages; 5) overhaul Medicaid and eliminate the two-tiered system for poor Americans; and 6) strategically enhance the supply of medical care while ensuring innovation.

HEALTH CARE TODAY: SETTING THE RECORD STRAIGHT

America is facing its greatest health care challenges in history. Unprecedented demand for medical care is a certainty. The number of Americans sixty-five and older has increased by a full six million in the past decade alone to over 13 percent of the overall population, while those eighty-five and older have increased by a factor of ten from the 1950s to today's six million. Older people harbor the most disabling diseases, including heart disease, cancer, stroke, and dementia—the diseases that depend most on specialists and complex technology for diagnosis and treatment. Simultaneously, obesity, America's most serious health problem, has increased to crisis levels, already affecting more adults and children in the United States than in any other nation. Given the known lag time for such risk factors to affect health, the next decades promise to reveal obesity's massive cumulative health and economic harms.

These daunting demographic realities combine with serious fiscal challenges that promise to worsen in the absence of change. America's national health expenditures now total over \$3.1 trillion per year, or more than 17.4 percent of GDP, and are projected to reach 19.6 percent of GDP by 2024.² Medicaid has expanded to cover over 70 million people³ at a cost of \$500 billion per year. Medicare spends over \$260 billion annually on hospital benefits alone and \$615 billion in total for 52 million enrollees. Workers paying taxes for the program will decline to 2.3 per beneficiary by 2030,⁴ half of the number at Medicare's inception. With the

aging of the baby boom generation, the program is unsustainable. Medicare's hospitalization insurance trust fund will face depletion in 2030. Barring changes, by 2049, federal expenditures for health care and Social Security are projected to consume all federal revenues, eliminating capacity for national defense, interest on the debt, or any other domestic program.⁵

At the same time, we have entered an extraordinary era in medical diagnosis and therapy. Innovative applications of molecular biology, advanced medical technologies, and new drug discoveries promise earlier diagnoses and safer, more effective cures. The possibilities of improving health through medical advances have never been greater.

Before designing reforms to achieve the promise of twenty-first-century health care for Americans, it is essential to understand the state of US health care before the ACA. Americans enjoyed unrivalled access to care,⁶ whether defined by preventive screening tests; waiting times for diagnosis and specialists; treatment for chronic diseases; timeliness of biopsies for cancer and life-changing surgeries; or availability of safer technology and the newest drugs that save lives. The leading medical journals prove that American medical care delivers exceptional results for virtually all of the most serious diseases. That includes survival for cancer, outcomes from heart disease and stroke treatment, and treatment of chronic diseases such as hypertension and diabetes—all better than in those countries with government-centralized health systems.⁷ The inescapable conclusion based on the facts is that both quality of medical care and the access to it have been superior in the United States than in those nationalized systems heralded as models for change by ACA supporters.

Partly based on now discredited studies⁸ alleging the poor quality of America's health care, the ACA was enacted. Its two core elements, a significant Medicaid expansion and subsidies for exchange-based private insurance, will each cost close to one trillion dollars over the next decade.⁹ Fundamentally, the ACA con-

sists of a huge centralization of health care and health insurance to the federal government, driving government control of health insurance to unprecedented levels while dramatically pushing up private insurance premiums. During the first three quarters of 2014, 89 percent of the newly insured under the ACA were enrollees into Medicaid, not private insurance.¹⁰ Coupled with population aging, Centers for Medicare and Medicaid Services projects that the 107 million under Medicaid or Medicare in 2013 will rapidly increase to 135 million just five years later, a growth rate tripling that of private insurance.¹¹

But the goals of health reform demand quite the opposite. Facts show that private insurance is superior to government insurance for both access and quality of medical care (see next section). History shows that the best way to control prices is through competition for empowered, value-seeking consumers. Instead of shunting more people into insurance and care provided by, heavily subsidized by, or massively regulated by the government, reforms should focus on how to deliver innovation and cost savings, thereby maximizing the availability and affordability of the best care for everyone. The key is to move away from hyper-regulated centralized models relying on misguided incentives necessitating more and more taxation to competition-driven markets that will respond to empowered consumers incentivized to seek value.

REFORMING HEALTH CARE TO INCREASE ACCESS, AFFORDABILITY, AND EXCELLENCE

Reform 1: Expand Affordable Private Insurance

The Importance of Private Health Insurance

Broad access to doctors and hospitals comes through private, not government, insurance. The harsh reality awaiting low-income Americans is that doctors already refuse new Medicaid patients in numbers that dwarf by eight to ten *times* the percentage that refuses new private insurance patients.¹² As of 2014, 55 percent of

doctors in major metropolitan areas refused new Medicaid patients.¹³ Even of those managed care providers signed by contract and on state lists to provide care to Medicaid enrollees, 51 percent are not available to new Medicaid patients.¹⁴ Likewise, about one-quarter of doctors no longer see Medicare patients or limit the number they see; in primary care, 34 percent refuse Medicare.¹⁵ The percentage of doctors who closed their practices to Medicare or Medicaid by 2012 had increased by 47 percent since 2008.¹⁶

The quality of medical outcomes is also superior with private insurance. For those with private insurance, that includes fewer in-hospital deaths, fewer complications from surgery, longer survival after treatment, and shorter hospital stays than similar patients with government insurance.¹⁷ It is highly likely that restricted access to important drugs, specialists, and technology under government insurance accounts for these differences.

The Harmful Impact of the ACA on Private Insurance

As a direct result of the ACA's new mandates and pricing regulations, the law has already forced more than five million Americans off their existing private plans. The Congressional Budget Office (CBO) projects that a stunning ten million Americans will be forced off their chosen employer-based health insurance by 2021—a *ten-fold increase* in the number that was initially projected back in 2011.¹⁸ Meanwhile, private insurance premiums have greatly increased under the ACA and are projected to skyrocket in 2016, in some cases increasing by 30 percent to 50 percent and more. Additionally, because government reimbursement for care is often below cost, costs are shifted back to private carriers, further escalating private premiums. Nationally, the gap between private insurance payment and government underpayment has become the widest in twenty years, doubling since the ACA began.¹⁹ More ominously, consolidation among the five big private insurers is accelerating; most believe this will further raise premiums for individuals and small businesses. This not only im-

pacts the individual, but all taxpayers, because all taxpayers subsidize those higher premiums via ACA insurance subsidies.

Private insurance choices and providers covered under them are dwindling as well. As of December 2014,²⁰ the exchanges offered 21 percent fewer plans than the pre-ACA individual market nationally. For those dependent on subsidized insurance through government exchanges, narrower provider networks doubled in 2013 since the previous year (although perhaps stabilizing in 2014).²¹ Exchange plans in 2015 restricted access to doctors and hospitals far more than plans bought off exchanges,²² and they completely exclude many top cancer hospitals and important specialists²³ in an attempt to quell premium increases caused by the law itself.

Keys to Expanding Affordable Private Insurance

The ACA has made private insurance less affordable and pushed health insurance reform in the wrong direction. It has furthered the erroneous view that insurance should subsidize the entire gamut of medical services, including routine medical care. American consumers, though, have demonstrated that higher deductible coverage generates more affordable insurance and reduces health spending.²⁴ Consumer spending has decreased with high deductible plans,²⁵ without any consequent increases in emergency room visits or hospitalizations and without harmful impact on economically vulnerable families.²⁶ In studies, more than one-third of the savings reflected lower costs per health care utilization,²⁷ i.e., value-based decision-making by consumers. Additional evidence from magnetic resonance imaging (MRI)²⁸ and outpatient surgery²⁹ shows that introducing price transparency and defined-contribution benefits further encourages price comparisons by patients. The evidence shows that given the opportunity, consumers make value-based decisions when purchasing health care.

Fundamental change to private insurance is vital to leverag-

ing consumer power and expanding affordable health care. It is first essential to reduce onerous regulations on insurance. While consumers are still increasingly opting for plans with deductibles greater than \$2,000, the growth rates have slowed compared to before ACA mandates and regulations.³⁰ We should eliminate unnecessary coverage mandates that have ballooned under the ACA, including so-called “minimum essential benefits” that have increased premiums by almost 10 percent³¹ as well as many of the more than 2,270 state mandates³² requiring coverage for everything from acupuncture to marriage therapy. We should also remove obstacles to competition, including archaic barriers to out-of-state insurance purchases, and restore pre-ACA actuarial restrictions on age-rated premiums to eliminate unfair cost shifts imposed by the ACA that raised premiums for younger, healthier enrollees by 19 percent to 35 percent.³³ Finally, we should repeal the ACA’s added health insurance providers fee that insurers pass on to enrollees through increased premiums (\$11.3 billion in 2015).³⁴

Health insurance reform is also a powerful opportunity to encourage healthy lifestyles, especially since three-fourths of health insurance claims may be due to lifestyle choices.³⁵ Cigarette smoking causes \$193 billion in direct health care expenditures and productivity losses each year, according to the Centers for Disease Control.³⁶ Annual medical costs for people who are obese were \$1,429 higher in 2006 than for those of normal weight; for Medicare patients, this difference was \$1,723, with almost 40 percent due to extra prescription drugs.³⁷ Extra medical care for obesity alone comprises up to 10 percent of total US health care costs,³⁸ while its total US societal costs exceed \$215 billion per year.³⁹ While smoking has declined, the burden of obesity to the health care system and to all taxpayers continues to increase. Just as in other insurance, premiums that reflect higher risks from voluntary behavior, such as obesity and smoking, are sensible.

Reform 2: Establish and Liberalize**Universal Health Savings Accounts**

Health savings accounts (HSAs) allow individuals to set aside money tax-free for uncovered expenses, including routine care. Despite the ACA's restrictions, HSAs continue to grow, with a one-year jump of 29 percent as of the end of 2014, reaching a record 14.5 million in mid-2015.⁴⁰ Nearly one-third of all employers (31 percent) now offer some type of HSA, up from just 4 percent since 2005. By the end of 2017, the HSA market will surpass \$46 billion in assets held in almost 25 million accounts.

Expanding HSAs with high deductible coverage reduces health care costs. System-wide health expenditures would fall by an estimated \$57 billion per year if even half of Americans with employer-sponsored insurance enrolled in plans combining HSAs with high deductibles.⁴¹ Savings would increase further if deductibles were truly high, e.g., \$4,000 to \$5,000, and if these plans were freed from the added costly mandates of the ACA.

The issue is not whether these accounts are effective; it is how to maximize their adoption and eliminate the government rules that serve as obstacles to their use. First, HSAs should be available to all Americans, regardless of age and without any requirement of specific insurance deductible. We should significantly increase ACA-defined HSA maximums, ease restrictions on their uses, and allow rollovers to surviving family members. We should also remove ACA-specified limits to financial incentives from employers, including deposits into employee HSAs, to increase these powerful motivators for employees to participate in wellness programs already proven to benefit workers and firms by improving health and reducing health costs.⁴²

Reform 3: Introduce Appropriate Incentives**with Rational Tax Treatment of Health Spending**

The income tax subsidy for unlimited health spending creates harmful incentives for consumers that are counterproductive to

competition and pricing, replaces higher take-home wages, and is highly regressive,⁴³ preferentially giving high-income earners more tax breaks. The largest tax subsidy—the exclusion from income and payroll taxes of employer and employee contributions for employer-sponsored insurance—costs approximately \$250 billion in lost federal tax revenue in 2013.⁴⁴ In addition, the federal tax deduction for health expenses (including premiums) exceeding 10 percent of the adjusted gross income is estimated to have cost \$12.4 billion in lost tax revenue in 2014.⁴⁵

Beyond the numbers, the tax exclusion creates perverse incentives counterproductive to consumer empowerment and competitive pricing. The exclusion makes health spending seem less expensive than it is, encouraging more expensive insurance policies with more elaborate coverage as well as higher demand for medical care, regardless of cost. The distortion of health insurance to cover almost all billable services, while minimizing direct payment by patients, is partly attributable to the tax preference. This has greatly increased the overall cost of health care.⁴⁶

Under the ACA, the tax exclusion will change in 2018. A new excise tax will be imposed on employment-based health benefits whose total value is greater than specified thresholds. (The Joint Committee on Taxation and the CBO project that 2018 thresholds will be \$10,200 for single coverage and \$27,500 for family coverage.) The excise tax will be equal to 40 percent of the difference between the total value of tax-excluded contributions and the threshold. But allowing a government to impose new, high taxes on products whose prices became unnecessarily high directly because of the government's policies is not only bad for consumers but frankly absurd.

Changing the tax treatment of health spending is an important part of urgently needed health care reforms; unfortunately, comprehensive tax reform into a broad-based, low-rate, simple system seems unlikely at this time. Given that reality, tax reforms should eliminate the ACA excise tax and incorporate a number of impor-

tant features, including: 1) universality, regardless of the source of health benefits and independent of employment; 2) limits on total allowed exclusion; and 3) new criteria on eligible spending for tax exclusion, such as only catastrophic coverage and HSA funding. Such tax reforms would realign incentives to encourage value-based health care purchasing and ultimately lower the cost of health care.

Reform 4: Modernize Medicare for the Twenty-first Century

Medicare is an antiquated, labyrinthine system designed for decades long past, and it is in serious financial trouble. The population of seniors is dramatically expanding, while the taxpayer base financing the program is dramatically shrinking. Nearly four million Americans now reach age sixty-five every year; in 2050, this population will reach 83.7 million. Americans live 25 percent longer after age sixty-five now than in 1972,⁴⁷ about five years longer than at the inception of Medicare. Today's seniors need to save money for decades, not just years, of future health care.

Despite the expanding needs, the ACA imposed a new obstacle to health care for seniors. Its Independent Payment Advisory Board, a group of political appointees, is specifically tasked with formulaically reducing payments to doctors and hospitals. And contrary to the administration's demonization of private insurers, Medicare already ranks at the top of the charts for the highest rates of claim refusals—more than nearly all comparable private insurers every year.⁴⁸ Meanwhile, doctors are increasingly refusing traditional Medicare, and this promises to accelerate.⁴⁹ Without significant change, seniors will have serious difficulty finding medical care; soon, Medicare will mirror the two-tiered system seen routinely in other nationalized systems, where only the affluent can circumvent the system.

Seniors have shown the path toward Medicare reform—more than 70 percent of beneficiaries already supplement or replace traditional Medicare with private insurance. Voluntary enrollment

in alternative Medicare Advantage, private health plans competing for business, has expanded to 31 percent of beneficiaries, tripling since 2004 to 16.8 million in 2015. Private prescription drug coverage in Part D has also been highly favored by beneficiaries.

To fix Medicare and prevent the collapse of this crucial safety net, we need to empower seniors—the heaviest users of health care—to seek and receive value. Modernizing Medicare for the twenty-first century centers on a three-pronged strategy: 1) increasing private insurance options for beneficiaries with competition-based premiums and integrated benefits, as well as consumer incentives to seek value; 2) expanding the eligibility and uses of large HSAs that share all features and limits with HSAs outside of Medicare; and 3) updating eligibility from the obsolete criteria of fifty years ago to reflect the demographics and health needs of today's seniors.

Reform 5: Overhaul Medicaid and Eliminate the Two-tiered System for Poor Americans

Instead of providing a pathway to excellent health care for poor Americans, the ACA's expansion of Medicaid continues and even exacerbates their second-class health care status, at a cost of \$500 billion per year to taxpayers that rises to \$890 billion in 2024.⁵⁰ As an alternative, a few states have taken the lead via special waivers to facilitate a transition into private coverage with better access to medical care. Arkansas and Iowa have received approval to use the "private option" in which Medicaid provides premium assistance to purchase private plans in lieu of direct Medicaid coverage.⁵¹ Additionally, Michigan and Indiana have added HSA options for Medicaid beneficiaries, and Arkansas has begun the approval process. Although still burdened with a mandated set of benefits and other regulations under the ACA, these are steps in the right direction.

We should transform Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance

instead of funneling low-income families into substandard traditional Medicaid coverage. We should also establish and seed-fund Medicaid HSAs that empower enrollees with the same control as all other Americans, including incentives for good health. Federal Medicaid funding via fixed dollar amounts to states should include incentives for states to ensure availability of private, lower-cost catastrophic coverage to all Medicaid-eligible families as well as to the entire state population; that funding should be contingent on meeting certain enrollment thresholds for Medicaid beneficiaries into private coverage and HSAs. These incentive-based Medicaid reforms could move Medicaid enrollees to private coverage, with access to the same doctors, specialists, treatments, and medical technology as the general population, thereby eliminating the two-tiered health system that the ACA furthers.

Reform 6: Strategically Enhance the Supply of Medical Care While Ensuring Innovation

The challenges to health care access and cost cannot be met without strategically modernizing the supply and delivery of medical care. Private-sector clinics staffed by nurse practitioners and physician assistants can provide routine primary care, including flu shots, blood pressure monitoring, and blood tests. Care at retail clinics is 30 percent to 40 percent cheaper than similar care at physicians' offices and about 80 percent cheaper than at emergency departments,⁵² potentially saving hundreds of millions of dollars per year while increasing the availability of primary care.⁵³ The key to encouraging the proliferation of these clinics rests on preventing obstacles to their use, such as unnecessarily burdensome documentation or overly complex insurance credentialing requirements. Additionally, states should follow the recommendations of the Institute of Medicine⁵⁴ and remove outmoded scope-of-practice limits and unfounded restrictions on nurse practitioners and physician assistants.

States should also modernize physician licensing. Nonrecipro-

cal licensing by states unnecessarily limits patient care, especially in our era of telemedicine. It is also time to relax tight limits that have stagnated medical school graduation numbers for almost forty years. Medical societies further harm consumers by artificially limiting the residency training positions and consequently restraining competition among doctors. These anti-consumer practices need to be open to public scrutiny and abolished. To alleviate the impending shortage of specialist doctors⁵⁵ who are trained to use advanced technology and further clinical innovation, we should rein in malpractice lawsuits with caps on non-economic damages and encourage streamlined training programs when possible.

Perhaps the most insidious consequence of the ACA is the threat to innovation. The overwhelming majority of the world's health care innovation occurs in the United States, but that is changing. Growth of total US research and development (R&D) from 2012 to 2014 averaged only 2.1 percent, down from 6 percent over the previous fifteen years.⁵⁶ This has been exacerbated by more than \$500 billion in new taxes over the ACA's first decade on device and drug manufacturers. Concurrently, Food and Drug Administration delays for approvals of new devices are now far longer than in Europe.⁵⁷

What can be done to reverse these damaging trends? First, strip back the heavy tax burdens that inhibit innovation, starting with a permanent repeal of the ACA's \$24 billion medical device excise tax and the \$30 billion tax on brand-name drugs. Repeal the law's investment tax to restore tax incentives for funding early-stage technology and life science companies. Simplify processes for new device and drug approvals, including low-cost generics, so that the FDA becomes a favorable rather than an obstructionist environment. Finally, despite legitimate security concerns, targeted immigration reforms are needed to encourage educated, high-skill entrepreneurs to stay in America. A decade ago, from two-thirds to over 90 percent of foreign students in the United

States remained here, but today only 6 percent of Indian, 10 percent of Chinese, and 15 percent of European students expect to make America their permanent home.⁵⁸ Although partly due to improving opportunities in those students' home countries, lawmakers should take a fresh look at easing counterproductive immigration restrictions. New skill-based visa programs should be instituted that target highly educated individuals, particularly students completing American university graduate-degree programs in science and technology.

CONCLUSION

Paradoxically, as our nation is doubling down on government authority over health care, those countries with the longest experience of nationalized health care, from Britain to Denmark to Sweden, are shifting patients toward private health care to remedy their failed systems.⁵⁹ Likewise, Europeans with means or power are increasingly circumventing their centralized systems. Private insurance in the European Union has grown by more than 50 percent in the past decade.⁶⁰ In reaction to unconscionable waits for care,⁶¹ about 11 percent of Britons, including almost two-thirds who earn more than \$78,700, hold private insurance—even though they are already paying \$175 billion in taxes for their “free” National Health Insurance⁶² and despite the government’s insurance premium tax to thwart its rise.⁶³ In Sweden, an average family pays nearly \$20,000 annually in taxes toward health care, yet almost 600,000 Swedes also buy private insurance, a number that has increased by 67 percent over the last five years.⁶⁴ Unless the ACA is drastically altered, America’s health care will mirror those systems and become even more divided with even more inequality, where ultimately only the lower and middle classes will suffer its full harm.

The debate in the United States should focus on what specific reforms are appropriate to fix the inadequacies and reduce the cost of American health care without jeopardizing its excellence.

Reforming US health care should specifically promote lower cost private insurance coverage and large, liberalized HSAs in order to expand market competition for better value and more consumer choices.

Voters overwhelmingly support such reforms. In answer to the question, “What would do more to reduce health care costs—more free market competition between insurance companies or more government regulation?” 62 percent of voters chose more free market competition, while only 26 percent chose more regulation.⁶⁵ A vast majority—a full 70 percent—say they have a right to choose between health plans that cost more and cover just about all medical procedures and other plans that cost less while covering only major procedures (only 18 percent are opposed).⁶⁶ An even greater majority, 80 percent to only 9 percent, say individuals should have the right to choose between plans that have higher deductibles and lower premiums versus plans with lower deductibles and higher premiums. It is the responsibility of government leaders to facilitate a health care system that reflects these important principles cherished by the American people.