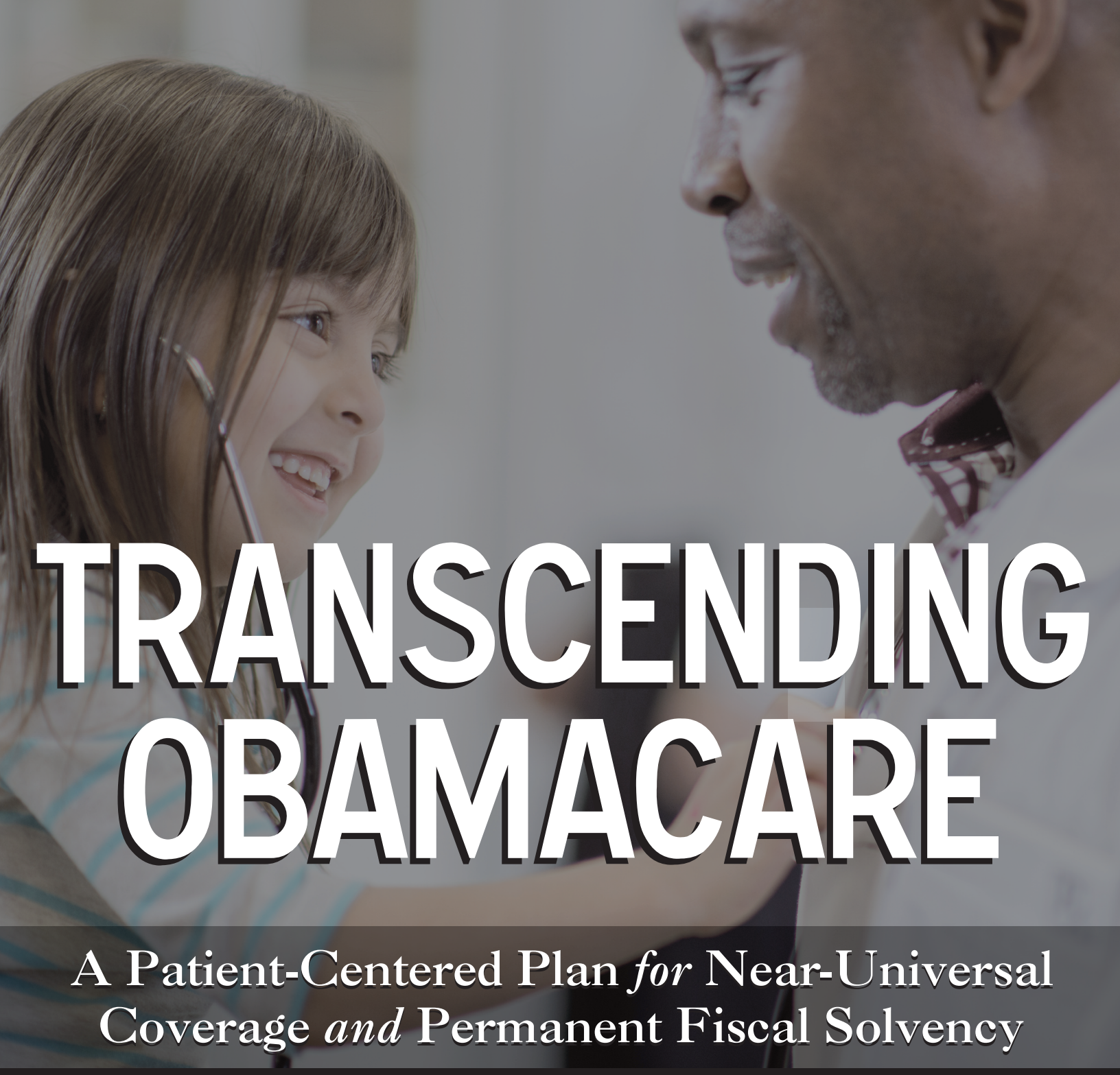

TRANSCENDING OBAMACARE

A Patient-Centered Plan *for* Near-Universal Coverage *and* Permanent Fiscal Solvency

SECOND EDITION

Avik S. A. Roy

The Foundation *for* Research *on* Equal Opportunity

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Printed in the United States of America
9 8 7 6 5 4 3 2 1

The Foundation for Research on Equal Opportunity
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Austin, Texas 78746-6773
www.freopp.org

Library of Congress Cataloging-in-Publication Data
Names: Roy, Avik S. A., 1972– , author.
Title: Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency, 2nd Edition / Avik S. A. Roy.
Description: Austin : The Foundation for Research on Equal Opportunity, 2016. | Includes bibliographical references.
Identifiers: ISBN 978-1-68419-122-2 (electronic)
Subjects: | MESH: Health Policy—economics—United States. | Health Care Costs—United States. | Health Services Accessibility—economics—United States. | Healthcare Disparities—United States.

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Executive Summary

One of the most significant challenges facing low- and middle-income Americans is the high cost of U.S. health care. Costly health insurance, in particular, is hampering the kind of social mobility that has long been the hallmark of the American economy. And because public spending has come to dominate the U.S. health care system, the high cost of health care is the primary driver of the nation's long-term fiscal instability.

These problems were at the center of the public debate in 2009 and 2010 around President Obama's signature health law, the Patient Protection and Affordable Care Act, also known as the "Affordable Care Act," the "ACA," or "Obamacare." The ACA has reduced the number of Americans without health insurance—an important goal—but it has done so by increasing the cost of U.S. health coverage, especially for those who directly purchase insurance. Increasing the cost of health coverage, in turn, has created additional challenges for millions of Americans.

The ACA has dramatically expanded Medicaid, a program with the poorest health outcomes of any health insurance system in the industrialized world. And the ACA, despite spending over $2 trillion over the next decade, will leave 28 million lawful U.S. residents without health insurance, according to estimates from the Congressional Budget Office (CBO).

In other words, the U.S. health care system remains in need of substantial reform, in ways that address the ACA's deficiencies as well as the system's preexisting flaws.

Many of the ACA's supporters acknowledge that the law has imperfections. But they wrongly contend it requires only minor tinkering in order to succeed. On the other hand, the ACA's critics, in seeking to repeal Obamacare, would not necessarily address the underlying problems that predate the ACA. Furthermore, while it is possible to "repeal and replace" the ACA with a better health care system, it is desirable to develop policy proposals that do not require the disruption implied by repeal in order to put U.S. health spending on a sustainable path.

With these considerations in mind, the proposal contained herein—dubbed the Universal Tax Credit Plan ("the Plan")—seeks to substantially repair both sets of health-policy problems: those caused by the ACA and those that predate it.

It is the latter set of problems that have denied affordable, high-quality health care to millions of Americans, while presenting the government with crushing health care bills.

The Universal Tax Credit Plan's reforms are perfectly compatible with the "repeal and replace" approach, but they do not require the full and formal repeal of the ACA in order to be enacted. The Plan would introduce major changes to the broad set of federal health care entitlements: Obamacare, Medicare, and Medicaid. It also proposes to overhaul veterans' health care, addresses the rising cost of prescription drugs, and seeks to deploy digital technologies to improve the delivery of health care.

The Plan uses a system of refundable, means-tested tax credits as the basis for far-reaching entitlement reform. The Plan would repeal many of the ACA's cost-increasing insurance mandates, in-

cluding the individual mandate. But it would preserve the ACA's guarantee that every American can purchase coverage regardless of preexisting conditions.

It would gradually migrate most Medicaid recipients, along with future retirees, into the new premium assistance program. This change would dramatically increase the quality of health coverage offered to Americans at or below the poverty line, and preserve the guarantee of health coverage for low- and middle-income seniors, while ensuring the fiscal sustainability of both federal health care commitments. The Plan proposes minor changes to the treatment of employer-sponsored health coverage, while giving workers additional tools to lower their health care bills. It curbs the pricing power of hospitals and drug companies, caps malpractice damages, and accelerates medical innovation.

Taken together, these changes could usher in a new era of consumer-driven, patient-centered health care.

According to our estimates, the Universal Tax Credit Plan would, by 2025, increase the number of U.S. residents with health coverage by 12.1 million, relative to the Affordable Care Act. Over time, we project that the Plan would outperform the ACA by an even wider margin.

The Plan would also expand economic opportunity for those struggling with high medical bills. It would improve the quality of health care delivered to the poor, and put America's finances on a permanently stable course.

LEARNING FROM THE BEST INTERNATIONAL HEALTH SYSTEMS

The Plan has its roots in real-world examples of market-oriented, cost-effective health reform. Notably, two wealthy nations—Switzerland and Singapore—spend a fraction of what the United States spends on health care subsidies; yet they have achieved universal coverage with high levels of access and quality.

In 2012, the Singaporean government spent $1,154 per capita on health care: roughly a quarter of what the U.S. spent, adjusted for purchasing power parity. Singapore has achieved its savings using a universal system of consumer-driven health care. The government funds catastrophic coverage for every Singaporean, and reroutes a portion of workers' payroll taxes into health savings accounts that can be used for routine expenses.

Switzerland offers its citizens premium support subsidies, on a sliding scale, for the purpose of buying private health insurance; there are no "public option" government insurers. Low-income individuals are fully subsidized; middle-income individuals are modestly subsidized; and upper-income individuals are unsubsidized. The sliding scale addresses a key challenge posed by welfare programs: mitigating the disincentive for

The Universal Tax Credit Plan's Key Reforms

Repeals ACA individual mandate, employer mandate, & tax hikes; replaces 'Cadillac Tax'
Reduces cost of care via regulatory reform • Combats hospital monopolies, high drug prices
High-quality, private coverage for Medicaid enrollees, future retirees, & interested veterans

Projected Fiscal and Coverage Outcomes

30-year deficit reduction of $8 trillion • 30-year revenue reduction of $2.5 trillion
Makes Medicare Trust Fund permanently solvent • Reduces private-sector premiums
For Medicaid population, improves provider access by 98%; medical productivity by 159%
By 2025, increases coverage by 12.1 million above ACA levels

welfare recipients to seek additional work, for fear of losing their benefits.

The Swiss system shares some of the unattractive features of the ACA, including the individual mandate. But because Switzerland focuses its public resources solely on lower-income individuals, the federation's universal coverage system is far more efficient than America's. In 2013, Switzerland public entities spent approximately $2,241 per capita on health care: 54 percent of U.S. public spending. Put another way, if U.S. government health spending was proportional to Switzerland's, the U.S. would be able to eliminate its budget deficit.

Of course, the U.S. is neither Switzerland nor Singapore. Each country has its own political system, its own culture, and its own demography. Those differences, however, are not large enough to erase the gains that would accrue here by adapting the most relevant features of the Swiss and Singaporean health care systems to that of the United States.

UNIVERSAL TAX CREDITS: A NEW OPTION

The Universal Tax Credit Plan, contemplated in this monograph, has five goals: (1) to expand coverage well above ACA levels, but without an individual mandate; (2) to improve the quality of coverage and care for low-income Americans; (3) to make all U.S. health care entitlement programs permanently solvent; (4) to reduce the federal deficit without raising taxes; and (5) to reduce the cost of health insurance.

The Plan would achieve each of these goals in a manner that is minimally disruptive to those who favor their current arrangements. As noted above, it employs a system of means-tested, tax-credit-based premium assistance as a mechanism for reforming entitlements, expanding coverage, and improving health care quality.

The Plan has five core elements:

Premium assistance. The Plan repeals the ACA's individual mandate requiring most Americans to purchase government-certified health coverage. The Plan restores the primacy of state-based insurance markets and regulation. It expands the flexibility of insurers to design individual policies that are more attractive to consumers, because they are of higher quality at a lower cost. The Plan expands access to health savings accounts. Because these reforms lower the cost of insurance for younger and healthier individuals, they have the potential to expand coverage, despite the lack of an individual mandate.

Employer-sponsored insurance reform. The Plan repeals the ACA's employer mandate, thereby offering employers a wider range of options for subsidizing workers' coverage. The Plan replaces the ACA's "Cadillac tax" on high-cost health plans with a capped standard deduction for employer-sponsored coverage. The plan repeals the ACA's other taxes, and proposes other reforms to regulations and statutes that artificially drive up the cost of employer-based insurance.

Medicaid reform. The Plan migrates the Medicaid *acute-care* population onto the premium assistance program, with 100 percent federal funding and state oversight. (Medicaid acute care is a form of conventional insurance for hospital and doctor services.) In exchange, the Plan returns to the states, over time, full financial responsibility for the Medicaid *long-term care* population. (Long-term care funds nursing home stays and home health visits for the elderly and disabled.) This clean division of responsibilities will improve coverage for the poor; reduce waste and fraud; and provide fiscal certainty to state governments.

Medicare reform. The Plan gradually raises the Medicare eligibility age by four months each year. The end result is to preserve Medicare for current retirees, and to maintain future retirees—in the early years of their retirement—on their individual or employer-sponsored health plans. (Today, the government does not allow the newly retired to remain on their old plans; instead, it forces them to enroll in Medicare or forfeit their Social Security benefits.) In total, these changes would make the Medicare Trust Fund permanently solvent.

Veterans' health reform. The Plan overhauls the

Veterans Health Administration, by giving veterans the option of private coverage and care via premium assistance, while improving traditional VA facilities.

Medical innovation. The Plan removes regulatory barriers to the use of the internet, mobile devices, and digital technology in health care. It puts patients in control of their own medical records. It tackles the high cost of innovative medicines, by reforming the FDA regulatory process, and by introducing a more patient-centered, consumer-driven mechanism for keeping high prices in check.

Other reforms. The Plan tackles the growing problem of hospital monopolies that take advantage of their market power to charge unsustainably high prices. The Plan reforms malpractice litigation in federal programs.

ASSESSING THE PLAN'S FISCAL EFFECTS

We estimated the fiscal effects of the Universal Tax Credit Plan by utilizing several methodologies, including a model developed by the Health Systems Innovation Network, and drew on data projections from the Congressional Budget Office and the Centers for Medicare and Medicaid Services.

While the sections on veterans' health reform, drug pricing, and digital health are new to the Second Edition of *Transcending Obamacare*, the sections on ACA, Medcaid, and Medicare reform are largely unchanged. Hence, the estimated fiscal effects herein are identical to those in the first edition, and do not take these added proposals into account.

For the purposes of comparative consistency, we continue to assume that the Plan is implemented in 2016 and estimated federal budget outcomes for three decades, from 2016 through 2045. As with projections generated by the CBO, estimates of the Universal Tax Credit Plan's performance beyond the first decade harbor considerable uncertainty.

However, given the gradual nature of the Plan's reforms, assessing its long-term impact on the health care system is critical to evaluating its merits. Relative to the ACA, we estimate that the proposal will do the following:

- Over the first ten years, the Plan will reduce federal spending by $283 billion and federal revenues by $254 billion, for a net deficit reduction of $29 billion.
- Over the first ten years, the Plan will reduce state tax revenues by $331 billion, offset by a larger reduction in net state Medicaid spending due to the transfer of acute-care Medicaid enrollees into the universal tax credit system.
- Over the first 30 years, the Plan will reduce federal spending by approximately $10.5 trillion and federal revenues by approximately $2.5 trillion, for a net deficit reduction of approximately $8 trillion.
- The Plan will render the Medicare Trust Fund permanently solvent, if the entirety of the proposal's Medicare savings were applied to the trust fund instead of toward deficit reduction.

We do not model the effects of this proposal on Treasury bond prices: the benchmark for the federal government's borrowing costs. However, it would be reasonable to assume that the proposal's substantial fiscal consolidation would lead to lower interest rates, and thereby less federal spending on interest payments.

Lower interest rates—in combination with a reduced tax burden, lower hiring costs, and lower health insurance premiums—should lead to higher economic growth, and thereby additional tax revenue and deficit reduction. We did not model these effects, instead assuming that the Plan has no impact on the CBO's long-term GDP projections.

COVERING MORE PEOPLE, MORE AFFORDABLY, AT HIGHER QUALITY

Policymakers and researchers focus intensely on the number and proportion of U.S. residents with health insurance coverage. There is,

however, far less focus on the *quality* of the coverage that Americans receive. As noted above, enrollees in Medicaid—and, to a lesser extent, Medicare—suffer from poorer access to physician care, and thereby poorer health outcomes, compared with individuals with employer-sponsored private coverage.

A central tenet of the Universal Tax Credit Plan is that offering subsidized, private coverage to the population currently eligible for Medicaid will improve the degree to which low-income Americans can gain access to physician care, and thereby to improved health outcomes.

In order to gauge the impact of the Plan on these individuals, we employed two indices developed by Stephen Parente and colleagues at the University of Minnesota: the Patient to Provider Access Index (PAI), measuring the breadth of choice of doctors and hospitals in a given plan; and the Medical Productivity Index (MPI), measuring health outcomes for different coverage arrangements.

Over the entire non-elderly adult population, relative to current law, we estimate that the Universal Tax Credit Plan will increase average provider access—as measured by PAI—by 4 percent. Those individuals who migrate from the traditional Medicaid acute-care program onto the reformed individual insurance markets are estimated to experience a substantial improvement in PAI: 98 percent.

Over the entire non-elderly adult population, relative to current law, the Universal Tax Credit Plan is estimated to increase average health outcomes—as measured by MPI—by 21 percent.

As with PAI, those individuals who migrate from the traditional Medicaid acute-care program onto the reformed individual insurance markets are estimated to experience a much more dramatic improvement in PAI: 159 percent.

The HSI microsimulation model indicates that the Universal Tax Credit Plan's reforms to the individual market would reduce the average cost of commercial insurance premiums by 17 percent for single policies and 4 percent for family policies. Despite the lack of an individual mandate, HSI models the Universal Tax Credit Plan as increasing health insurance coverage. If the Plan were adopted in 2016, 12.1 million more individuals would gain health insurance coverage by 2025 relative to current law.

A FAR-REACHING HEALTH-REFORM PROPOSAL

The Universal Tax Credit Plan contemplates a broad range of far-reaching reforms to the U.S. health care system.

We have estimated the fiscal effects of the Plan over three decades, but considerable uncertainty surrounds all long-term projections. The Congressional Budget Office assumes that, from 2016 to 2035, U.S. economic output will grow at an average nominal rate of 4.1 percent per year, and that inflation over the same period will approximate 2.4 percent per year. If long-term inflation is higher, and/or long-term economic growth is slower, the U.S. fiscal picture will worsen considerably, affecting the reach of our proposed reforms.

No proposal to reform the U.S. health care system is immune from trade-offs, and the Universal Tax Credit Plan is no different. What it tries to do is to stitch together ideas from all sides to fix flaws in the system, new and old.

It would increase the progressivity of health care–related federal outlays and tax expenditures. It would spend less subsidizing insurance for high-income employed and retired individuals, but spend more on insurance for the poor and the uninsured. However, it would do so not by employing a single-payer, government-run system, but rather by migrating low-income Americans and younger retirees into private, consumer-driven insurance plans.

Many people have justly criticized the ACA for its complexity and length. Legislative language for the Universal Tax Credit Plan, while not nearly as complex, will not fit onto two pages. The Plan seeks to expand coverage and reduce costs while minimizing disruption to the currently insured, an

approach that requires addressing the existing complexities of a health care system that consumes $3 trillion a year.

Those who believe that there is no legitimate role for the federal government in funding health coverage for the uninsured may not find it satisfactory that the Plan preserves that role. Also left unsatisfied may be those who believe that the existence of private insurers is morally illegitimate.

In contrast to some other areas of public policy, however, it is possible for both progressives and conservatives to achieve important objectives under the Universal Tax Credit Plan.

The Plan brings us closer to true universal coverage. It permanently stabilizes the fiscal condition of the United States, by reducing the federal deficit by approximately $8 trillion over its first three decades and, over the long term, by encouraging U.S. gross domestic product to grow at a faster rate than federal health care spending.

It sows the seeds for a consumer-driven health care revolution, one that could substantially improve the quality of health care that every American receives, and restore America's place as the world's most dynamic economy.

Most importantly, it addresses one of the most significant economic challenges facing low- and middle-income Americans: ensuring that every American has access to high-quality health coverage; now, and for decades to come.

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Preface

To the Second Edition

The first edition of *Transcending Obamacare* was published in August 2014, seven months after the law's key provisions had gone into effect.

In the two years since then, there have been a number of new developments in American health care, both inside and outside of the Affordable Care Act. For those who are struggling to afford health coverage and care, the news has been worse than expected.

RATE SHOCK SUPPRESSES ENROLLMENT

The *individual* or *non-group* health insurance market is of particular importance to those with below-median incomes, because it is the market that serves those who do not receive employer-sponsored health insurance and who do not qualify for other federal programs like Medicare, Medicaid, and the Veterans Health Administration.

While there was considerable evidence prior to 2014 that the ACA's regulatory scheme would substantially increase premiums in the individual market, the concept of "rate shock" was highly controversial.[i] Today, rate shock is an incontrovertible fact, and it has made affordable coverage elusive for tens of millions of Americans. Premiums have continued to rise on the ACA exchanges; cumulatively, median premiums have more than doubled in the ACA's first four plan years (49 percent in 2014, 7 percent in 2015, 11 percent in 2016, and 22 percent in 2017, for a cumulative increase of 116 percent).[ii]

Enrollees with incomes near the Federal Poverty Level have been insulated from these changes, because the ACA nearly fully subsidizes their premiums, co-pays, and deductibles.

As ***Figure i*** notes, 81 percent of those with incomes between 100 and 150 percent of FPL eligible for subsidized coverage on the exchanges have enrolled; however, only 17 percent of those with incomes between 301 and 400 percent of FPL have.[iii, iv]

This is because, as one goes up the income scale, the ACA's premium subsidies do not compensate for the much higher gross premiums that insurers have been forced to charge.

As a result, enrollment in the ACA exchanges has fallen well below originally projected levels. As shown in ***Figure ii***, the Congressional Budget Office had originally projected that 21 million individuals would be enrolled in the exchanges in 2016; the actual figure was 12 million.[v]

Based on a median household size of 2.54 and median income of $52,250 in 2015, the median FPL is approximately 286 percent; hence, a majority of those with incomes below the U.S. median, and eligible for exchange-based coverage, have not enrolled.

THE LARGEST INSURERS ARE ENDING THEIR EXCHANGE PARTICIPATION

In 2016, UnitedHealth, Aetna, and Humana all announced that they are planning to cease participation in the ACA exchanges, due to losses they have absorbed. United has reported that it lost more than $720 million in 2015 on exchange-based plans; Aetna lost $200 million and Humana $176 million.[vi-viii]

Non-profit Blue Cross plans have lost more than $2 billion over that time frame, including $1.5 billion alone from the Health Care Services Corporation, the Blue insurer covering Illinois, Texas, Montana, New Mexico, and Oklahoma.[ix]

The withdrawing insurers cited a constantly-changing

set of implementation rules regarding enrollment in the exchanges as a major driver of higher than expected costs. Furthermore, while insurers expected ACA enrollees to be sicker and older than average, enrollees were even more so than they expected, leading to higher claims costs.

An additional problem is that two of the ACA's risk mitigation strategies—risk corridors and reinsurance—will expire at the end of 2016. Both programs were designed to provide a financial cushion to insurers if their claims (i.e., health care costs for enrollees) exceeded premiums (revenues from enrollees). As those programs expire, insurers will have to raise premiums even higher, knowing that they will be fully exposed to any excess costs.

There is considerable evidence that lower premiums in a given ACA market are correlated with greater competition; hence, the withdrawal of these large insurers is likely to lead to further premium increases in the future.

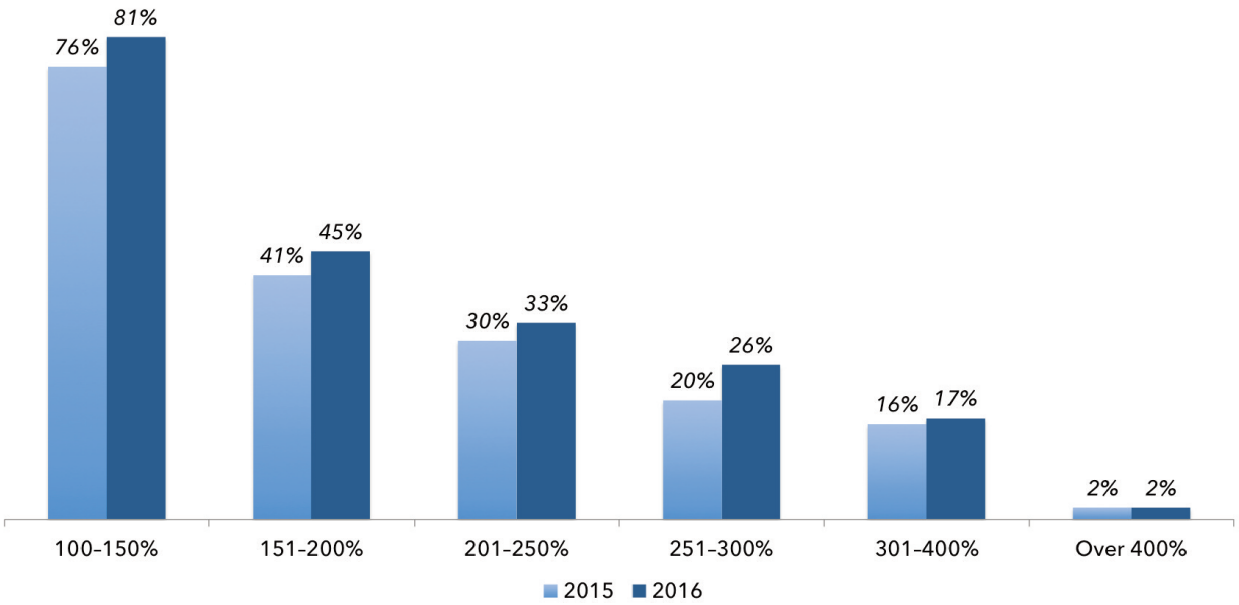
For example, a 2015 study by Milliman found that the entrance of one additional insurer to a given ACA market was correlated to a reduction of $6.50 per member per month for 21-year-olds purchasing the second least expensive "silver" plan.[x] Another 2015 study by Leemore Dafny and colleagues associated UnitedHealth's presence in an ACA market with a 5.4 percent decrease in premiums.[xi]

THE VETERANS HEALTH ADMINISTRATION SCANDAL

THE U.S. HEALTH CARE SYSTEM FOR VETERANS IS fully socialized, with the federal government providing the insurance, owning the providers, and employing the physicians who provide care. While problems with VA care are longstanding, efforts to reform the VA run into resistance from those who are comfortable with, or benefit from, the incumbent system.

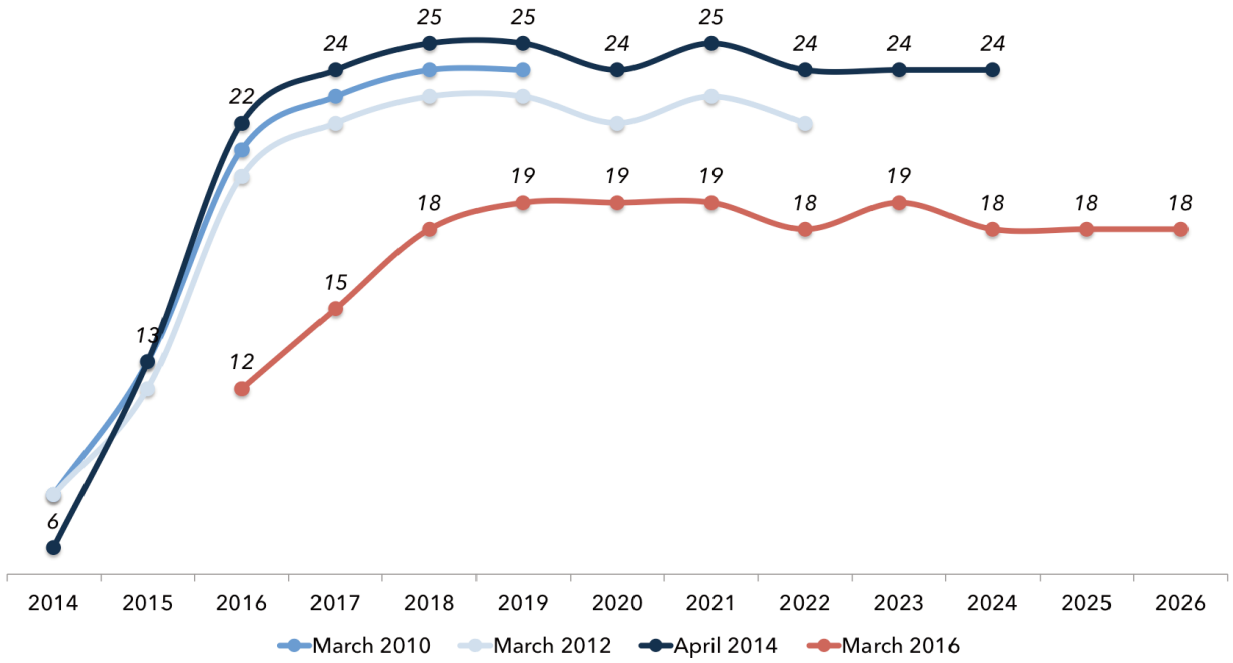
In April 2014, CNN reported that 40 U.S. veterans died while awaiting care at Veterans Health Administration facilities in Phoenix. Later, it came to light that VA officials around the country were falsifying patient wait lists in order to claim that veteran patients were being seen in a timely fashion.

Figure i. Percentage of Eligible Individuals in Exchange Plans, by Income (% of Federal Poverty Level)



ACA premium subsidies are not sufficient to compensate for higher ACA gross premiums. The ACA's premium increases, driven by the law's extensive regulations of the individual insurance market, exceed the subsidies that most Americans are eligible for. As a result, as one ascends the income scale, net premiums are costlier today than they were prior to the debut of the exchanges in 2014. *(Source: Avalere Health, HHS Assistant Secretary for Planning and Evaluation)*

Figure ii. CBO Exchange Enrollment Projections Over Time (Millions of Enrollees)



2016 enrollment is 9 million short of CBO's 2010 estimates. The Congressional Budget Office has significantly reduced its estimates of exchange enrollees. CBO remains optimistic that enrollment will increase substantially in 2017 and 2018; these estimates are likely to decrease over time. The above figures include both subsidized and unsubsidized participants. *(Source: Congressional Budget Office)*

Rob Nabors, President Obama's Deputy Chief of Staff, described the VA's problems as the result of "significant and chronic system failures" and a "corrosive culture."[xii] Kenneth Kizer, a former leader of the VHA, said that "The culture of the VA has become rather toxic, intolerant of dissenting views and contradictory opinions. They have lost their commitment to transparency."[xiii] These developments have provided renewed momentum to VA reformers.

HIGH DRUG PRICES BECOME INCREASINGLY CONTROVERSIAL

The high price of prescription medicines in the United States has been commented upon for many years. But complaints about high drug prices reached a crescendo after Matrin Shkreli, founder of Turing Pharmaceuticals, raised the price of Daraprim from $13.50 per pill to $750: a 5,456 percent increase.[xiv]

Daraprim was approved by the FDA in 1953, and its patents expired decades ago, but no generic version was available, giving Turing a monopoly on the drug's production, and its use for life-threatening diseases such as toxoplasmosis.

While Turing's pricing policies garnered the most media conroversy, they only differ in degree, not kind, from the practices of many established pharmaecutical companies.

Among policymakers, however, the debate about drug prices did not change. Progressives argued for price controls, and conservatives, opposing price controls, argued for the status quo.

BUILDING THE 'UBER OF HEALTH CARE'

The last several years have witnessed an explosion in venture capital funding of digital health companies: companies that aim to deploy the internet and related technologies to improve health care.

In 2015, venture capital supplied $4.5 billion in fund-

ing to digital health startups, compared to $1.1 billion in 2011: an annualized growth rate of 32 percent.[xv]

Digital health harbors the promise of doing more to improve the quality of health care delivery than any other initiative. However, the ability of digital technologies to improve health care is severely hampered by antiquated regulations and organized rent-seeking.

For example, in April 2015, the Texas Medical Board enacted draconian restrictions on the practice of *telemedicine*, i.e., the use of telephones, e-mail, and videoconference technologies between doctors and patients.

Many Texan physicians were concerned that telemedicine would expose them to competition from out-of-state physician practices. The ruling of the Texas Medical Board is now the subject of litigation in the federal appeals court system.

REFORM THE ACA OR REPLACE IT?

The debate among policymakers as to how best to reform the health care system has evolved since 2014. Democratic presidential nominee Hillary Clinton has promised to "defend and expand the Affordable Care Act" by adding a government-run health insurer to the ACA exchanges, and by allowing those over 55 to "buy into Medicare."[xvi]

Republican nominee Donald Trump has to "ask Congress to immediately deliver a full repeal of Obamacare" on the first day of his administration. Among other things, he would replace the law with reforms that would allow individuals to buy insurance across state lines, and allow all Americans to fully deduct their health insurance premiums from their income tax liabilities.[xvii]

Paul Ryan, the Republican House Speaker, has proposed repealing the ACA and replacing it with a system of non-means-tested tax credits that would subsidize, to a lesser degree than the ACA, the purchase of health coverage.[xviii]

Few of these proposals are likely to make it into law. Many of Mrs. Clinton's measures, including the "public option," were debated during the drafting of the ACA in 2009, and could not pass the U.S. Senate when Democrats controlled 60 votes in that body. Similarly, Republican proposals that would lead to fewer Americans possessing health coverage—as Mr. Trump's plan would—stand little chance of gaining the support of 60 senators, and thereby overcoming a filibuster.

Hence, there remains a critical need to identify opportunities for bipartisan reform that can help the uninsured afford coverage, while also improving the quality and fiscal sustainability of U.S. health care.

New in the second edition of *Transcending Obamacare* are sections on reforming veterans' health care, reducing the cost of prescription drugs, and deploying digital technologies to improve health care quality. We have preserved the original plan's fiscal modeling; hence, these additional proposals are not counted toward the plan's estimates for deficit reduction.

The core theme remains the same. *Transcending Obamacare* provides a bipartisan path for improving health outcomes for the poor, reducing the cost of coverage, and increasing the number of Americans with health insurance, all with less regulation, spending, and taxation than we have today.

Introduction

One of the principal economic challenges faced by middle- and lower-income Americans is the expense and instability of American health insurance. Health insurance keeps getting more and more expensive, forcing many families to choose between paying health care bills and buying other essential goods and services.

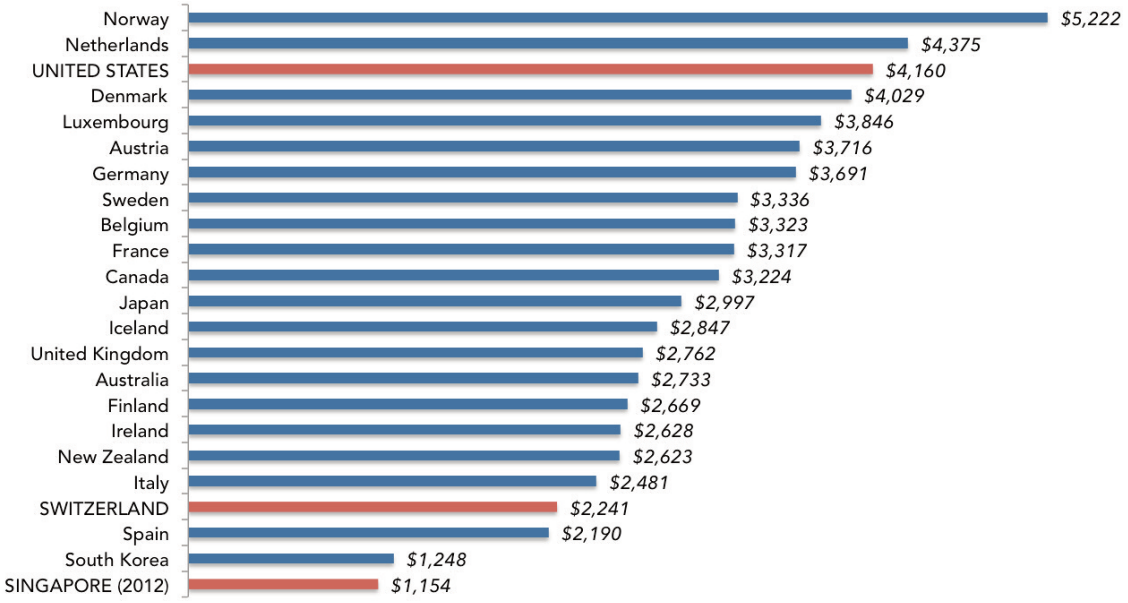
Furthermore, there is no issue more important to the future of low-income Americans than America's long-term fiscal sustainability. Those who most rely on government support will be most exposed to the draconian spending cuts that a full-fledged fiscal crisis would precipitate. The long-term fiscal sustainability of the United States, in turn, has been placed in jeopardy primarily by the structure and expense of America's federally sponsored health insurance programs.

These problems, rightly, remain at the center of our public policy debate. Our political system has, thus far, failed to solve them. They require our urgent attention.

THE HISTORICAL LEFT-RIGHT DIVIDE ON HEALTH CARE

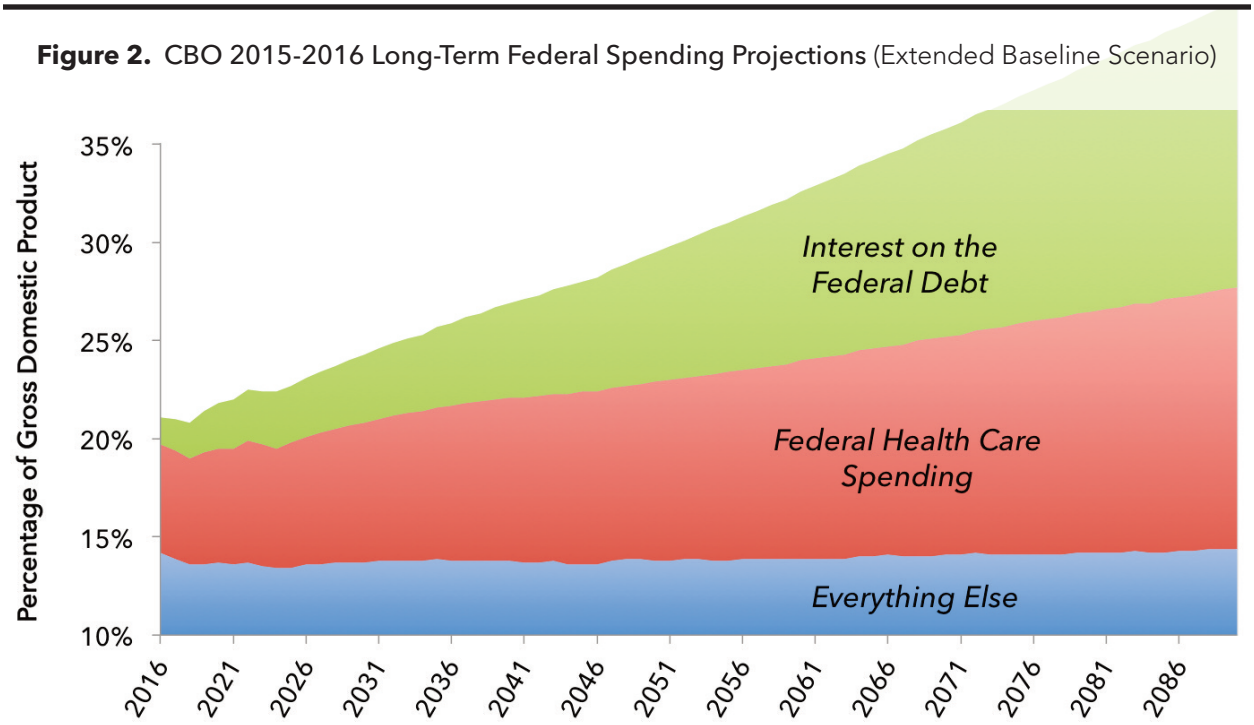
For nearly a century, the progressive movement has sought to build a comprehensive, government-

Figure 1. 2013 Public Health Expenditure per Capita (US$ purchasing power parity–adjusted)



Both single-payer and market-based systems outperform the U.S. Contrary to perception, U.S. government entities spent far more than their European peers on health care prior to the ACA. While single-payer systems like Canada's spend less than the U.S., market-oriented systems in Singapore and Switzerland are far more fiscally efficient. *(Source: OECD, WHO, A. Roy analysis)*

Figure 2. CBO 2015-2016 Long-Term Federal Spending Projections (Extended Baseline Scenario)



sponsored system of national health insurance that would guarantee health coverage for every resident of the United States.

For just as long, American conservatives have resisted federal attempts to subsidize health coverage, on the grounds that the provision of health insurance is not an appropriate, constitutionally enumerated role for the federal government.

Both sides have often agreed on the distinct feature of America's health care system: that it is a "free market" one, in contrast to those of the social democracies of western Europe. For the Left, this is seen as a flaw to be corrected; for the Right, it is a virtue to be preserved. For better or worse, however, the United States has not had a free-market health care system for generations.

As ***Figure 1*** illustrates, in 2013, according to the Organization for Economic Co-operation and Development (OECD), U.S. government entities collectively spent $4,160 per capita on health care, the third-highest such total in the world.[1]

Notably, these figures represent America's standing prior to the implementation of the ACA's spending provisions in 2014. On a per-capita basis, the vast majority of universal health care systems in the industrialized world spend less taxpayer money than does that of the U.S.

There are many things that American health care does well. Since the end of World War II, more than half of all Nobel laureates in medicine or physiology have been American. The U.S. remains the unparalleled world leader in pharmaceutical, biotechnology, and medical device innovation. People from all over the world come to America to seek treatment for rare or complex diseases.

However, according to the Congressional Budget Office, nearly the entirety of the growth in federal spending as a share of the economy—excluding interest—can be explained by government health programs: Medicare, Medicaid, the Medicaid-related Children's Health Insurance Program, and the Affordable Care Act (***Figure 2***).[2]

Put simply, America's long-term fiscal sustainability can be achieved only by ensuring the fiscal sustainability of its public health care programs.

Of equal importance is the fact that the high cost of American health care has left many low- and middle-income Americans without the financial security that health insurance can provide.

These two problems are inextricably linked, and present us with an opportunity. By reducing the cost of health care and coverage, and reforming our public health insurance programs accordingly, we can increase the number of Americans with health coverage, expand economic opportunity for those struggling with high medical bills, improve the quality of health care for the poor, and put America's balance sheet on permanently stable footing.

THE ACA LEAVES MANY PROBLEMS UNSOLVED, AND EXACERBATES OTHERS

While the Affordable Care Act is projected to reduce the number of uninsured U.S. residents, the CBO estimates that in 2024, there will remain 23 million lawful U.S. residents without health insurance under the new law.[3]

Furthermore, a substantial portion of the Affordable Care Act's health coverage expansion will be delivered through the Medicaid program. The Medicaid program has the poorest health outcomes of any health insurance system in the industrialized world.[4]

In 2013, a study published in the *New England Journal of Medicine* found that Medicaid "generated no significant improvement in measured physical health outcomes" relative to being uninsured.

The ACA may have a negative impact on U.S. medical innovation, by imposing an excise tax on pharmaceutical and medical device sales that will disproportionately affect early- and mid-stage companies: the ones most likely to be developing new therapies and new technologies.

The Affordable Care Act will increase the cost of health coverage for those with private-sector insurance. A Manhattan Institute study found that, among those who purchase coverage on their own, the average state has seen an increase in underlying premiums of 41 percent in 2014 relative to 2013.[5]

A follow-on study found that the average county will experience a premium increase of 49 percent over the same period.[6] Many individuals with employer-sponsored coverage are also experiencing increased health care costs under the law. Despite the fact that the U.S. already spends an enormous amount on publicly financed health care, the ACA is slated to increase federal spending on health care by approximately 15 percent, when fully implemented.

Hence, while the ACA has made a substantial dent in

Figure 3. CBO Projection of New Federal Health Spending Due to ACA, vs. Prior Law (Billions)

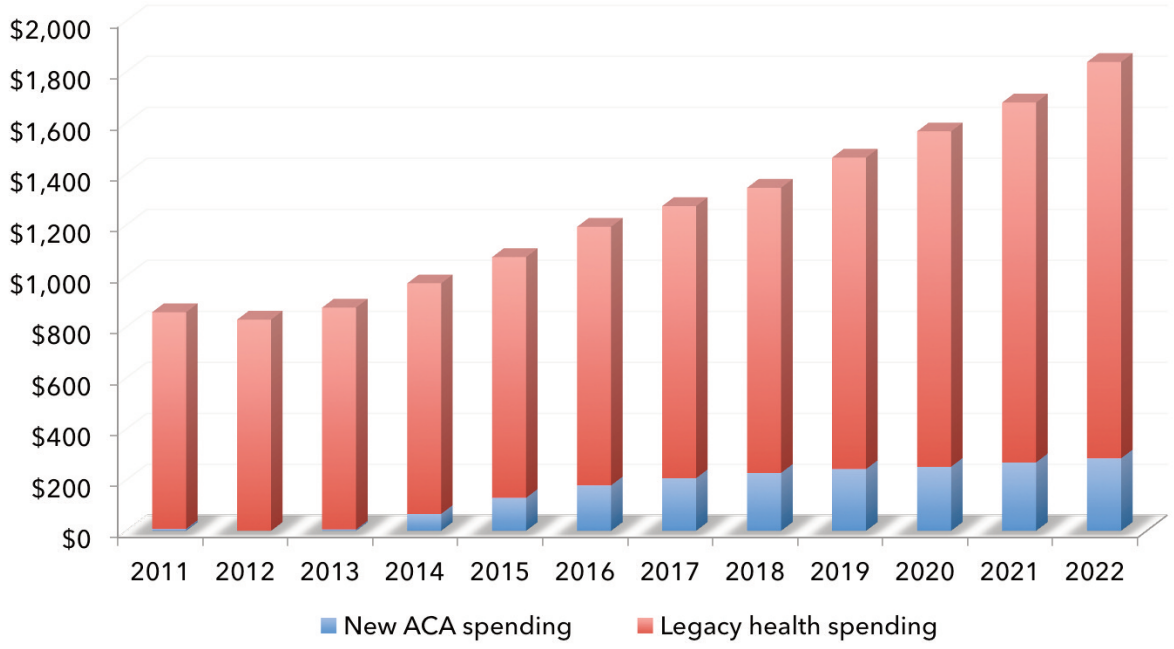
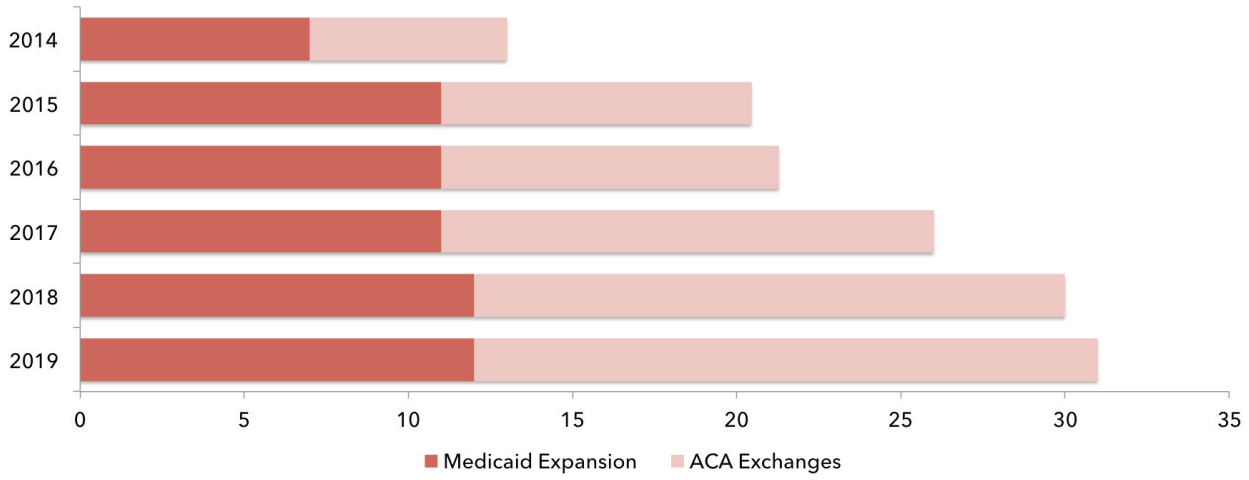


Figure 4. Actual & CBO Estimates of U.S. Residents on ACA-Sponsored Coverage, 2014–19 (Millions)



the number of Americans who are uninsured, it has done so by exacerbating several other long-standing problems with the U.S. health care system. The law will meaningfully increase America's already unsustainable level of government health care spending, as shown in ***Figure 3***. It has also increased the cost of health coverage for tens of millions, if not hundreds of millions, of Americans.

Rather than address the severe problems with quality and outcomes in Medicaid, the ACA expanded the existing, unreformed program. This expansion will place additional pressure on physicians to drop out of the program, worsening the program's health outcomes. Similar reimbursement pressures, exacerbated by the ACA, may lead to decreased provider access for Medicare-enrolled retirees.

Hence, there is an urgent need to reform the U.S. health care system as a whole, including the parts that the ACA has changed for the worse.

MINOR, TECHNICAL CHANGES ARE NOT SUFFICIENT TO ADDRESS ACA'S WEAKNESSES

In Congress, debate about the Affordable Care Act has focused on two general lines of thought. Supporters of the law argue that it is essentially fine as is, though it could be improved by minor, technical changes. This view, for the reasons outlined above, is not a satisfactory response to the serious challenges that the U.S. health care system continues to face.

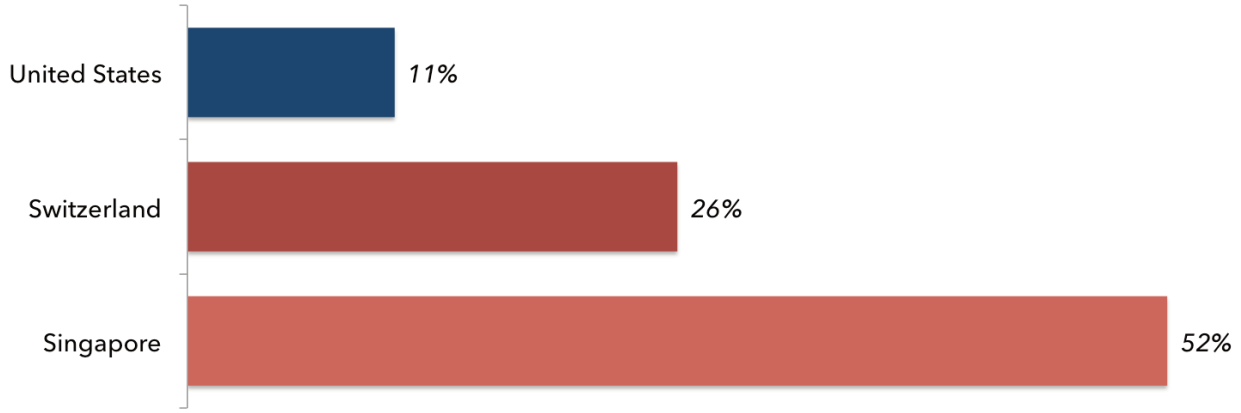
Opponents of the law argue that it can be "repealed and replaced" by a more attractive alternative. While this is theoretically possible, as a policy strategy it faces three challenges: (1) full repeal of the ACA, under current Senate rules, will require at least 60 senators to vote for it, something that is extremely improbable; (2) repealing the ACA would cause a considerable amount of disruption to the 26 million Americans who, as ***Figure 4*** illustrates, may be on ACA-sponsored insurance by 2017; (2) by focusing only on the Affordable Care Act, "replace" plans often fail to address the deep, underlying problems with the health care system that predate the ACA.

There is, however, a way to make substantial changes to the Affordable Care Act and also to the preexisting set of U.S. health care entitlements. By tackling both problems at once, such an approach could expand health coverage to higher levels than that of the ACA, while addressing the cost and quality problems that the law has failed to solve.

LEARNING FROM SWITZERLAND AND SINGAPORE

The good news is that we do have real-world models for market-oriented, cost-effective health reform. Notably, two wealthy nations—Switzerland and

Figure 5. 2011 Out-of-Pocket Spending, as a Percentage of National Health Expenditures



The U.S. does not have a consumer-driven health care system today. One way to compare the degree of consumer-driven health care in advanced economies is to examine the percentage of national health spending that consumers pay for directly, rather than through third parties (i.e., insurance). Health savings accounts–the key instruments of consumer-driven care–are more widespread in Switzerland, and especially in Singapore. *(Source: OECD, WHO, A. Roy analysis)*

Singapore—spend a fraction of what the U.S. does on health care subsidies, and yet have achieved universal coverage with high levels of access and quality. Neither the Swiss nor the Singaporean health care systems could be described as libertarian. Nor are they single-payer, government-dominated systems.

In 2012, the Singaporean government spent $1,154 per capita on health care: one-fourth of what the U.S. spent, on a purchasing power parity–adjusted basis.[7]

Singapore has achieved this using a universal system of consumer-driven health care. The government funds catastrophic coverage for every Singaporean, and reroutes a portion of workers' payroll taxes into health savings accounts that can be used for routine expenses.

While Singapore-style health care would not be easy to adopt in the United States, given the ample differences in the two countries' political systems, Singapore does show us the economic power of returning health coverage to the insurance model used in other parts of the economy: catastrophic coverage that protects against large financial loss, with health savings accounts that give consumers control over their own health care dollars. According to the World Health Organization, as noted in ***Figure 5***, 52 percent of Singaporean health spending is out-of-pocket, compared with only 11 percent in the United States.

Biotech entrepreneur William Haseltine, now at the Brookings Institution, observes in his book *Affordable Excellence: The Singapore Healthcare Story* that Singapore has proved "that healthcare systems can be designed that provide high-quality healthcare to all citizens in a highly developed economy at a cost the economy can afford, and that costs can be controlled while delivering excellent service."[8]

Switzerland subsidizes, on a sliding scale, the premiums its citizens pay for private health insurance: a system known in the U.S. as "premium support." There are no "public option" government insurers in Switzerland, unlike in the United States, where nearly one-third of the population is enrolled in single-payer health care (***Figure 6***). In Switzerland, low-income individuals are fully subsidized; middle-income individuals are modestly subsidized; and upper-income individuals are not subsidized.

The sliding subsidy scale mitigates one of the key challenges with traditional welfare programs, in which recipients are no longer eligible for a defined benefit once their income exceeds a specified threshold.

These "benefit cliffs" discourage welfare recipients from seeking additional work, because by increasing their wage income, they are decreasing their *overall* income, once the value of the rescinded welfare benefits is taken into account.

The Swiss system shares some of the unattractive features of the ACA. The Swiss heavily regulate the types of health care services that insurers must offer, leading to higher costs and less innovation. Younger individuals must pay a steep premium well in excess of the cost of insuring against their actual health risks, and they are given no choice but to pay it, through an individual mandate.

But because Switzerland focuses its public resources solely on lower-income individuals, the federation's universal coverage system is far more efficient than America's. Only one-fifth of Swiss citizens receive federal health insurance subsidies, whereas nearly four-fifths of Americans do. In 2013, Switzerland public entities spent approximately $2,241 per capita on health care: 54 percent of U.S. public spending.[9]

Put another way, if U.S. government health spending were proportional to Switzerland's, the United States would be able to eliminate its budget deficit. While Switzerland spends more on health coverage than Singapore does, a modified version of the Swiss system is a more realistic—and more attractive—path for U.S. reform.

Some might contend that Switzerland is not a useful model for U.S. health reform because the Alpine federation is demographically dissimilar to the United States. But Harvard's Regina Herzlinger conducted a study comparing Switzerland's performance with that of certain U.S. states, such as Massachusetts and Connecticut, whose demographics and population densities are similar to Switzerland's.[10] Concluded Herzlinger, "Swiss health care expenses are considerably lower than those of the United States and comparable states, while outcomes for cerebrovascular disease and diabetes, which are linked to the socioeconomic characteristics we selected, are roughly equal or better."

An irony of the polarized health care debate in the United States is that there are some common elements between Democratic and Republican health-reform proposals.

The ACA deploys Swiss-style private insurance for the low-income population. And the model of Medicare reform most widely espoused by Republicans involves adapting the Swiss model to Medicare: migrating future retirees into a system under which seniors would be given premium support subsidies, tied to a benchmark plan, to shop for private health insurance.

Variations of this proposal have been endorsed by the House of Representatives, led by Speaker Paul Ryan, in several recent annual budget resolutions, and most recently in the Medicare section of the "A Better Way" series of policy proposals.

Premium support was also embraced by former Massachusetts Gov. Mitt Romney in his 2012 presidential campaign. And, as discussed above, the ACA's exchanges, designed to offer subsidized private coverage to the uninsured, are also modeled after the Swiss system.

Hence, it is possible to conceive of a new path for health care and entitlement reform—one that learns from Switzerland's experience with premium support, and Singapore's experience with health savings ac-

Figure 6. Percentage of Population on Single-Payer Health Care (Excludes Medicare Advantage)

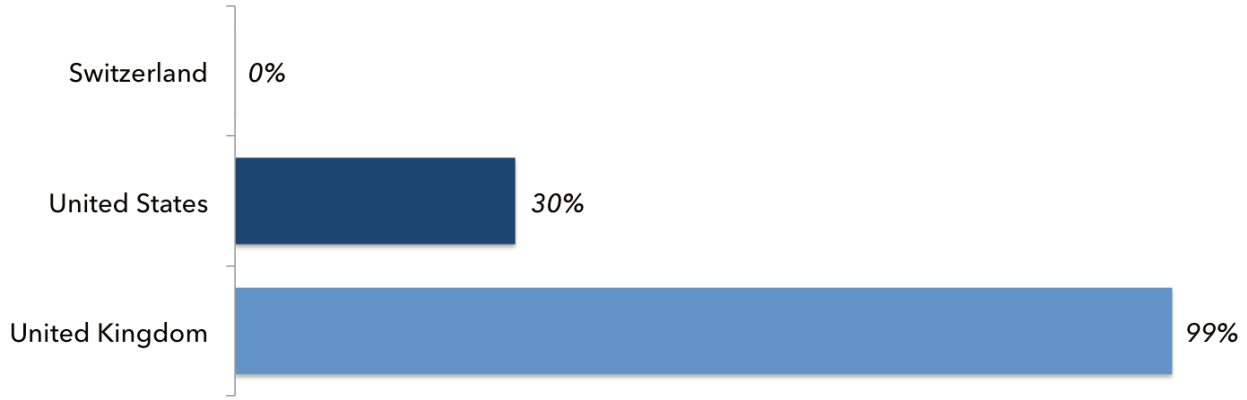
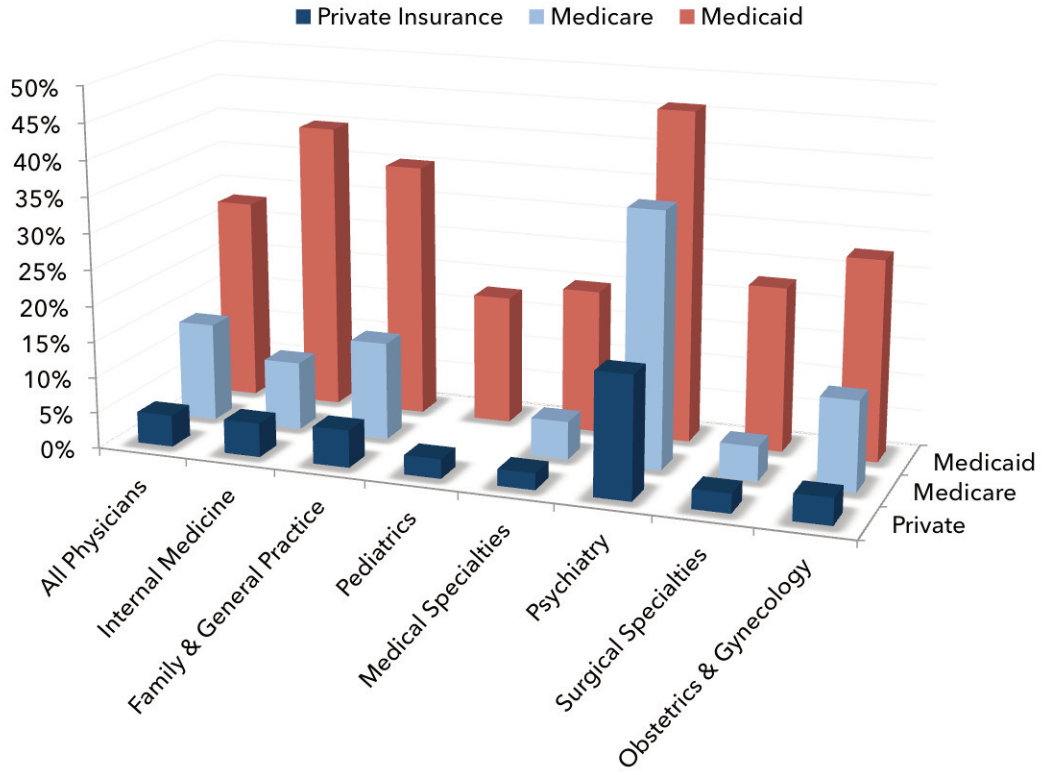


Figure 7. Proportion of Physicians Who Accept No New Patients, by Insurance Status, 2008



Fewer physicians are willing to see Medicaid and Medicare enrollees. The 2008 Health Tracking Physician Survey found that individuals with commercial health insurance enjoyed broad access to physicians, while those in Medicaid–and increasingly Medicare–do not. Reimbursement rates for Medicaid and Medicare, relative to private insurance, have fallen since 2008, suggesting that these access gaps have widened further. *(Source: Center for Studying Health System Change)*

counts—to place America's health care system on permanently stable footing.

UNIVERSAL, MEANS-TESTED TAX CREDITS: A NEW HEALTH-REFORM OPTION

This monograph proposes a Universal Tax Credit Plan, in order to achieve five goals: (1) to expand health insurance coverage well above ACA levels, without an individual mandate; (2) to improve the quality of coverage and care for low-income Americans; (3) to achieve the permanent solvency of U.S. health care entitlements; (4) to reduce the federal deficit without raising taxes; and (5) to reduce the cost of health insurance for individuals and businesses.

The Universal Tax Credit Plan—hereafter referred to as "the Plan"—proposes to achieve these goals in a manner that is minimally disruptive to those who favor their current arrangements.

The proposal would use means-tested refundable tax credits as a mechanism for reforming entitlements, expanding coverage, and improving the quality of health care delivery. These tax credits would differ from those in the ACA insofar as the federal government would have far less of a role in prescribing the way individuals obtain health coverage.

There are five core elements of the Plan:

Premium assistance. The Plan repeals the ACA's individual mandate requiring most Americans to purchase government-certified health coverage. The Plan restores the primacy of state-based insurance markets and state-based insurance regulation. It expands the flexibility of insurers to design non-group policies that

are more attractive to consumers, because they are of higher quality at a lower cost. The Plan expands access to health savings accounts. Because these reforms lower the cost of insurance for younger and healthier individuals, they have the potential to expand coverage, despite the lack of an individual mandate.

Employer-sponsored insurance reform. The Plan repeals the ACA's employer mandate, thereby offering employers a wider range of options for subsidizing workers' coverage. The Plan replaces the ACA's "Cadillac tax" on high-cost health plans with a standard deduction for employer-sponsored health insurance. It repeals other taxes, and reforms other regulations that artificially drive up the cost of employer-based insurance.

Medicaid reform. The Plan migrates the Medicaid *acute-care* population onto the reformed private individual insurance market, with 100 percent federal funding and state oversight. (Medicaid acute care is a form of conventional insurance for hospital and doctor services.) In exchange, the Plan returns to the states, over time, full financial responsibility for the Medicaid *long-term care* population. (Long-term care funds nursing home stays and home health visits for the elderly and disabled.) This clean division of responsibilities will improve coverage for the poor; reduce waste, fraud and abuse; and provide fiscal certainty to state governments.

Medicare reform. The Plan gradually raises the Medicare eligibility age by four months each year. The end result is to preserve Medicare for current retirees, and to maintain future retirees—in the early years of their retirement—on their individual or employer-sponsored health plans. (Today, the government does not allow the newly retired to remain on their old plans; instead, it forces them to enroll in Medicare, or forfeit their Social Security benefits.[11]) In total, these changes would make the Medicare Trust Fund permanently solvent.

Veterans' health reform. The Plan overhauls the Veterans Health Administration, by giving veterans the option of private coverage and care via premium assistance, while improving traditional VA facilities.

Medical innovation. The Plan removes regulatory barriers to the use of the internet, mobile devices, and digital technology in health care. It puts patients in control of their own medical records. It tackles the high cost of innovative medicines, by reforming the FDA regulatory process, and by introducing a more patient-centered, consumer-driven mechanism for keeping high prices in check.

Table 1. Projected Impact of Universal Tax Credit Plan on Patient to Provider Access Index and Medical Productivity Index, 2016–23 Average (Overall and Previously Medicaid-Eligible Populations)

Measured Index	Improvement
Provider Access Index (Overall)	4%
Provider Access Index (Medicaid)	98%
Medical Productivity Index (Overall)	21%
Medical Productivity Index (Medicaid)	159%

Other reforms. The Plan tackles the growing problem of hospital monopolies that take advantage of their market power to charge unsustainably high prices. The Plan reforms malpractice litigation in federal programs.

ASSESSING THE PROPOSAL'S FISCAL EFFECTS

We estimated the fiscal effects of the Universal Tax Credit Plan by utilizing several methodologies.

We first enlisted the peer-reviewed microsimulation model developed by the Health Systems Innovation (HSI) Network, in order to estimate the fiscal and coverage impact of the proposal's reforms to the ACA and the Medicaid program. The HSI microsimulator estimated the impact of the universal tax credit plan on annual premiums, insurance coverage, patients' access to providers, health outcomes, and the federal budget.

The HSI microsimulator assumed that the Plan is implemented in 2016, and estimated federal budget outcomes for two decades: the years 2016–35. Using the long-term growth rates and fiscal trends of the HSI simulation, we then modeled federal budget outcomes for a third decade: the years 2036–45.

As with projections generated by the Congressional Budget Office, estimates of the Universal Tax Credit

Table 2. Projected Change in Private-Sector Premiums Under Universal Tax Credit Plan, vs. Current Law, 2016–23 (by Insurance Category)

Premium vs. Current Law	2016	2017	2018	2019	2020	2021	2022	2023	Avg. 2016–23
Single Policies	**-16.3%**	**-16.6%**	**-16.8%**	**-16.8%**	**-17.2%**	**-17.4%**	**-17.6%**	**-17.7%**	**-17.0%**
High PPO	-9.7%	-9.6%	-9.6%	-9.5%	-9.4%	-9.3%	-9.3%	-9.2%	-9.5%
Medium PPO	-10.0%	-9.9%	-9.8%	-9.7%	-9.6%	-9.5%	-9.5%	-9.4%	-9.7%
Low PPO	-10.4%	-10.3%	-10.1%	-10.0%	-9.9%	-9.8%	-9.8%	-9.7%	-7.5%
Narrow network	-11.0%	-11.0%	-11.0%	-10.9%	-10.9%	-10.9%	-10.9%	-10.8%	-10.9%
HSA/HDHP	-29.0%	-28.7%	-28.4%	-28.0%	-27.7%	-27.4%	-27.1%	-26.8%	-27.9%
Family Policies	**-3.4%**	**-3.5%**	**-3.5%**	**-3.5%**	**-3.6%**	**-3.6%**	**-3.6%**	**-3.7%**	**-3.6%**
High PPO	-1.8%	-1.7%	-1.7%	-1.6%	-1.5%	-1.5%	-1.4%	-1.4%	-1.6%
Medium PPO	-2.0%	-2.0%	-1.9%	-1.8%	-1.7%	-1.7%	-1.6%	-1.5%	-1.8%
Low PPO	-2.3%	-2.2%	-2.1%	-2.1%	-2.0%	-1.9%	-1.8%	-1.8%	-2.0%
Narrow network	-2.3%	-2.2%	-2.2%	-2.2%	-2.2%	-2.2%	-2.1%	-2.1%	-2.2%
HSA/HDHP	-6.4%	-6.4%	-6.3%	-6.2%	-6.2%	-6.1%	-6.0%	-6.0%	-6.2%

PPO = Preferred Provider Organization; HSA/HDHP = Health Savings Account equivalent & High Deductible Health Plan.

Plan's performance beyond the first decade must be understood to harbor considerable uncertainty. However, given the gradual nature of the Plan's reforms, assessing its long-term impact on the health care system is critical to evaluating its merits.

We then supplemented the HSI analysis with additional modeling of reforms to Medicare and Medicaid, based primarily on projections from the Congressional Budget Office and the Centers for Medicare and Medicaid Services. Relative to the ACA, we estimate that the proposal will do the following:

- Over the first ten years, the Plan will reduce federal spending by $283 billion and federal revenues by $254 billion, for a net deficit reduction of $29 billion.

- Over the first ten years, the Plan will reduce state tax revenues by $331 billion, offset by a larger reduction in net state Medicaid spending due to the transfer of acute-care Medicaid enrollees into the universal tax credit market.

- Over the first 30 years, the Plan will reduce federal spending by approximately $10.5 trillion and federal revenues by approximately $2.5 trillion, for a net deficit reduction of approximately $8 trillion.

- The Plan will render the Medicare Trust Fund permanently solvent, if the entirety of the proposal's Medicare savings were applied to the trust fund instead of toward deficit reduction.

We do not model the effects of this proposal on Treasury bond prices: the benchmark for the federal government's borrowing costs.

However, it would be reasonable to assume that the proposal's substantial fiscal consolidation would lead to lower interest rates, and thereby less federal spending on interest payments.

In addition, lower interest rates—in combination with a reduced tax burden, lower hiring costs, and lower health insurance premiums—should lead to higher economic growth, and thereby additional tax revenue and deficit reduction.

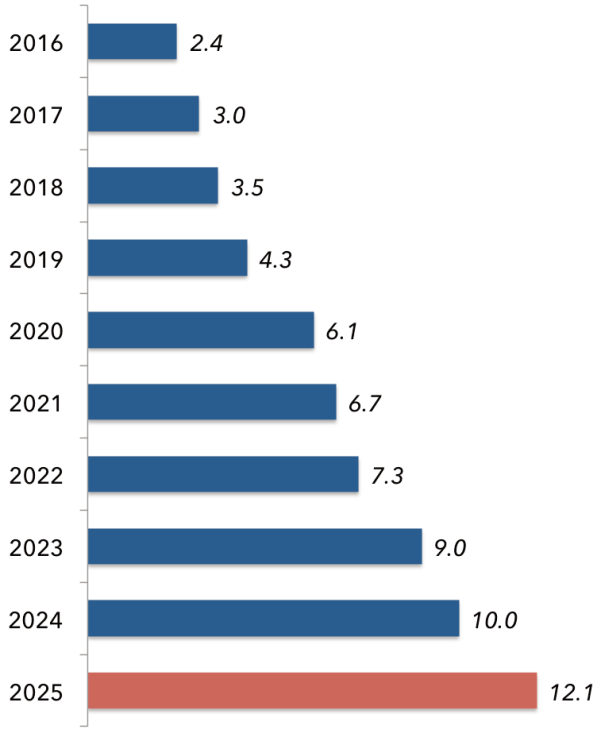
The proposal does not model these effects, instead assuming that the Plan has no impact on the Congressional Budget Office's long-term GDP projections.

ESTIMATING THE IMPACT ON PROVIDER ACCESS AND HEALTH OUTCOMES

Policymakers and researchers focus intensely on the number and proportion of U.S. residents with health insurance coverage. There is, however, far less focus on the *quality* of the coverage that Americans receive. As noted above, enrollees in Medicaid—and, to a lesser extent, Medicare—suffer from poorer access to physician care (***Figure 7***), and thereby poorer health outcomes, compared to individuals with employer-sponsored private coverage.

A central tenet of the Universal Tax Credit Plan is that offering subsidized private coverage to the population currently eligible for Medicaid will improve the degree to which low-income Americans can gain access to physician care, and thereby improved health outcomes. There is strong evidence that the 2006 coverage expansion in Massachusetts—most of which came from its private insurance-based Commonwealth Care program—improved health outcomes in that state.[12]

Figure 8. Projected Coverage Expansion of Universal Tax Credit Plan vs. Current Law, 2016–25 (Millions of U.S. Residents)



In order to gauge the impact of the Plan on these individuals, we employed two indices developed by Stephen Parente and colleagues at the University of Minnesota.

The first index is the *Patient to Provider Access Index* (PAI). The PAI, based on a survey of patient-provider access published by the Parente group, indicates the degree of provider choice available in a given health plan, relative to Medicaid's provider network. A higher score indicates broader access to health care providers.

The second index is the *Medical Productivity Index* (MPI). The MPI was developed by analyzing the Medicare National Claims History File (NCH) and the Resource-Based Relative Value Scale (RBRVS) in order to correlate a patient-level measure of health to the specific health care services that a patient receives.[13] As with the PAI, the MPI is benchmarked to health outcomes under Medicaid.

As summarized in ***Table 1***, over the entire non-elderly adult population, relative to current law, we estimate that the Universal Tax Credit Plan will increase average provider access—as measured by PAI—by 4 percent. Those individuals who migrate from the traditional Medicaid acute-care program into the universal tax credit system are estimated to experience a substantial improvement in PAI: 98 percent.

Over the entire non-elderly adult population, relative to current law, the Universal Tax Credit Plan is estimated to increase average health outcomes—as measured by MPI—by 21 percent.

As with PAI, those individuals who migrate from the traditional Medicaid acute-care program into the universal tax credit system are estimated to experience a much more dramatic improvement in PAI: 159 percent.

These peer-reviewed indices, PAI and MPI, give us cause for optimism that the Universal Tax Credit Plan can expand coverage, reduce the deficit, and improve access to care and health outcomes for the low-income population.

MODELING THE EFFECTS OF UNIVERSAL TAX CREDITS ON COVERAGE AND INSURANCE PREMIUMS

The HSI microsimulation model indicates that

the Universal Tax Credit Plan's reforms to the individual insurance market would reduce the average cost of commercial insurance premiums by 17 percent for single policies and 4 percent for family policies.

As described in ***Table 2***, savings would be greatest for those choosing consumer-driven health plans that combine high-deductible insurance with health savings accounts.

Despite the lack of an individual mandate, HSI models the Universal Tax Credit Plan as increasing health insurance coverage. As ***Figure 8*** illustrates, if Congress and the President were to enact the Plan, HSI projects that 12.1 million more individuals would gain health insurance coverage by 2025, relative to current law.

Let us now examine in detail the features of the Universal Tax Credit Plan.

Part One

Replacing the ACA Exchanges

The concept of subsidized private health insurance—through which low-income individuals can purchase privately sponsored coverage with the help of a defined subsidy or premium support payment—has long attracted advocates across the political spectrum.

PREMIUM SUPPORT'S BIPARTISAN HERITAGE

In 1995, Henry Aaron of the Brookings Institution and Robert Reischauer, former director of the Congressional Budget Office under President Clinton, first proposed a "premium support" system for the reform of Medicare.[14] Under this approach, seniors would be offered fixed subsidies, or defined-contribution payments, that they would then use to purchase private health insurance plans whose terms and scope would be regulated by the government.

The Aaron-Reischauer paper drew upon a 1978 proposal by Stanford economist Alain Enthoven for a "consumer-choice health plan" for universal coverage. The Enthoven concept was to offer subsidies to individuals "based on financial and predicted medical need" to purchase "qualified health insurance or delivery plans" that would contain certain specified features.[15]

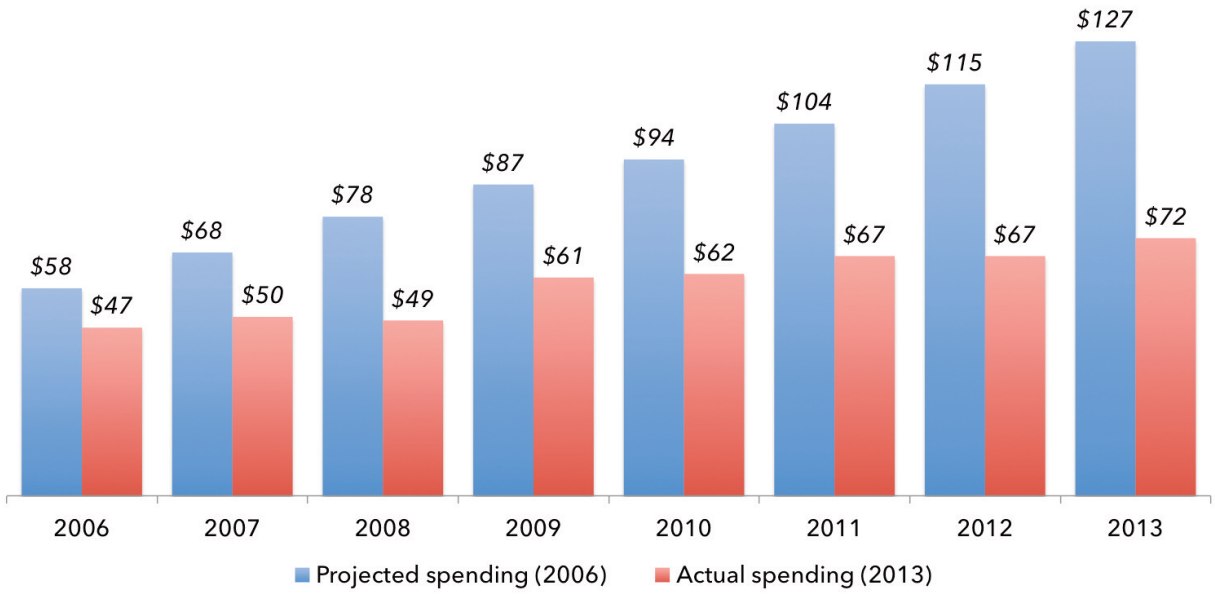
The premium support concept was carried forward in 1999 by the National Bipartisan Commission on the Future of Medicare, led by Democratic Sen. John Breaux of Louisiana, Republican Rep. Bill Thomas of California, and future Republican Gov. Bobby Jindal of Louisiana.[16]

Today, premium support is most closely identified with Republican Rep. Paul Ryan of Wisconsin. Rep. Ryan's "Path to Prosperity" budget resolution for the fiscal year 2015, passed by the House of Representatives, proposes to employ premium support to allow future seniors to purchase coverage on a "newly created Medicare Exchange":[17]

> For future retirees, the budget supports an approach known as "premium support." Starting in 2024, seniors (those who first become eligible by turning 65 on or after January 1, 2024) would be given a choice of private plans competing alongside the traditional fee-for-service Medicare program on a newly created Medicare Exchange. Medicare would provide a premium support payment either to pay for or offset the premium of the plan chosen by the senior, depending on the plan's cost. For those who were 55 or older in 2013, they would remain in the traditional Medicare system.
>
> The Medicare recipient of the future would choose, from a list of guaranteed-coverage options, a health plan that best suits his or her needs. This is not a voucher program. A Medicare premium support payment would be paid, by Medicare, directly to the plan or the fee-for-service program to subsidize its cost. The program would operate in a manner similar to that of the Medicare prescription-drug benefit. The Medicare premium support payment would be adjusted so that the sick would receive higher payments if their conditions worsened; lower-income seniors would receive additional assistance to help cover out-of-pocket costs; and wealthier seniors would assume responsibility for a greater share of their premiums.
>
> This approach to strengthening the Medicare program—which is based on a long history of bipartisan reform plans—would ensure security and affordability for seniors now and into the future.

Premium assistance has long been considered as an approach to broader health reform. Arguably the greatest distortion in the U.S. health care system is the fact that the value of employer-sponsored health coverage

Figure 9. Medicare Part D Spending, Projected by CMS in 2006 vs. Actual (Billions)



is exempt from all taxation: a substantial advantage for those who benefit from this subsidy, relative to independent contractors, unemployed individuals, and employed individuals without an offer for employer-sponsored coverage.

In response to this problem, Edmund Haislmaier of the Heritage Foundation conceived of exchanges as a mechanism for converting the tax exclusion for employer-sponsored health insurance into a defined-contribution payment, whereby individuals could take the cash value of the tax exclusion and use it to shop for the coverage of their choice.

Haislmaier's work found its way into the Massachusetts exchange instituted by Gov. Mitt Romney in 2006 and the Utah exchange implemented in 2009 by Gov. Jon Huntsman and his successor, Gary Herbert.[18]

On two separate occasions, Congress has employed exchanges and premium support for nationwide health reform.

In the first instance, the Medicare Modernization Act of 2003, passed by a Republican Congress and signed into law by President George W. Bush, created a new Medicare prescription drug benefit using the premium support approach.

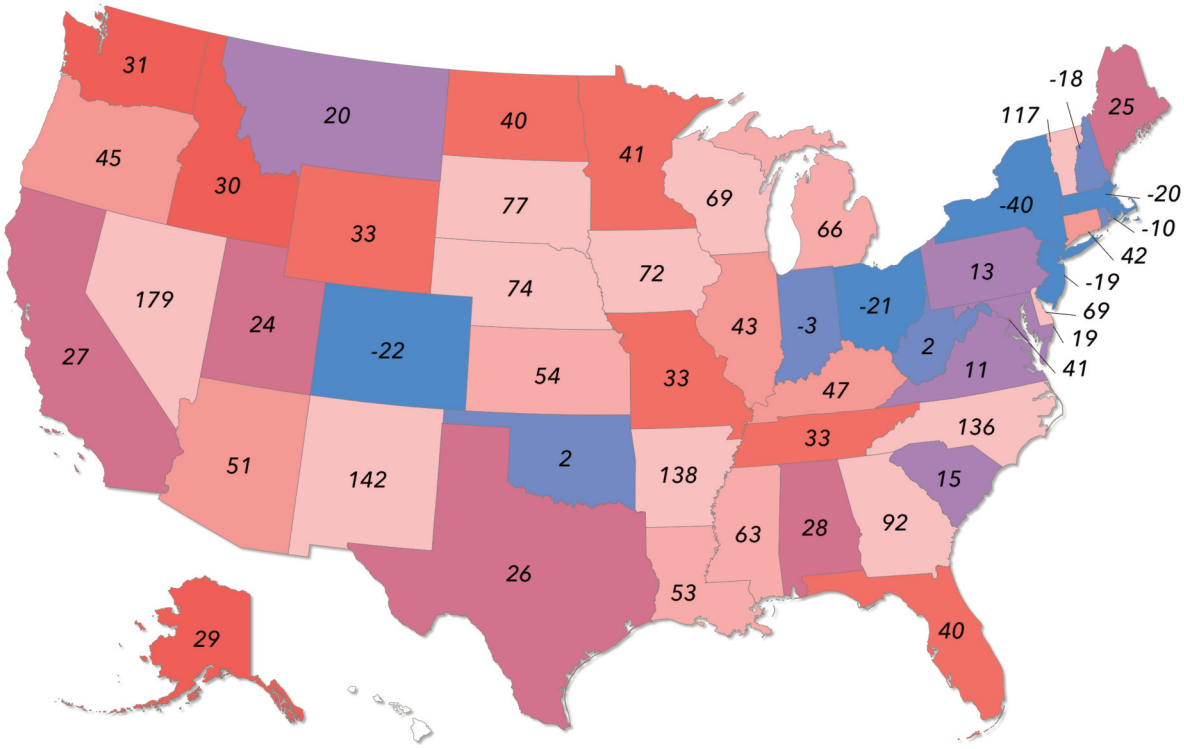
While the Medicare drug benefit—also known as Part D—was highly controversial at the time because it was not funded by additional tax revenue or spending reductions, its annual program costs have come in vastly below government projections.

For example, in 2006, the Medicare Trustees projected that 2013 Part D spending would total $127 billion. In fact, as shown in ***Figure 9***, the program cost only $72 billion that year—43 percent below the earlier projection.

Most famously, the Affordable Care Act has created a nationwide set of exchanges through which to subsidize health insurance for individuals with incomes below 400 percent of the Federal Poverty Level—in 2014, $46,680 for a childless adult—who are not otherwise eligible for Medicaid. Other individuals who wish to purchase exchange-based coverage are welcome to do so, but without a federally funded premium support subsidy.

Details of these various proposals, bills, and laws that have employed exchanges and premium support have varied. The Utah exchange was built as a lightly regulated "clearinghouse" whereby a broad range of affordable plans, with varying benefit designs, could be purchased by interested individuals. The ACA ex-

Figure 10. Change in Individual Market Premiums Under ACA, 2013–14 (Percent)



Rate shock in the non-group health insurance market. Prior to 2010, the market for health insurance purchased by individuals on their own was almost entirely regulated by states. The ACA added a new—and costly—layer of federal regulation upon this market. Many healthy individuals experienced rate increases of 100 to 200 percent. Even when taking into account those with pre-existing conditions, the ACA increased underlying rates in the average county by 49 percent. In 2015 and 2016, according to McKinsey, rates increased by 7 and 11 percent, respectively, on average; 2017 rates are expected to increase by at least 10 percent again, leading to a cumulative increase of at least 95 percent. *(Source: Manhattan Institute)*

changes, on the other hand, were composed in a highly prescriptive fashion, in which—for the first time—the federal government would regulate how individually purchased health plans could be designed by private companies.

DRAWBACKS OF THE ACA EXCHANGES

Apart from the basic aim of expanding health coverage, the authors of the ACA exchanges sought to achieve several objectives by heavily regulating the individual insurance market.

Their first goal was *consumer protection*. They required that all participating insurers offer plans to anyone who sought one (guaranteed issue). They also required that plans compete on the basis of standardized financial benefits (actuarial value), so that consumers would not have to worry that a plan's fine print would leave them with unanticipated medical expenses.

Their second goal was *redistribution*. They forbade plans from charging lower premiums to healthier individuals, and constricted the ability of plans to charge lower premiums to younger enrollees ("community rating").

They required insurers to charge the same rates to men and women: in effect, a redistribution from men *to* women, because women, on average, consume more health care services. They required all plans to cover services ("essential health benefits"), such as drug addiction therapy, that few people might need: in effect, requiring all insured individuals to subsidize those services on behalf of the minority who use them.

Their third goal was *utility conversion*. They sought to

convert the existing private insurers into regulated utilities, whose rates and operating margins ("medical loss ratios") would be prescribed and regulated by the federal government. The ACA authors believed that there is a fundamental conflict between the economic interests of insurers and those of patients.

Unfortunately, this approach has significant drawbacks. Most importantly, the ACA significantly drives up the cost of individually purchased health insurance in most of the country. As noted above, and in ***Figure 10***, a Manhattan Institute study found that the average county will experience premium increases of 49 percent in the individual market.[19] The ACA imposes these cost increases principally on healthier and younger individuals, and on men more than on women.

Because the ACA so significantly drives up the cost of coverage for healthier individuals, it also contains an individual mandate that penalizes healthy individuals who might otherwise be reluctant to overpay for coverage they don't need. While the U.S. Supreme Court upheld the constitutionality of the individual mandate on a 5-4 vote, many scholars continue to consider the individual mandate an unprecedented and unconstitutional expansion of congressional power.

In addition, by mandating that consumers purchase costly plans with an overly broad set of benefits, and limiting cost-sharing options for certain populations, the ACA incentivizes patients to be less conscious of the value and cost-effectiveness of the care they receive, further driving costs upward.

PRINCIPLES OF NON-GROUP REFORM

The Universal Tax Credit Plan seeks to expand coverage by reducing the underlying cost of health insurance, while also ensuring that those who cannot afford insurance due to income or illness have the help they need.

The Plan seeks to do this by overhauling the Affordable Care Act's plethora of costly regulations, mandates, and taxes, so as to drive down the cost of insurance. In addition, the Plan puts patients in charge of a greater proportion of their health care dollars, allowing cost-conscious consumers to put downward pressure on the price of health care services.

At the same time, the Plan preserves important consumer protections that make it easier for individuals to have the information they need to shop for the coverage they want, and to know that the purchase of health insurance will grant them real financial security.

'REPEALING AND REPLACING' THE ACA EXCHANGES

Congressional Republicans have nearly unanimously committed to "repealing and replacing" the ACA. While the political plausibility of this commitment is unclear, and there would be multiple policy considerations to take into account, it would certainly be possible to install the Universal Tax Credit Plan's reforms through a "repeal and replace" bill. The end result, in terms of the individual private insurance market, would be identical.

Public exchanges are, in important ways, extraneous; after all, privately sponsored websites like eHealthInsurance.com have long provided a place for individuals to shop for coverage. In addition, some fear that state-based exchanges are, in reality, a vehicle for overbearing insurance regulations. (It must be noted that governments can—and have—heavily regulated insurance markets in the absence of exchanges.)

Under the Plan, state governments would not need to continue to maintain insurance exchanges, provided that states can assure the flow of premium support tax credits to eligible individuals, and that at least two private entities will set up internet-based insurance markets in their states.

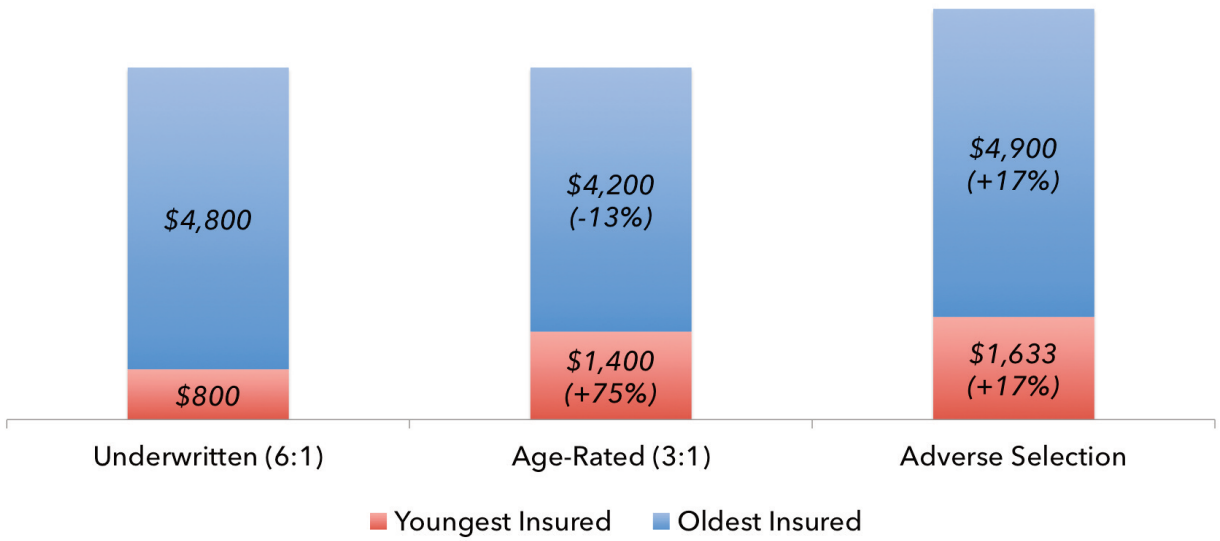
PROPOSED CHANGES TO THE NON-GROUP HEALTH INSURANCE MARKET

1. Preserve consumer protections

The Universal Tax Credit Plan preserves notable features of the Affordable Care Act related to consumer protection.

It preserves the consumer-friendly system of metal tiers—Bronze, Silver, Gold, and Platinum—that allow individuals to easily compare the financial value of competing health plans. It maintains the "guaranteed issue" requirement that all insurers offer coverage to anyone willing to pay the necessary premium. It continues the law's prohibition on lifetime and annual dollar limits on received benefits. In this way, the Plan

Figure 11. An Illustration of Age-Based Community Rating and Adverse Selection



Forcing the young to pay more drives costs up for everyone. The average 64-year-old consumes six times as much health care, in dollar value, as the average 21-year-old. Hence, in an *underwritten* (i.e., actuarially priced) insurance market, insurance premiums for 64-year-olds are roughly six times as costly as those for 21-year-olds. Under the ACA, policies are *age-rated*; i.e., insurers cannot charge their oldest policyholders more than three times what they charge their youngest customers. If every customer remains in the insurance market, this has the net effect of increasing premiums for 21-year-olds by 75 percent, and reducing them for 64-year-olds by 13 percent. However, if half of the 21-year-olds recognize this development as a bad deal for them, and drop out of the market, *adverse selection* ensues, driving up the average health care consumption per policyholder, thereby driving premiums up for everyone, including the 64-year-olds who were supposed to benefit from 3:1 age rating. In an attempt to mitigate this problem, the ACA includes an *individual mandate* forcing most young people to purchase government-certified insurance.

ensures that every American has access to the benefits of true insurance: protection from catastrophic financial loss due to illness or injury.

2. Reduce adverse selection

The Universal Tax Credit Plan revises and/or repeals ACA regulations that needlessly drive up the cost of coverage for healthier individuals. By driving away these individuals, the average premiums under the ACA are higher than they need to be.

First and foremost, the Plan revises the system of community rating imposed by the ACA.

It preserves the ACA's requirement that insurers charge identical premiums to men and women, and to those of varying health status. But it allows insurance issuers to charge their oldest policyholders up to six times what they charge their youngest policyholders: an "age rating band" of 6 to 1. This is a change from the ACA, whose age band is 3 to 1: in effect, forcing younger people to pay far more for health coverage than they normally would, as illustrated in ***Figure 11***.

In this manner, the Plan makes it much more affordable for healthier and younger people to enroll in individual insurance coverage.

Because the ACA's subsidy system caps the percentage of income that any subsidy-eligible enrollee will spend on premiums, older, sicker, and poorer individuals remain protected against unaffordable premiums under this system. In addition, by encouraging healthier and younger individuals to purchase insurance, this approach reduces average individual premiums.

However, a straightforward change of the ACA's age bands could result, temporarily, in higher premiums—relative to the ACA—for a small subet of participants in the individual insurance market: those nearing retirement whose incomes that are too high to garner

premium assistance subsidies. In order to transition these individuals into the reformed system, the Plan includes transitional premium assistance. In 2017, those with incomes between 317 and 600 percent of FPL would be eligible for premium assistance for costs above 10 percent of their income. The 600 percent FPL threshold would gradually decrease back down to 317 percent in 2027, resulting in an estimated ten-year outlay of $12 billion.

3. Reduce overall premium costs

The Universal Tax Credit Plan reduces overall premium costs by maximizing the flexibility of insurers to design cost-effective plans.

a. Essential health benefits

The Plan minimizes the prescriptiveness of the ACA's ten "essential health benefits"—ambulatory patient services, prescription drugs, emergency care, mental health services, hospitalization, rehabilitative and habilitative services, preventive and wellness services, laboratory services, pediatric care, and maternity and newborn care—in order to encourage innovation in insurance plan design, and to lower costs.

For example, ACA regulations require that insurers cover "at least the greater of: (i) one drug in every United States Pharmacopeia (USP) therapeutic category and class; or (ii) the same number of prescription drugs in each category and class as the [essential health benefit] benchmark plan" in a given exchange. The net effect of this rule is to force insurers to cover many brand-name drugs that are not cost-effective, merely because they happen to be in a unique class.

States would retain the option of requiring a broader range of insurance benefits, above and beyond the federal benchmark.

However, states will have to bear the increased premium costs of any regulatory additions. The ACA specifies that states "shall make payments to an individual enrolled in a qualified health plan…to defray the cost of any additional benefits" that a state requires.[20]

That way, if one state increases health insurance premiums through regulatory expansion, taxpayers in other states are not liable for the expense.

Esssential health benefit regulations would be clarified under the Plan, such that they could not be interpreted to limit the value of consumer-driven health plans with high-deductible coverage and health savings accounts. In addition, certain ACA regulations require employers to provide coverage that violates their First Amendment rights to the free exercise of religion. Under the Universal Tax Credit Plan, these First Amendment rights would be restored.

b. Actuarial value reforms

The plan would reduce the actuarial value ranges required in the exchanges' metal tiers. Under the ACA, Bronze plans are required to have an actuarial value of 60 percent; this means that the insurer expects to pay out, on average, 60 percent of the value of health claims incurred by plan participants. (The insurer expects that the remaining 40 percent will be paid by the policyholder, in the form of out-of-pocket expenditures.) Silver, Gold, and Platinum plans are required to have actuarial values of 70, 80, and 90 percent, respectively. These high actuarial values drive up the premiums associated with ACA exchange plans.

In order to provide consumers with more affordable choices, the Universal Tax Credit Plan actuarial value tiers are 40, 55, 70, and 85 percent, respectively, for Bronze, Silver, Gold, and Platinum. Those eligible for subsidized coverage would be eligible for a benchmark plan with an average effective actuarial value comparable to the Gold tier in the reformed framework (Silver under the ACA framework).

c. Repeal of premium-increasing ACA taxes

The ACA contains several counterproductive tax increases whose net effect is to increase exchange premiums, and thereby, federal exchange subsidies.

These include: the tax on health insurance premiums; the tax on medical devices; the tax on pharmaceutical products; the tax on flexible spending accounts; the tax on medical expenses exceeding 7.5 percent of adjusted gross income; the tax on over-the-counter medicines; and the tax on early HSA withdrawals. The Universal Tax Credit Plan repeals all of these taxes.

4. Return insurance regulatory authority to the states

The Universal Tax Credit Plan proposes to return as much regulatory authority to the state level as is actuarially feasible, by significantly limiting the federal

role in prescribing how non-group plans are designed and regulated. Many of these regulatory changes are described above. In addition, the Plan eliminates the redundant federal role in annually reviewing any proposed increases in premiums; this role is already performed at the state level.

The Plan also eliminates federal regulation of insurers' medical loss ratios: the so-called 80/20 rule that requires insurers to spend a particular fraction of their premium revenues on medical claims. Because insurers are already competing on price in the exchanges, regulating medical loss ratios prevents carriers from investing in customer service and other quality initiatives, because those services and initiatives do not count as medical claims. In addition, the 80/20 rule perversely disincentivizes insurers from rooting out wasteful medical utilization, because doing so risks reducing medical loss ratios below the federally prescribed levels.

Section 1334(a) of the ACA instructs the U.S. Office of Personnel Management to offer "multi-State qualified health plans through each Exchange in each State." Many observers are concerned that this provision encourages the creation of government-sponsored "public option" insurers, insurers whose underlying objective would be to drive private insurers out of business and move to a single-payer model.

The Universal Tax Credit Plan would prohibit the creation of "public option" insurers, and specify that neither the Secretary of Health and Human Services nor the Office of Personnel Management are authorized to introduce government-run insurers into the non-group insurance market.

5. Expand consumer-driven health plans

Consumer-driven health plans are centered around the principle that patients should be in as much control of their health spending as possible, while still providing an insurance product that protects individuals from catastrophic financial loss.

Consumer-driven plans achieve this goal by combining high-deductible, catastrophic insurance coverage with health savings accounts (HSAs) that allow individuals to save for their own health expenses.

As noted above, Singapore's universal system of catastrophic coverage with health savings accounts is the world's most cost-effective health care system, by a wide margin. Singapore spends less than a quarter of what the United States spends on health care, as a percentage of gross domestic product, while achieving universal coverage and superior health outcomes.

Catastrophic plans have much lower premiums than comprehensive plans, because they are more actuarially efficient. In addition, health savings accounts counteract the problem of *moral hazard*, by economically rewarding individuals for staying healthy and engaging in preventive care.

Under the ACA, the benchmark plans used to determine subsidies are Silver plans with relatively low deductibles and comprehensive benefits. These plans are the opposite of consumer-driven health plans. Under the Universal Tax Credit Plan, the benchmark plan has an average deductible of approximately $7,000 per individual per year, or $14,000 per family per year. Annual growth in the benchmark deductible would be linked to the Consumer Price Index plus 1 percent (CPI+1%).

Under the Plan, those eligible for premium support subsidies are eligible, on average, for a subsidized contribution to a health savings account of approximately $1,800 per individual per year, or $3,600 per family, also growing at an annual rate of CPI+1%. Individuals with incomes below 250 percent of the Federal Poverty Level would receive additional HSA subsidies, as described below.

These HSA contributions could be used by the enrollee to pay for a retainer-based primary care physician (sometimes called a "concierge" physician). Alternatively, the HSA subsidies could be saved by the recipient, so as to fully fund the deductible as the subsidies accumulate over several years. The value of combining a $7,000 deductible with an $1,800 HSA subsidy can be thought of as initially comparable to that of a plan with a $5,200 deductible and no HSA subsidy. That is, a person who spends more than $5,200 on health care in a given year is covered for further expenses either way.

The differences are that the HSA subsidy can be used for first-dollar health care expenses, and that an individual who stays healthy can roll over the HSA savings into successive years. As a result, the effective average actuarial value of an HSA-driven plan, over time, is significantly higher than that of an ACA benchmark plan. The Universal Tax Credit Plan would adjust the average deductible and HSA subsidy on the basis of age:

older individuals would enjoy lower deductibles and higher HSA contributions, in order to protect those with greater health care needs.

The consumer-driven reforms of the Universal Tax Credit Plan have the potential to revolutionize health care in America, by allowing—for the first time—low-income individuals to accumulate substantial wealth in health savings accounts that further grow through compound interest. These HSAs also give a broad range of Americans a powerful economic reward for maintaining their health through routine preventive measures.

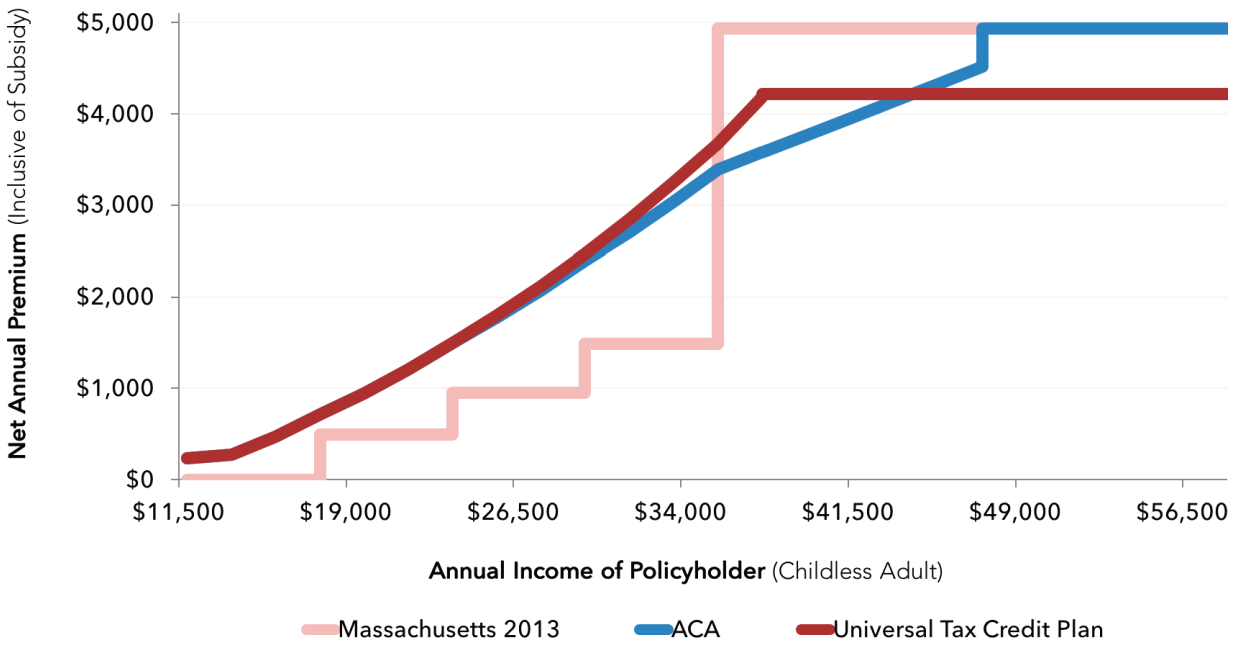
6. Convert ACA cost-sharing subsidies into HSA contributions

The Affordable Care Act includes cost-sharing subsidies to defray the costs of deductibles, co-pays, and other cost-sharing features of exchange-based plans, for individuals with incomes below 250 percent of the Federal Poverty Level.

Those with incomes between 100 and 150 percent of FPL are subsidized such that the effective actuarial value of their coverage is 94 percent. Those between 150 and 200 percent of FPL are subsidized to an effective actuarial value of 87 percent. Those between 200 and 250 percent of FPL are subsidized to an effective actuarial value of 73 percent.

Under the Universal Tax Credit Plan, these subsidies are converted on a fiscally equivalent basis into health savings account subsidies that supplement the HSA contributions contained in the benchmark consumer-driven plan. In this way, low-income families can retain the value of these subsidies if they do not need to deploy them in a given year.

Figure 12. Subsidy Cliffs in Massachusetts and the ACA vs. the Universal Tax Credit Plan



Mitigating the disincentives for self-advancement. In this illustrative example, we take a childless adult whose annual health premiums amount to the same figure: $4,930. Under the Massachusetts-based reforms known as "Romneycare," a rather large subsidy cliff has evolved: as an individual's income exceeds 300% of the Federal Poverty Level, his net premiums increase by $3,445, because he is no longer eligible for subsidies. Under the ACA, a similar individual crossing the 400% FPL threshold faces a more modest, but still significant, subsidy cliff of $416. The Universal Tax Credit Plan seeks to mitigate the effect of the ACA subsidy cliff by adjusting the income-based formula for determining premium subsidies, and by reducing the underlying cost of health isnurance. Under the Plan, in this illustrative example, the subsidy cliff is only $38 per year, or $3.17 per month.

7. Reform means-tested tax credits

The Massachusetts health reforms of 2006 achieved near-universal coverage by offering premium support subsidies to uninsured Massachusetts residents with incomes below 300 percent of FPL who were otherwise ineligible for Medicaid. Eligible recipients received subsidies on a sliding scale; the amount of the subsidy decreased as one's income increased.

The ACA, on the other hand, offers subsidies to those with incomes between 100 and 400 percent of FPL. (In states that expand Medicaid under the ACA, the lower eligibility threshold increases to 138 percent.) Subsidies are designed so that an individual's net premium is capped at a certain percentage of his income. For example, someone whose income is just above 100 percent of FPL would be required to pay a maximum of 2 percent of his income in net premiums. Someone whose income is just below 400 percent of FPL would pay no more than 9.5 percent of his income in net premiums.

The pre-ACA Massachusetts subsidy scale and the ACA subsidy scale suffer from a common flaw. At the point at which subsidy eligibility ends—300 percent of FPL for Massachusetts, and 400 percent of FPL for the ACA—there is a *subsidy cliff* that effectively penalizes an individual for increasing his income above the threshold at which subsidies end. Subsidy cliffs are problematic because they discourage workers from seeking higher wages.

In 2013, the structure of subsidies in the pre-ACA Massachusetts exchange result in a rather drastic subsidy cliff. The example in ***Figure 12*** describes a Silver plan with an annual cost of $4,930. Under this scenario, if a pre-ACA Massachusetts resident increases his income such that he is no longer eligible for subsidized coverage, his premiums increase by $3,445. There are additional, smaller subsidy cliffs for Massachusetts residents who cross earlier (i.e., lower) thresholds.

The ACA attempted to address this problem to some degree, by moving to a Swiss-style system in which subsidies are designed to *cap the percentage of one's income* spent on health insurance premiums. Still, under the scenario described in the illustration, an individual crossing the 400% FPL threshold faces a subsidy cliff of $416.

The Universal Tax Credit Plan reforms the ACA subsidy scale, so as to take advantage of the fact that Massachusetts achieved near-universal coverage with a subsidy threshold of 300 percent of FPL. (This result was corroborated by a November 2013 analysis by the Congressional Budget Office, which found that "capping [ACA] exchange subsidies at 300 percent of the FPL would reduce the deficit without increasing the number of people without health insurance" because most individuals with incomes between 300 and 400 percent of FPL have access to employer-sponsored coverage.)[21]

Under the Universal Tax Credit Plan, eligibility for subsidies ends at 317 percent of FPL. In addition, the subsidy scale is structured so as to mitigate the subsidy cliff problem. In the illustrated example, the subsidy cliff amounts to only $38 per year, or $3.17 per month. While a small number of people—those with incomes around 317 percent of FPL—will see their net premiums slightly increase under the Plan, this will be offset by a substantial drop in premiums for those with incomes above 375 percent of FPL, because the Plan's reforms decrease average premiums by 17 percent: a savings of $716 per year in the illustrated example.

Furthermore, under the Universal Tax Credit Plan, the income thresholds used to determine tax credit levels would be adjusted each year so as to ensure that the overall growth in subsidy spending comports with the long-term inflation-based index described in the Affordable Care Act.

8. Repeal the individual mandate; auto-enrollment; reform open enrollment; late enrollment penalties

One of the ACA's most controversial provisions is its individual mandate, requiring most U.S. residents to purchase federally certified health insurance or pay a fine. In 2014, the fine was the greater of $95 per adult, or 1 percent of household income above the tax-filing threshold. From 2016 onward, the fine is the greater of $695 per adult, or 2.5 percent of household income above the tax-filing threshold. The fine is capped at the average premium of the lowest-cost plans available across the exchanges.

For a childless adult making $50,000 per year who does not purchase a federally certified plan, then, the annual mandate penalty in 2016 is approximately $1,000: $50,000 less the filing threshold of approximately $10,000, multiplied by 2.5 percent. While a $1,000 fine may seem steep, it is much lower than the cost of health insurance under the ACA. Median pre-

miums on the ACA exchanges exceeded $4,000 in 2016, and are likely to exceed $5,000 by 2018.

The ACA's mandate penalty is considerably lower than the one Massachusetts instituted in 2006. The Massachusetts penalty was 50 percent of the cost of the lowest-cost plan available to an individual, less any premium subsidy the individual was eligible for.

Hence, the ACA mandate suffers from two problems. The first is that it may be too weak to persuade healthier and younger people to overpay for insurance they don't need. The second is that, despite the mandate's weakness, it represents an unprecedented—if not unconstitutional—expansion of congressional power: compelling individuals to purchase a privately delivered service.

The Universal Tax Credit Plan rolls back the regulations that make ACA-based insurance excessively costly for healthy and young people. As a result, the Plan enjoys far less adverse selection than does the ACA. For these reasons, the Plan can and does repeal the individual mandate without serious repercussions in the individual insurance market.

The IRS encourages employers to auto-enroll their workers into individual retirement account programs like 401(k) plans. Auto-enrollment has had a significant impact on the success and scale of enrollment in IRA programs.

Similarly, the Universal Tax Credit Plan allows states to automatically enroll their residents in a state-assigned default plan and default health savings account, so long as auto-enrollees have the ability to opt out of the enrolled plan if they so choose.

As a further protection against any remaining adverse selection in the absence of an individual mandate, the Plan reforms the ACA's *open enrollment period*. An open enrollment period is the period within which individuals can enroll in insurance coverage that benefits from consumer protections such as guaranteed issue.

In 2014, the ACA exchanges' open enrollment period lasted for more than six months: from October 2013 to April 2014. In 2015, the period was scheduled to last for two months: from November 15, 2014 to January 15, 2015. Instead, enrollment was extended to April 30, 2015.

Beginning in 2017, the Plan would reform open enrollment such that it takes place for a six-week period *every two years*. Under this system, individuals who choose to forego coverage could do so without paying a fine; however, they could not simply enter and exit the system at will and take advantage of consumer protections such as coverage for preexisting conditions, and cross-subsidies such as community rating.

In 2009, Paul Starr of Princeton University first advanced this reform as an alternative to the individual mandate.[22] Starr proposed adapting an analogous provision from Germany, where there is no individual mandate, but where the open enrollment period takes place once every five years.

"Congress," he wrote, "could give people a right to opt out of the mandate if they signed a form agreeing that they could not opt in for the following five years. In other words, instead of paying a fine, they would forego a potential benefit."

Open enrollment reform has an additional attraction: it rewards the development of longer-term health insurance contracts. Insurers that know they will be managing an enrollee's care for a longer period of time have an additional incentive to engage in prevention, knowing that they are more likely to reap its rewards in the form of better long-term health.

The Plan would also introduce late enrollment penalties, modeled after those used in the Medicare program, in order to incentivize timely enrollment. The combination of less adverse selection, longer insurance contracts, and late enrollment penalties will lead to a much stronger non-group insurance market.

9. Enact individual market reforms via statute

The Obama administration has frequently introduced regulations that violate both the implicit intent and the explicit specifications of the ACA. For example, the administration has unilaterally delayed the imposition of the law's employer and individual mandates, and expanded the authority of federally-run insurance exchanges, without congressional authorization. In order to minimize the ability of future administrations to undermine individual market reforms through regulatory action, it is important that as many of these reforms as is feasible are enacted by Congress, rather than by the executive branch.

Part Two

Reforming Employer-Sponsored Health Insurance

More Americans obtain health coverage through their employers than through any other source. According to the Census Bureau, 175 million U.S. residents obtained employer-based coverage in 2014, while 62 million obtained coverage through Medicaid; 50 million through Medicare; and 14 million through military health benefits. An additional 46 million purchased private coverage directly.

Americans don't expect their employers to provide them with auto insurance or life insurance. The reason that they expect health insurance from their jobs has to do with a historical accident: the tax exclusion for employer-sponsored health insurance.

THE HISTORY OF EMPLOYER-SPONSORED HEALTH COVERAGE

The tax exclusion is the unintended outgrowth of World War II economic policy. Prior to the war, health insurance was rare: health technology was in its infancy, and most medical care still took place in patients' homes.

But in 1929, a group of teachers in Dallas—spurred by their increased need for hospital services—came together and signed an agreement with Baylor University Hospital under which the teachers would pay $6 a year in exchange for 21 days of hospitalization.

The plan grew to cover additional employee groups in Dallas; eventually, the American Hospital Association encouraged other hospitals to adopt similar plans. Hospitals liked the idea because it gave them more predictable income streams and ensured that their bills were paid; beneficiaries, meanwhile, enjoyed the advantages of insurance.

Thus the Blue Cross system was born.

The system offered several advantages to patients as well as providers. The AHA required that Blue Cross–branded plans allow beneficiaries to freely choose their doctors and hospitals. Blue Cross plans charged sick and healthy people similar premiums (i.e., community rating). And because they were organized as nonprofit corporations, insurers enjoyed tax-exempt status and were freed from certain insurance regulations that would have required them to keep assets in reserve against potential claims.

Soon, physicians began establishing similar plans for their own services under the Blue Shield label. Both Blue Cross and Blue Shield plans served a significant number of low-income patients—but the secret of their success was covering large populations of healthy, employed workers.

As a result, the plans were able to build a large pool of clients who did not often require expensive care; the savings from these patients went toward covering the costs of those who did need frequent or expensive care.

For-profit insurers came to notice the success of Blue Cross and Blue Shield, and began to enter the health insurance market. They did not have community-rating rules, and so could attract healthier clients with lower premiums. A serious health insurance sector began to emerge.

The connection between health insurance and employment was first forged in the midst of World War II, as a result of the Economic Stabilization Act of 1942.

With most young American men off to war, the government was concerned that employers would rapidly raise wages to attract the shrinking labor pool, thereby contributing to inflation and other economic problems. But while the 1942 law placed significant constraints

on employers' ability to raise wages, it did not restrict their ability to increase benefits. Employers took advantage of this loophole to introduce ever more generous health insurance as a fringe benefit—in lieu of the prohibited higher wages—to compete for the best workers.

In 1943, a federal court ruling asserted that direct payments by employers to insurers did not count as taxable employee income—meaning that any amount of an employee's overall compensation dedicated to providing health insurance rather than direct cash wages would not be taxed.

This, of course, created an enormous financial incentive for employer-provided coverage.

The Internal Revenue Code reinforced this incentive in 1954 by explicitly exempting employer-sponsored health benefits from taxation. Employer-provided health coverage soon became a routine benefit.

Over the years, employer-sponsored insurance brought health care coverage to hundreds of millions of Americans. But the tax exemption for employer-sponsored plans also created massive problems that have endured to this day.

For one thing, employer-sponsored insurance makes many workers reluctant to leave unsatisfactory jobs for fear of losing their coverage. Those who fall ill while between jobs are burdened with the additional concern that a new insurance company might refuse to accept them, or raise their premiums beyond what they can afford.

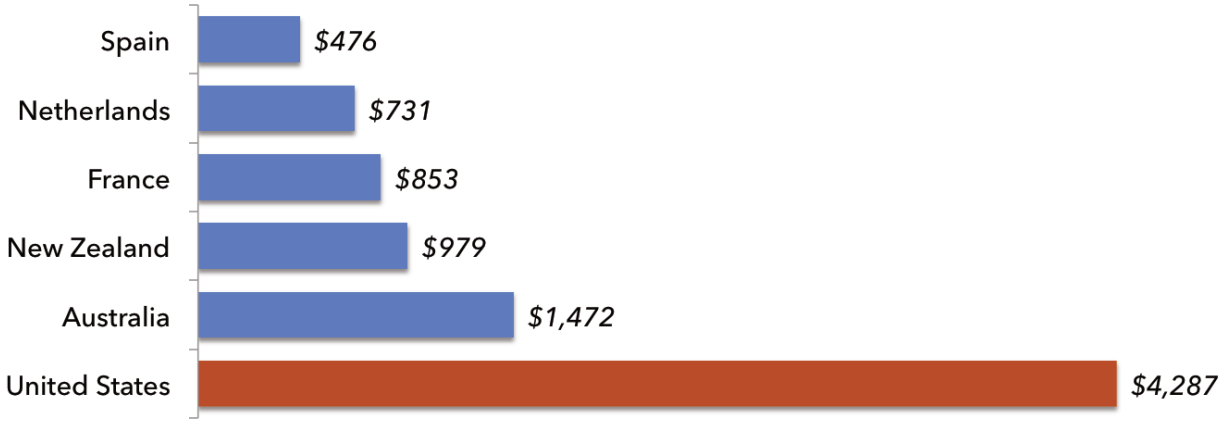
Insurers also face less competition and are less consumer-oriented, since they are at less risk of losing their customers. And, as noted above, because workers do not choose their own insurance, they are less likely to have plans that suit their needs.

THE ACA 'CADILLAC TAX' ON HIGH-VALUE HEALTH PLANS

Moreover, because employer-sponsored insurance is tax-exempt, employers have a major incentive to provide generous benefit packages. For example, a worker who pays federal and state income taxes at a combined rate of 30 percent will net $7,000 for every $10,000 his employer provides in gross salary. But the same employee will receive $10,000 in benefits for every $10,000 his employer spends on health insurance—a 43 percent improvement.

These generous benefits incentivize workers and employers to shift compensation away from cash wages,

Figure 13. Average Daily Cost for a Hospital Stay, 2012



U.S. hospital prices are extreme. In 2013, the average hospital stay in the U.S. was 4.8 days long, compared to an average of 7.8 in the OECD-member advanced economies. The average cost of a hospital stay in the United States, however, was nearly three times that of its OECD peers, despite the shorter length of stay. This is because U.S. hospitals charge far higher prices than hospitals do in other countries. This is reflected in average *per diem* hospital charges, as exemplified by the annual survey of the International Federation of Health Plans, whose 2012 findings are illustrated above.

Figure 14. Federal, State, & Local Expenditures on Health Care Entitlements, 2009–17 (Billions)

Employer-sponsored health coverage is the nation's second largest entitlement. There is no official government estimate of the total size of the tax exclusion for employer-sponsored health insurance, inclusive of lost revenue to federal, state, and local governments. However, in 2007, the Joint Committee on Taxation estimated the effect on federal revenue of repealing the tax exclusion for employer-sponsored coverage and related expenses from 2009–17. In 2006, Thomas Selden and Bradley Gray estimated that the additional effect on state and local governments was 13 percent of the federal total. Combining these two analyses, the size of the employer tax exclusion exceeded that of Medicaid in 2014. *(Source:* Health Affairs*, JCT, CMS, CBO, A. Roy analysis)*

and into health care, even if those workers would benefit from higher wages. And by further divorcing workers from the cost and quality of the care they receive, the exclusion has encouraged hospitals and physicians to charge far higher prices in the United States than they do in other countries (***Figure 13***).

The Joint Committee on Taxation—Congress' in-house, non-partisan agency devoted to measuring the fiscal impact of tax-related legislation—has estimated that, in 2016, the federal government will subsidize employer-sponsored coverage by $509 billion: the total amount of lost federal income taxes, Social Security payroll taxes, and Medicare payroll taxes that arise from the substitution of wage income with health benefits.[23]

In addition, as shown in ***Figure 14***, state and local governments will lose an estimated $67 billion in 2016 tax revenue because of the employer tax exclusion.[24]

At over $500 billion a year, then, the size of the tax expenditure for employer-sponsored coverage is as large as total spending on the Medicaid program, making it the largest entitlement in the tax code, and the second-largest entitlement—next to Medicare—overall. Another notable feature of the employer tax exclusion is that it disproportionately benefits wealthy people. Those in the highest income-tax brackets benefit the most from the fact that their health benefits are excluded from taxation.

The Affordable Care Act attempts to gradually roll back the employer tax exclusion, by employing a "Cadillac tax" on high-value health plans.

Under the ACA, the tax was originally scheduled to go into effect in 2018; it applied a 40 percent excise tax on premiums that exceed $10,200 for individual coverage and $27,500 for family coverage, with some adjustments. These thresholds increase in 2019 by a rate equivalent to the Consumer Price Index plus 1 percent (CPI+1%), and in 2020 and thereafter by the Consumer Price Index alone (CPI).[25]

In December 2015, Congress passed legislation that delayed the implementation of the Cadillac tax until 2020, and modified the tax so that businesses could

count the tax as a deductible expense, thereby significantly reducing its bite.

The Universal Tax Credit Plan replaces the Cadillac tax with a fiscally equivalent cap on the size of the employer tax exclusion, and implements it in 2017, at thresholds comparable to those that the original Cadillac tax were to use for 2018.

Furthermore, the Plan eliminates most of the special-interest exceptions the ACA makes for particular labor unions, while preserving those for genuinely high-risk occupations such as law enforcement and fire protection.

REPEALING THE ACA'S EMPLOYER MANDATE

THE ACA ALSO CONTAINS AN EMPLOYER MANDATE, requiring firms with 50 or more full-time workers to offer federally defined "minimum essential coverage" or pay a fine of $2,000 times the total number of full-time-equivalent employees at the firm, less 30.

The employer mandate represents unwise public policy, on a number of fronts.

First, it increases the cost for businesses to *hire new workers*, thereby acting as a drag on economic growth by increasing unemployment and the cost of goods and services.

Second, it perpetuates the *inefficient linkage between health insurance and employment*. As noted above, economists across the political spectrum have long advocated transitioning away from employer-sponsored insurance toward individually owned insurance.

Employer-sponsored coverage is costlier and less portable than individually owned coverage. Furthermore, employer-sponsored coverage is not tailored to the specific needs of individual employees but rather to the interests of the employer.

Third, the mandate has *little to no impact on the number of people with health insurance*, according to several nonpartisan studies. An Urban Institute study published in July 2013 found "that the ACA can achieve all its major objectives without the employer mandate."[26] A follow-on study published in May 2014 estimated that the number of Americans with health insurance in 2016 would decline by a mere 0.08 percent if the mandate were repealed.[27]

Fourth, transitioning from employer-sponsored coverage to individually purchased coverage would have a *minor impact on the deficit*. A March 2012 study by the Congressional Budget Office found that if an additional 14 million workers moved from employer-based to exchange-based coverage, the deficit would actually decrease by $13 billion over ten years. This is because the increase in exchange subsidies is offset by a reduction in lost revenue from the tax exclusion for employer-sponsored insurance.[28]

In July 2013, the CBO estimated that a one-year delay of the employer mandate would increase spending on the exchanges by $3 billion, increase tax revenue by $1 billion due to an increase in taxable income, and reduce tax revenue by $10 billion due to the elimination of the employer mandate fine.[29]

Fifth, the employer mandate gives firms a *perverse incentive to avoid hiring low-income workers*. According to the Medical Expenditure Panel Survey, 97 percent of firms with 50 or more workers already offer health benefits. 97 percent is not 100 percent, of course, and not all firms offer coverage to every employee. But the ACA's employer mandate, perversely, incentivizes employers to avoid hiring low-income workers, precisely the type who tend to be uninsured.

As Robert Greenstein and Judith Solomon of the Center on Budget and Policy Priorities put it in 2009: "In essence, affected firms would pay a tax for hiring people from low- or moderate-income families."[30]

The penalties associated with the employer mandate are triggered only if a worker is not offered what the ACA deems "affordable" coverage, and if the worker then gains subsidized coverage on an ACA-sponsored insurance exchange.

The ACA thereby gives employers four incentives: (1) to hire fewer full-time workers; (2) to offer so-called unaffordable coverage, for which the penalties are lower; (3) to hire workers from high-income families, who are not eligible for subsidies; and (4) to hire illegal immigrants, who are also ineligible for subsidies.

In sum, the employer mandate penalizes firms for hiring low-income Americans. Through the Affordable Care Act, these individuals are able to gain subsidized health insurance. But they will be tagged with a scarlet "S"—for gaining those subsidies—because, to employers, hiring subsidized individuals will be far more costly than hiring unsubsidized ones.

For all of these reasons, the Universal Tax Credit Plan repeals the employer mandate.

LOWERING THE COST OF EMPLOYER-SPONSORED COVERAGE

The Affordable Care Act's impact on health insurance premiums is most greatly felt in the market for people who shop for coverage on their own: what economists call the *individual* or *non-group* market. This is because the employer-sponsored insurance market has already incorporated many of the premium-increasing features of the ACA.

For example, when employers purchase group coverage for their employees, insurers are typically required to offer coverage to everyone designated by the employer (guaranteed issue), with similar premiums regardless of health status (community rating).

However, some insurance regulations that affect the individual insurance market also affect the employer-sponsored market, especially the *small group market.*

Employer-sponsored insurance can be divided into three categories. The "small group" market applies to employers with an average of one to 100 total employees. The "large group" market encompasses employers with an average of more than 100 total employees.

There is a third category of companies: companies that take advantage of the Employee Retirement Income Security Act, or ERISA, to *self-insure.* Instead of paying premiums to an insurer, which then reimburses hospitals and doctors for incurred health claims, self-insured employers pay those claims directly. These self-insured ERISA plans are exempt from state insurance regulations, though they are subject to many of the ACA's federal insurance regulations.

Small group plans, in particular, are affected by the ACA's requirements regarding essential health benefits and medical loss ratios. The Universal Tax Credit Plan's individual market reforms, as proposed in Part One of this monograph—the ones that expand insurer flexibility around benefit design and financial structure—will have the added effect of modestly lowering the cost of employer-sponsored coverage.

The Universal Tax Credit Plan would expand the ability of small employers to amalgamate their workers into larger insurance pools, for the purpose of utilizing the consumer-driven private insurance exchanges that are growing in popularity among self-insured ERISA employers.

Repealing the ACA's excise taxes on health insurance premiums, pharmaceutical products, and medical devices, recommended in Part One, will reduce the cost of employer-sponsored coverage.

Reforming the Medicaid and Medicare programs, as described in Parts Three and Four of this report, will reduce the cost of employer-sponsored coverage in two principal ways: (1) by mitigating the phenomenon of *cost-shifting*, whereby health care providers charge commercial insurers higher rates to compensate for low reimbursements from government-sponsored health plans; and (2) by addressing the inefficiencies in Medicaid and Medicare that drive up overall health care costs.

Part Six of this report proposes ways to reduce the cost of prescription drugs, one of the largest components of employers' health care costs. Part Seven identifies ways in which digital health technologies can improve health care delivery and reduce costs.

And Part Eight of the Universal Tax Credit Plan describes other health care reforms, pertaining to such things as malpractice litigation and hospital market concentration which, if left unreformed, increase the cost of employer-sponsored coverage.

Part Three

Medicaid Reform: Transforming Health Outcomes for the Poor

Medicaid, enacted in 1965 under Lyndon Johnson's "Great Society" initiative, was designed to provide health coverage to low-income Americans, especially those with incomes below the Federal Poverty Level. The Affordable Care Act expands eligibility for Medicaid to individuals with incomes below 138 percent of the Federal Poverty Level.

However, under the June 2012 U.S. Supreme Court opinion in *NFIB v. Sebelius*, states can choose whether or not to expand their Medicaid programs along the ACA's lines. As of July 2016, 31 states and the District of Columbia had chosen to participate.

Studies consistently show that patients on Medicaid have the worst health outcomes of any insurance program in America—far worse than those with private insurance and, strikingly, no better than those with no insurance at all.

MEDICAID'S POOR HEALTH OUTCOMES

A landmark study published in the *New England Journal of Medicine* compared health outcomes for Oregon residents who had won a lottery to enroll in that state's Medicaid program with demographically similar residents who had lost the lottery and remained uninsured.

After following these individuals for two years, the authors found that Medicaid "generated no significant improvement in measured physical outcomes" such as mortality, high blood pressure, high cholesterol, and diabetes.[31]

Other studies have found similar results. A University of Virginia study published in the *Annals of Surgery* examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.[32]

The authors divided their patient population by the type of insurance they held—private, Medicare, Medicaid, and uninsured—and adjusted the database to control for age, gender, income, geographic region, operation, and comorbid conditions. That way, they could correct for the obvious differences in the patient populations (for example, older and poorer patients are more likely to have ill health).

They then examined three measurements of surgical outcome quality: the rate of in-hospital mortality; average length of stay in the hospital (longer stays in the hospital are a marker of poorer outcomes); and total costs.

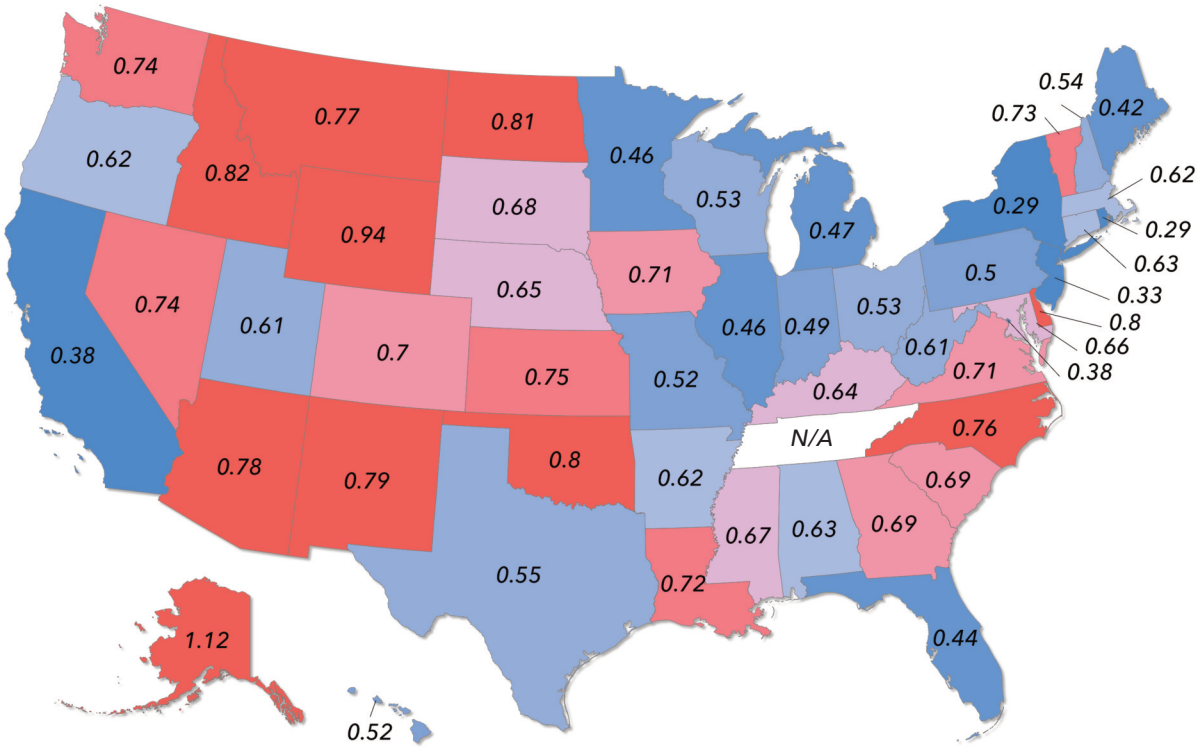
The in-hospital death rate for surgical patients with private insurance was 1.3 percent. Medicare, uninsured, and Medicaid patients were 54 percent, 74 percent, and 97 percent, respectively, more likely to die than those with private insurance.

The average length of stay in the hospital was 7.38 days for those with private insurance; on an adjusted basis, those with Medicare stayed 19 percent longer; the uninsured stayed 5 percent shorter; and those with Medicaid stayed 42 percent longer.

Total costs per patient were $63,057 for private insurance; Medicare patients cost 10 percent more; uninsured patients 4 percent more; and Medicaid patients 26 percent more.

A University of Pennsylvania study published in *Cancer* found that, in patients undergoing surgery for colon cancer, the mortality rate was 2.8 percent for Medicaid patients, 2.2 percent for uninsured patients, and 0.9

Figure 15. Medicaid Reimbursement Rates for Primary Care, vs. Private Insurers, 2008



States have reduced Medicaid reimbursements to physicians in response to fiscal pressures. States that have been most aggressive in expanding eligibility and services within their Medicaid programs–like California, New York, and New Jersey–have faced the most pressure to reduce reimbursement rates to physicians and hospitals. *(Source: Urban Institute, A. Roy analysis)*

percent for those with private insurance.[33] The rate of surgical complications was highest for Medicaid, at 26.7 percent, as compared with 24.5 percent for the uninsured and 21.2 percent for the privately insured.

A Columbia-Cornell study in the *Journal of Vascular Surgery* examined outcomes for vascular disease. Patients with clogged blood vessels in their legs or clogged carotid arteries (the arteries of the neck that feed the brain) fared worse on Medicaid than did the uninsured; Medicaid patients outperformed the uninsured if they had abdominal aortic aneurysms.[34]

A study of Florida patients published in the *Journal of the National Cancer Institute* found that Medicaid patients were 6 percent more likely to have late-stage prostate cancer at diagnosis (instead of earlier-stage, more treatable disease) than the uninsured; 31 percent more likely to have late-stage breast cancer; and 81 percent more likely to have late-stage melanoma.[35] Medicaid patients did outperform the uninsured on late-stage colon cancer (11 percent less likely to have late-stage cancer).

A University of Pittsburgh study of patients with throat cancer, published in *Cancer*, found that patients on Medicaid or without insurance were three times as likely to have advanced-stage throat cancer at the time of diagnosis, compared with those with private insurance. Those with Medicaid or without insurance lived on for a significantly shorter period than those with private insurance.[36]

A Johns Hopkins study of patients undergoing lung transplantation, published in the *Journal of Heart and Lung Transplantation*, found that Medicaid patients were 8.1 percent less likely to be alive ten years after their transplant operation, compared with those with private insurance and those without insurance. Medicaid was a statistically significant predictor of death

three years after transplantation, even after controlling for other clinical factors. Overall, Medicaid patients faced a 29 percent greater risk of death.[37]

LOW REIMBURSEMENT RATES RESULT IN POOR PHYSICIAN ACCESS

WHY DO PATIENTS FARE SO POORLY ON MEDICAID? The key reason is that Medicaid pays physicians far below market rates to care for Medicaid beneficiaries.

In 2008, according to the Centers for Medicare and Medicaid Services, as shown in ***Figure 15***, Medicaid paid physicians approximately 58 percent of what private insurers paid them for comparable services.

Surprisingly, doctors fare even better treating the uninsured than they do caring for those on Medicaid.

A 2007 study by MIT economists Jonathan Gruber and David Rodriguez found that, for nearly 60 percent of physicians, the average Medicaid fees were less than two-thirds of those paid by the uninsured, and that three-quarters of physicians receive lower fees for treating Medicaid patients than they do for treating the uninsured.[38]

The difference in reimbursement rates does not capture the additional hassles involved in treating Medicaid patients—such as late payments from the government and excessive paperwork—relative to the uninsured, who pay in cash.

Surveys consistently show that patients with private insurance have far superior access to care than those on Medicaid. The 2008 Health Tracking Physician Survey found that internists were 8.5 times as likely to refuse to accept any Medicaid patients, relative to those with private insurance.[39]

A 2011 study published in the *New England Journal of Medicine* found that individuals posing as mothers of children with serious medical conditions were denied an appointment 66 percent of the time if they said that their child was on Medicaid (or the related Children's Health Insurance Program), compared with 11 percent for private insurance—a ratio of 6 to 1.[40]

Among clinics that did accept both Medicaid/CHIP and privately insured children, the average wait time for an appointment was 42 days for Medicaid and 20 days for the privately insured. A related study, published by the same group in *Pediatrics*, found that 63.5 percent of Medicaid/CHIP beneficiaries were unable to get an appointment, compared with 4.6 percent of those with private insurance—a ratio of 14 to 1.[41]

These differences in access to physician care go very far in explaining why Medicaid patients suffer from poorer health outcomes than their counterparts with private insurance. It is likely that the poor outcomes of cancer patients on Medicaid are caused by the fact that those patients' cancers are not diagnosed early enough to receive effective treatment.

In addition, even when Medicaid patients gain access to care, the quality of that care is below average. A UCLA study published in the *Journal of the American Medical Association* found that those on Medicaid were far more likely to be treated in low-volume surgical centers than high-volume ones; high-volume surgical centers have consistently demonstrated superior outcomes.[42]

CREATIVE FINANCING GIMMICKS HAVE DISTENDED MEDICAID'S BUDGET

IN TURN, THE PRINCIPAL DRIVER OF MEDICAID'S POOR provider reimbursement rates is its dysfunctional fiscal structure. Medicaid is jointly funded by state governments and the federal government. Because neither party has full responsibility for the program, both parties have engaged in irresponsible behavior.

As Medicaid has grown over time, state budgets have come under increasing strain. States' Medicaid obligations now crowd out spending on other important responsibilities, such as education and public safety.

But it is mostly illegal for states to increase co-pays, deductibles, or premiums for Medicaid enrollees. Moving people off of the Medicaid rolls is highly controversial. And most attempts by state governments to enact minor programmatic changes must survive a lengthy waiver process with the U.S. Department of Health and Human Services.

As a result, the path of least political resistance has been for states to reduce Medicaid's reimbursements to health care providers: paying hospitals and doctors less for the same level of service.

But states are not innocent victims of the federal government; they, too, have at times imprudently ex-

panded their Medicaid programs by establishing creative financial schemes that transferred the costs of Medicaid expansions onto federal taxpayers.

As a result, when it comes to Medicaid, the interests of states and the federal government have diverged.

States have attempted to offload more costs onto the federal government, and the federal government has attempted to offload more costs onto the states.

As the Bipartisan Policy Center describes in its 2010 fiscal-reform proposal drafted by a panel co-chaired by Pete Domenici and Alice Rivlin, a federally mandated Medicaid expansion of Medicaid eligibility in the 1980s drove state governments to seek "every possible opportunity to amend the financing structure of state- and locally funded health care programs to cover additional services under Medicaid, and hence receive federal matching payments for these services."[43] In addition:

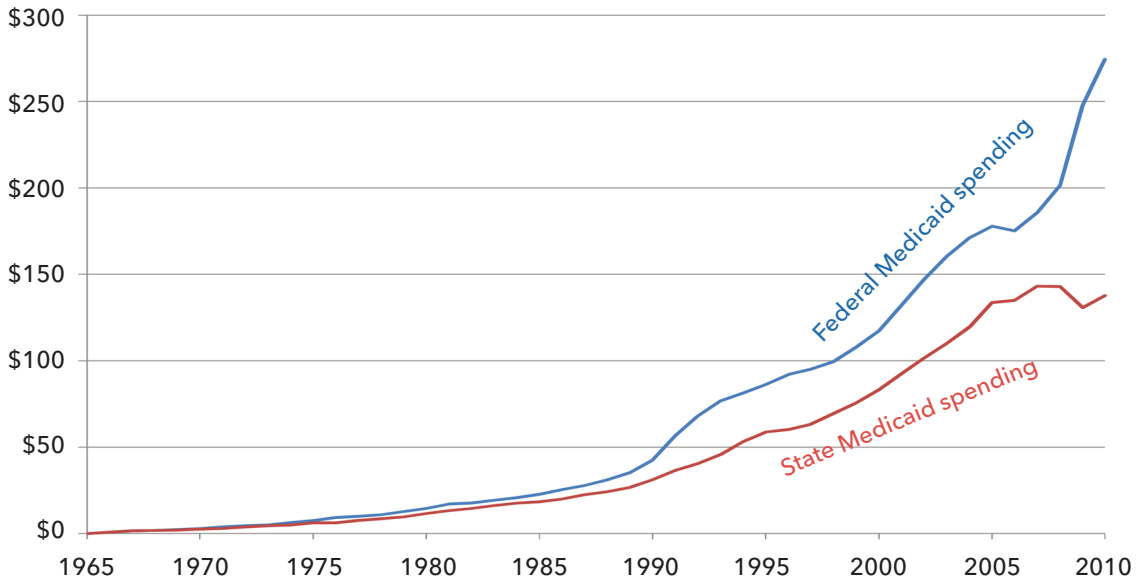
> States became highly creative in obtaining Medicaid for health services—such as visits to the school nurse by low-income children—that were previously fully funded with state and local resources. This search for federal dollars, referred to as "Medicaidization," brought dozens of new provider types and service categories under Medicaid.

States then created additional strategies to drive up federal funding.

In order to siphon additional Medicaid funding from federal taxpayers, they invented special Medicaid hospital taxes that increased state tax revenue, while also driving up the cost of care and thereby triggering additional federal Medicaid subsidies.

For example, a state hospital tax of $100 might be entirely passed on to the Medicaid program in the form of higher costs. If the federal government is required to fund 60 percent of a state's Medicaid program, that

Figure 16. Growth in Federal vs. State Spending on Medicaid, 1966–2009 (Billions)



States have gamed the system to attract more federal funds, while still reducing provider payments. During the first two decades of the Medicaid program (1965–85), state (*red*) and federal (*blue*) spending on Medicaid grew in concert. However, a federally mandated expansion of Medicaid eligibility in the 1980s drove states to deploy creative accounting techniques, such as provider and premium taxes, that could increase the proportion of Medicaid spending borne by the federal government. According to the official government formula–the Federal Medical Assistance Percentage, or FMAP–the federal government is paying for 60 percent of the pre-ACA Medicaid program, while the states are paying 40 percent. In reality, however, the federal government is paying 67 percent, and the states 33 percent: a difference of more than $30 billion per year. *(Source: Bipartisan Policy Center, CMS)*

$100 tax results in a net gain to the state of $60 in extra federal Medicaid funding.

Similarly, states have also instituted sales and excise taxes on private health insurance premiums, and then contracted out their Medicaid programs to private insurers in order to collect premium taxes on the privately managed Medicaid plans.

These schemes did nothing to improve the quality of care offered to Medicaid beneficiaries, or increase reimbursement rates, but merely drove federal funds to state budgets, giving states the freedom to pursue other priorities with their own tax revenue.

The Bipartisan Policy Center observes that "by the early 1990s, the effective [federal contribution] for [Medicaid] hospital services exceeded 70 percent, far more than the national average matching rate of 56 percent that had prevailed throughout the first 25 years of the program" (***Figure 16***).

To this day, what BPC describes as a "shoving match" continues between state governments and the federal government, as each party strives to engage in ever more complex fiscal engineering, decreasing the stability of Medicaid's financial structure.

MIGRATING THE MEDICAID ACUTE-CARE POPULATION INTO THE INDIVIDUAL MARKET

The Affordable Care Act's system of means-tested tax credits, as reformed by the Universal Tax Credit Plan, offer an opportunity to address these problems, and also to substantially increase the quality of health coverage currently offered to the Medicaid and Children's Health Insurance Program populations.

The Universal Tax Credit Plan achieves this by seeking to migrate the entire Medicaid acute-care population onto the reformed individual market. (For the purposes of simplicity, when this document refers to "Medicaid" it is referring to both the adult Medicaid program and the related CHIP.)

Medicaid funds two separate insurance programs: *acute care*, a form of conventional health insurance for hospital and physician services; and *long-term care*, which funds nursing home stays and home health visits for the elderly and disabled. The premium and cost-sharing subsidies for private coverage that are now available to those with incomes between 100 and 133 percent of the Federal Poverty Level, under the ACA, would under the Universal Tax Credit Plan be also available to all those with incomes below the poverty line.

By default, Medicaid acute-care enrollees would be gradually migrated onto the benchmark individual market plan in their states. Those who wished to remain in Medicaid, and not migrate onto the individual market, could opt out and remain in the legacy Medicaid program until January 1, 2027.

Another important problem facing the Medicaid population is the problem of *churn* between different types of insurance coverage. Poor individuals tend to have highly volatile incomes, leading to eligibility for different health insurance programs from month to month. This can end up disrupting relationships between patients and doctors, as different health plans offer different physician networks. By migrating Medicaid-eligible individuals into the reformed individual market, the Universal Tax Credit Plan would considerably mitigate the problem of churn.

States fund, on average, approximately 40 percent of the traditional Medicaid program; the federal government funds the remainder. However, the Affordable Care Act's insurance exchanges are entirely funded by the federal government. Hence, migrating the Medicaid acute-care population into the individual market, over a ten-year period, would increase federal funding responsibilities by approximately $1.2 trillion, and reduce state spending by a corresponding amount, excluding the impact of higher per-member costs with individual coverage (accounted for elsewhere in the Plan), and the fiscal offsets described below:

1. Returning responsibility for long-term care to the states

Under the plan, states that agree to transfer their Medicaid acute-care populations into the reformed individual market would be required, over time, to take over full funding and administrative responsibility for the Medicaid long-term care program.

This would operate, in effect, like a block grant from the federal government to the states, with two important differences: most states would eventually be 100 percent responsible for funding their long-term care programs; and they would be required to fund the program at levels that were no less than what the Centers for Medicare and Medicaid Services would have pro-

jected as the annual costs of the long-term care program through 2036 (i.e., a "maintenance of effort" requirement).

By requiring states to fund their long-term care programs at existing levels, but increasing their administrative flexibility, states could do much more than Medicaid currently allows. For example, they could assist beneficiaries with capital expenditures, such as increasing the accessibility of their homes to wheelchairs. Giving beneficiaries the tools they need to remain in their homes, instead of in long-term care facilities, will improve the quality of their lives while also optimizing program expenditures.

One significant advantage of cleaning up Medicaid's lines of responsibility is that it would substantially improve states' authority over their Medicaid-eligible populations. While the Universal Tax Credit Plan assigns to the federal government the financial responsibility of funding acute-care insurance for this cohort, state governments would have the authority to regulate the private health insurance plans that individuals would purchase on the reformed individual market.

This feature, combined with states' full authority over the long-term care program, would end the "1115 Waiver" system, in which state governments must ask federal permission, and wait years, to implement even trivial Medicaid reforms.

As John Holahan of the Urban Institute has pointed out, moving financial responsibility for Medicaid long-term care to the states will affect different states differently, depending on the size and scale of their long-term care populations.[44] Under a swap, a minority of states would end up as fiscal "losers," with a total net loss amongst them of $4.5 billion a year in 2011 dollars. These disparities can be managed through a gradual transition in which states with large long-term care populations receive supplemental grants from the federal government.[45]

In sum, the Medicaid swap and related offsets below would be designed in such a way so as to be modestly fiscally advantageous to every state government, relative to the federal government, in order to encourage states' participation.

2. Prohibition of state Medicaid provider taxes

The report published in 2010 by President Obama's National Commission on Fiscal Responsibility and Reform—popularly known as Simpson-Bowles—recommends "asking states to take responsibility for more of Medicaid's administrative costs by eliminating Medicaid payments for administrative costs that are duplicative of funds originally included in the Temporary Assistance for Needy Families (TANF) block grants."[46] We estimate that doing this would reduce federal spending by $3 billion between 2017 and 2026.

Importantly, the Simpson-Bowles report took on the issue of creative financing, noting that "many states finance a portion of their Medicaid spending by imposing taxes on the very same health care providers who are paid by the Medicaid program, increasing payments to those providers by the same amount and then using that additional 'spending' to increase their federal match. We recommend restricting and eventually eliminating this practice."

3. Sales and excise tax exemption for subsidized health insurance

An important driver of inflated health insurance premiums in the United States is state-based sales taxes and premium taxes. These taxes are passed onto consumers in the form of higher premiums, and passed onto taxpayers in the form of larger federal and state subsidies for health insurance premiums.

Take the example of an employer-based family health insurance plan costing $15,000 per year. Ohio, for instance, imposes a 5.5 percent sales tax and a 1 percent premium tax, amounting to an additional $975 per family. If that family is in the 25 percent federal tax bracket, and is liable for 15.3 percent in payroll taxes, these state taxes also result in $393 in lost revenue to the federal government. In other words, federal taxpayers are subsidizing Maryland's sales and premium taxes.

The problem is even worse in states that contract with private managed-care companies to administer their Medicaid programs. A $15,000 Medicaid plan, thereby subject to $975 in sales and premium taxes, might be 60 percent subsidized by the federal government, leading to $585 in additional federal spending.

The state government, by contrast, makes money on this deal: $975 in additional tax revenue, for $390 in additional state Medicaid spending, for a net gain of $585. In effect, the tax gimmick allows states to tax the citizens of other states. For every dollar of taxes that a state levies on its Medicaid program, 60 cents

are levied upon the taxpayers of other states. It is not difficult to see why many state-based politicians have found this maneuver appealing.

Furthermore, these premium taxes give states a perverse incentive to mismanage their Medicaid programs, by making commitments they cannot sustain over time. In order to rectify this problem, the Universal Tax Credit Plan renders all federally subsidized health insurance plans—from Medicare, Medicaid, CHIP, individual tax credits, and employers—as exempt from state and local sales and premium taxes.

We estimate that the gross federal deficit-reducing effect of this change could exceed $100 billion in 2019, though it would be more than offset under the Plan by decreased state spending on the Medicaid acute-care population.

HARMONIZING FEDERAL ASSISTANCE FOR THE DISABLED

The federal government provides assistance to the disabled through the Medicaid and Medicare programs. Under the Universal Tax Credit Plan, Medicaid's long-term care for the disabled would be transitioned fully to the states, while Medicaid's acute-care coverage for the disabled would become entirely a federal responsibility.

The Universal Tax Credit Plan would take into account the special needs of the disabled population by consolidating acute-care coverage for the disabled in Medicare with the federal government's newly expanded responsibilities for acute care for the disabled Medicaid population.

The Plan would create a bipartisan commission to consider and enact reforms of this consolidated acute-care program for the disabled, in order to achieve the following goals:

Ensure that federal resources are focused on the truly disabled. This involves reexamining Reagan-era reforms that rolled back the use of objective health criteria in evaluating eligibility for disability coverage.[47]

Address the currently uninsured disabled population. The commission would examine the broader suite of eligibility criteria to see if there are gaps in the disabled population for whom assistance is warranted.

Harmonize asset limitations. Under Medicaid, many states require a disabled individual to have very low amounts of assets—under $2,000, for example—in order to gain certain types of disability coverage. However, Medicare does not have asset limits. As a result, low-income individuals have far stricter asset requirements than high-income individuals for federal disability coverage. These asset limits should be harmonized across the federally assisted population.

Rationalize the relationship between cash aid and health coverage. It may be worthwhile to convert some of the cash assistance offered to disabled individuals into health coverage, or vice versa, in order to maximize the efficacy of federal assistance.

Fiscal neutrality. Reforms adopted by the commission should, in total, have the net effect of maintaining federal spending on the disabled at its currently projected levels.

'DUAL ELIGIBLES' CONSOLIDATED ONTO THE REFORMED INDIVIDUAL MARKET

Approximately 10 million U.S. residents, primarily low-income retirees, are eligible for both Medicare and Medicaid. Because these individuals today gain health coverage from two very different government programs, with overlapping benefits and differing physician networks, care for these vulnerable individuals is often of poor quality and excessive cost.

Under the Universal Tax Credit Plan, all of these "dual eligible" individuals would be migrated onto the reformed individual market, where they would receive an tax credit-based insurance benefit of the same actuarial value as that represented by their existing Medicare and Medicaid coverage.

This would amount to a benchmark individual plan with the cost-sharing subsidies—in the form of health savings account subsidies—needed to achieve actuarial equivalence. In this way, dual-eligible individuals could gain coverage from a single health plan managed by a single insurer, with a unified network of physicians and hospitals. Over time, such an approach should lead to substantially higher-quality care, and lower costs, than the existing patchwork system.

Part Four

Medicare Reform: Ensuring the Permanence of Seniors' Health Benefits

While Medicare remains popular with seniors, the program's flawed design has led to trillions of dollars in cost overruns. Medicare remains at the heart of the fiscal challenges faced by the United States.

While some talk of a slowdown in the growth of Medicare spending, the Medicare trustees predicted in 2016 that the Medicare Trust Fund will run out of money in 2028, two years earlier than its previous estimate. In the meantime, as the baby boomers retire, the program continues to accumulate deficits at an alarming pace.

In the *Wall Street Journal*, Robert Reischauer, a Democratic Medicare trustee and former CBO director, has warned against fiscal complacency, because it will only make the problem worse: "The sooner that lawmakers act, the broader will be the array of policy options that they can consider, and the greater the opportunity will be to craft solutions that are both balanced and equitable."[48]

MEDICARE'S INHERENTLY FLAWED DESIGN

In most other industrialized countries, state-funded health insurance began with the poor, and was gradually extended up the income ladder. But in mid-twentieth-century America, there was still a significant stigma attached to being "on the dole," and income tests were considered demeaning.

Policymakers who sought an expanded role for government in health care thus believed that starting with the elderly would be more politically palatable. After all, the elderly were a far more sympathetic group in the public's eyes: older Americans had less opportunity to earn their own money to fund their health care, and were therefore generally poorer than other Americans (along with being less healthy).

Being both relatively poor and relatively unhealthy, they were, in turn, less likely to have health insurance. And policymakers believed that the model of Social Security as a "self-financed" program for the elderly, paid for with a dedicated payroll tax, could easily be extended to health insurance.

But by creating a universal, single-payer health care program for every American over 65, regardless of financial or medical need, the drafters of Medicare made the program extremely difficult to reform.

THE MEDICARE POLICY TRAP

Princeton sociologist Paul Starr describes this feature of Medicare as a "policy trap." In Starr's 2011 book, *Remedy and Reaction*, he observes:

> When America finally adopted critical tax and health-financing policies in the two decades after World War II, it ensnared itself in a policy trap, devising an increasingly costly and complicated system that has satisfied enough of the public and so enriched the health care industry as to make change extraordinarily difficult. Escaping from that policy trap has become a politically treacherous national imperative.

Today, Medicare's finances are on autopilot. In contrast to most government programs, which are funded by explicit congressional appropriations, Medicare beneficiaries are eligible for guaranteed health benefits, regardless of their cost.

And the illusion of pre-funded benefits—the notion

that Americans pay into the system while they work and then merely withdraw the funds they put in when they retire—no longer bears any relation to reality.

According to calculations published in 2011 by Eugene Steuerle and Stephanie Rennane of the Urban Institute, the average two-earner married couple retiring in 2010 had paid $109,000 in Medicare taxes while working, but will receive $343,000 in inflation-adjusted benefits during retirement. A similar couple retiring in 2030 will have paid $167,000 in taxes and will receive $530,000 in inflation-adjusted benefits.[49]

Medicare is simply a massive—and growing—transfer of resources from younger workers to older retirees. And since the elderly are no longer the poorest Americans—on the contrary, Americans over the age of 65 are now significantly wealthier than younger Americans—Medicare is largely a transfer of resources from poorer to wealthier individuals.

MEDICARE'S KLUDGEOCRACY

Johns Hopkins political scientist Steven Teles has observed a growing phenomenon in American public policy that he calls the "kludgeocracy." Citing the *Oxford English Dictionary*, he explains that "a 'kludge' is 'an ill-assorted collection of parts assembled to fulfill a particular purpose'…To see policy kludges in action, one need look no further than the mind-numbing complexity of the [American] health care system."[50]

While kludgeocracy does certainly describe the U.S. health care system as a whole, the Medicare program is a particularly notable manifestation of one. Its four separate programs—Part A for hospital insurance, Part B for physician services, Part C for privately managed benefits, and Part D for prescription drugs—are profoundly inefficient, requiring most seniors to receive uncoordinated and costly care that can lead to suboptimal health outcomes.

For all its spending—$683 billion in 2016—Medicare does not provide catastrophic coverage against long-term hospitalizations. In 2016, Medicare's Part A hospital insurance covers the first 60 days of a hospitalization, with a $1,288 deductible. The next 30 days include a coinsurance fee of $322 per hospital day. After a specified reserve period, retirees are liable for all hospital costs. Hence, while Medicare pays for many services, seniors are still liable for catastrophic costs above those covered by Part A.

Many seniors purchase an additional kludge—supplemental insurance called "Medigap"—at additional cost in order to address this problem. These Medigap policies do much to accelerate Medicare's wasteful spending, however, by wiping out the cost-sharing features of the program such as co-pays and deductibles.

Medigap plans have proven difficult to reform, because a single organization—the AARP—generates billions of dollars in royalty fees from them. In 2011, AARP received $528 million in Medigap royalties, nearly twice the $297 million the organization received in membership dues.[51]

The Medicare kludgeocracy has resulted in Medicare costs that far exceed those of coverage expansions in other countries. Private health insurance for the non-elderly is also far costlier than it should be, because Medicare's poor cost controls initially allowed hospitals and doctors to charge whatever they want, knowing that taxpayers would foot the bill.

Amy Finkelstein of MIT has shown that Medicare's impact on increased hospital spending is over six times greater than what a normal expansion of health insurance would have been expected to yield.[52]

Growth in Medicare spending has slowed in recent years, largely because of decreasing payments to hospitals and physicians for delivered medical services. But that has led an increasing number of doctors to stop taking Medicare patients.

MODERNIZING AND MEANS-TESTING THE HEALTH BENEFITS OF FUTURE RETIREES

Both of these problems—Medicare's unsustainable costs and the program's wasteful design—can be addressed by gradually migrating younger future retirees onto the reformed individual insurance market.

The Universal Tax Credit Plan's core Medicare reform is quite simple. Beginning in 2016, the Plan increases the Medicare eligibility age by four months each year, forever.

Today, seniors become eligible for Medicare when they turn 65. Under the Plan's reforms, for example, those born in 1954 would not become eligible for Medicare until they turn 67, in 2021. However, be-

tween the ages of 65 and 67, nearly all of them would have the option to remain on the health insurance plans they had been on when they were 64: either subsidized coverage in the reformed individual market, employer-sponsored coverage, or unsubsidized, individually purchased insurance.

The net effect of this change—especially in the years 2036–45—is to focus the federal government's financial resources on providing a comprehensive, modern, private-sector health insurance benefit to low-income retirees of the future, while preserving Medicare for those who are currently enrolled in the program.

When Medicare was enacted, in 1965, the average life expectancy at birth was 70.2 years. In other words, it was anticipated that Medicare would cover an average person's health expenditures for the last 5.2 years of his life. In 2010, the average American lived to the age of 78.4; Medicare thus covered the last 13.4 years of his life—a 158% increase in the coverage period. The U.S. Census Bureau projects that, in every successive eight-year interval, American life expectancy will increase by an additional year.

By gradually raising Medicare's retirement age, the Universal Tax Credit Plan returns Medicare to its traditional role of managing the needs of those near the end of their lives. It encourages those who are willing and able to remain in the workforce, enhancing economic growth, tax revenue, and productivity. And it provides a modern insurance benefit, with catastrophic protection and coordinated care, to those who are in need of federal assistance.

Moreover, as noted above, the arrival of means-tested tax credits—as reformed by the Universal Tax Credit Plan—allows us to reform Medicare while actually *increasing* the continuity of coverage for those in their sixties. Note that, due to an age-based adjustment, the benchmark individual plan under the Universal Tax Credit Plan is more financially generous: it has a lower deductible level, and a larger HSA subsidy, relative to the benchmark plan for younger individuals.

Most importantly, this approach ensures the permanent solvency of the Medicare program, by focusing the program's resources on the most elderly Americans. Premiums of older seniors who remained in the traditional Medicare program would not be affected by younger retirees moving to the individual market.

Over a 30-year period, we estimate that raising the eligibility age for Medicare by four months per year would reduce Medicare spending by $6.6 trillion, with an offsetting increase in premium tax credits of $1.5 trillion, for a net spending reduction of $5.1 trillion. These savings would be even larger in future decades.

BIPARTISAN REFORMS OF THE TRADITIONAL MEDICARE PROGRAM

THERE ARE ADDITIONAL, INCREMENTAL, BIPARTISAN reforms that the Universal Tax Credit Plan proposes for the Medicare program.

The Plan adopts several proposals from the Simpson-Bowles National Commission on Fiscal Responsibility and Reform, and also from a bipartisan proposal from U.S. senators Joe Lieberman of Connecticut and Tom Coburn of Oklahoma, published in 2011:

1. Reduce Medicare subsidies for hospitals' uncollected bills

As the Simpson-Bowles commission noted: "Currently, Medicare reimburses hospitals and other providers for unpaid deductibles and copays owed by beneficiaries. We recommend gradually putting an end to this practice, which is not mirrored in the private sector." As a complement to this initiative, Congress should ensure that hospitals have the necessary freedoms to collect unpaid bills that exist in other industries such as credit cards and telecommunications. We estimate 30-year savings from this provision as $128 billion.

2. Exempt Part C and Part D plans from state and local sales and premium taxes

As noted in Part Three of this report, state governments frequently apply sales and premium taxes to privately administered health plans, including Medicare Part C and Part D plans. The Universal Tax Credit Plan renders all federally subsidized plans as exempt from such taxes.

3. Replace Medicare's cost-sharing kludge with a unified annual deductible; reform Medigap insurance plans

The Lieberman-Coburn proposal notes the value of combining Medicare Parts A and B into a single insurance product for hospital and medical care, and capping the amount of money that a Medicare enrollee

would have to spend out of pocket in a given year. We estimate 30-year savings from this reform of approximately $635 billion.

The Congressional Budget Office has also analyzed the potential of bundling payments for inpatient care and 90 days of post-acute outpatient care. We estimate 30-year savings from this reform of approximately $410 billion.

4. Introduce additional means-testing into Medicare Part D premiums

The Universal Tax Credit Plan also introduces additional means-testing into the Medicare prescription-drug benefit, also known as Part D, for a 30-year savings of $211 billion.

5. Reduce waste, fraud, and abuse

The U.S. Government Accountability Office estimates that as much as 10 percent of Medicare spending was improper in 2009. Harvard fraud expert Malcolm Sparrow has testified that "loss rates due to fraud and abuse could be 10 percent, or 20 percent, or even 30 percent in some segments."[53]

In 2012, Stephen Parente and colleagues at Fortel Analytics took a set of algorithms designed by scientists in 1993 to achieve real-time fraud prevention in the credit-card industry, and applied them to Medicare. By analyzing Medicare claims representing 20 percent of all enrollees—and 100 percent of enrollees for a 3 percent sample of all national Medicare providers—they estimated that their approach would have reduced 2009 Medicare waste by $20.7 billion in Medicare Part A, $18.1 billion in Medicare Part B, and $17.5 billion in retrospective recovery.[54]

The Universal Tax Credit Plan implements this system.

6. Restore the ability of seniors to opt out of Medicare and purchase private health coverage

In 1993, the Clinton administration passed a regulation requiring Medicare-eligible retirees to enroll in the program, or forfeit their Social Security benefits.

In 2012, the rule was upheld in a 2-1 decision by the U.S. Court of Appeals for the District of Columbia;[55] though the plaintiffs appealed to the Supreme Court, the high court declined to hear the case.[56]

Sen. Jim DeMint of South Carolina, Rep. Sam Johnson of Texas, and others in 2011 introduced legislation to guarantee that seniors could opt out of Medicare and retain their Social Security benefits, "in accordance with a process determined by the Secretary" of Health and Human Services.[57]

The Universal Tax Credit Plan incorporates similar language, while limiting open enrollment periods to protect against adverse selection.

7. Restore the pre-ACA tax subsidy for employer-sponsored retiree coverage

The Medicare Modernization Act of 2003—which created the Part D prescription-drug benefit—carved out a tax exclusion for employer-sponsored retiree prescription-drug coverage. The carve-out amounted to an effective subsidy of 28 percent of retiree prescription-drug costs, with a cap of $1,677 per beneficiary in 2010.

This provision was included in the MMA to encourage employers to continue to provide privately sponsored prescription-drug coverage, instead of dropping seniors' drug coverage onto Medicare.

The ACA repealed this subsidy in order to recapture $5.4 billion in federal revenue over ten years, according to the Joint Committee on Taxation. The Universal Tax Credit Plan restores the carve-out, in order to encourage more employers to sponsor retiree health benefits.

8. Address the physician shortage through additional graduate medical education funding and visa expansion

According to the Association of American Medical Colleges, in 2020 the United States will face a shortage of more than 91,500 physicians. The group estimates that by 2025 the physician shortage will increase to 130,600.[58]

This shortage has been exacerbated by the Balanced Budget Act of 1997, which capped the number of federally funded residency positions at 26,000.

Catherine Dower, of the University of California at San Francisco, estimates that the federal government spent more than $11.5 billion on graduate medical education in 2012, of which $9.5 billion came from Medicare and $2 billion from Medicaid.[59] Other fed-

eral and state agencies, such as the Defense Department, the Department of Veterans Affairs, and the National Institutes of Health also fund graduate medical education.

The Universal Tax Credit Plan seeks to eliminate the physician shortage projected by the AAMC in the following ways: (1) by increasing federal funding of graduate medical education by $6 billion a year starting in 2016, contingent on a corresponding increase in residency and internship slots; (2) by separating federal funding of graduate medical education out from Medicare, Medicaid, and other agencies into a discrete congressional appropriation; and (3) by expanding the number of foreign visas for immigrant physicians who have passed U.S. medical board licensing examinations.

MODERNIZING THE CARE OF DISABLED AND MEDICAID-ELIGIBLE SENIORS

As noted in Part Three, approximately 10 million U.S. residents—primarily low-income retirees—are eligible for both Medicare and Medicaid. Because these individuals gain health coverage from two very different government programs, with overlapping benefits and differing physician networks, care for these vulnerable individuals is often of poor quality and excessive cost.

Under the Universal Tax Credit Plan, these "dual-eligible" individuals would be migrated entirely into the subsidized individual market, where they would receive an insurance benefit of the same actuarial value as that represented by their existing Medicare and Medicaid coverage. This would amount to a benchmark individual plan with the cost-sharing subsidies—in the form of health savings account subsidies—needed to achieve actuarial equivalence.

In this way, dual-eligible individuals could gain coverage from a single health plan managed by a single insurer, with a consistent network of physicians and hospitals. Over time, such an approach should lead to substantially higher-quality care, and lower costs, than the existing patchwork system.

In addition, the Universal Tax Credit Plan would take into account the special needs of the disabled population by consolidating acute-care coverage for the disabled in Medicare with the federal government's newly expanded responsibilities for acute care for the disabled population. The Plan would create a bipartisan commission to propose reforms of this consolidated acute-care program for the disabled.

Part Five

Achieving Health Care Independence for Veterans

There are few promises made by the United States more sacred than the ones made to its soldiers. For centuries, the federal government has provided compensation and care to those injured while risking their lives to defend their country. But this promise has come under increased strain. Recent scandals have highlighted the inconsistent quality of health care for veterans—and the long, checkered history of federal veterans' programs. But from scandal and tragedy arise opportunity: the opportunity to offer injured and low-income veterans the kind of health care enjoyed by most Americans.

On April 23, 2014, Scott Bronstein and Drew Griffin of CNN reported that more than 40 veterans had died while waiting for appointments at the Phoenix Veterans Affairs Health Care System. Worse still, Bronstein and Griffin obtained internal e-mails from top officials at the Phoenix VA, who had signed off on an "elaborate scheme [to] hide that 1,400 to 1,600 sick veterans were forced to wait months to see a doctor."

On September 28, 2013, Thomas Breen, a 71-year-old Navy veteran and cancer survivor, discovered blood in his urine. His son and daughter-in-law brought him to the emergency room at the Phoenix VA. The ER staff examined Breen and wrote that he urgently needed to see a urologist or a primary care physician. They then sent him home.

Despite numerous calls by Breen's daughter-in-law, Sally, to the VA, it took nearly ten weeks for the medical center to offer him a physician's appointment. "We finally have that appointment," said the VA official. "We have a primary for him." Sally responded, "Really, you're a little too late, sweetheart." Breen had died the previous week, of Stage 4 bladder cancer. Phoenix VA officials, it turned out, were producing two patient waiting lists: an "official" list send to VA headquarters in Washington, asserting timely care for veterans; and a secret—but more accurate—list, in which ailing veterans waited more than a year to see a doctor.

"The scheme was deliberately put in place to avoid the VA's own internal rules," rules that require the VA to provide timely care, said Sam Foote, a recently retired VA physician. "I feel very sorry for the people who work at the Phoenix VA," continued Foote. "They're all frustrated. They're all upset. They all wish they could leave 'cause they know what they're doing is wrong. But they have families, they have mortgages, and if they speak out or say anything to anybody about it, they will be fired, and they know that."

It soon became apparent that the problem of officials manipulating official patient waiting lists was not isolated to the Phoenix VA. VA medical centers in Colorado, Illinois, Missouri, North Carolina, Texas, Wyoming, and elsewhere were doing the same things.

Our health care system for veterans has proven uniquely vulnerable to these kinds of problems. Efforts to reform the VA have proven extremely difficult. To understand why, it is important to review the institutional history of veterans' health care in the U.S.

THE ORIGINS OF THE VA: FINANCIAL AID FOR DISABLED VETERANS

Today, the Veterans Healthcare System is the largest non-defense employer in the federal government, with more than 275,000 workers. Its closest analogue among western health care systems is the British National Health Service. Like the British NHS, the VHA is a socialized system, in which the government owns the hospitals, employs the physicians, and functions as the insurer. Complaints about the VA—long wait times, inconsistent quality, bureaucratic care—are akin to those commonly lodged at the NHS.

But the VA evolved in the direction it did for reasons

that were understandable at the time, reasons that are worth reviewing if we are to understand how best to improve veterans' health care.

On May 31, 1776, the Continental Congress created a committee "to consider what provision ought to be made for such as are wounded or disabled in the land or sea service, and report a plan for that purpose." The idea was that disabled veterans could not work for a living, and needed a form of workers' compensation in the event of a disabling injury.

John Adams declared, in a letter to a colleague, that "the equity and the policy of making provision for the unfortunate officer or soldier is extremely just." Eight weeks after the Declaration of Independence, the Congress passed the nation's first federal pension law, promising half pay for life to any officer, soldier, or sailor disabled in the service of the United States.

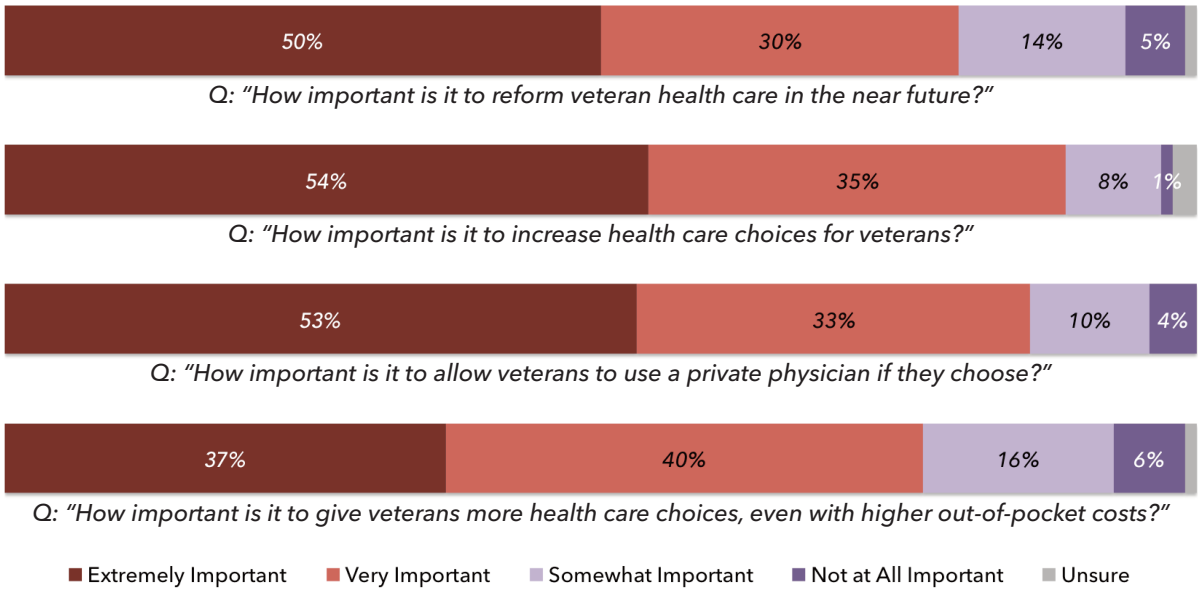
Despite repeated pleadings from General George Washington, that promise was not initially kept. When war ended in 1783, the fledgling federal government was drowning in debt. Instead of providing half pay for life, disabled veterans received interest-bearing "commutation certificates" whose cash value dwindled over time.

But federal finances gradually stabilized. In 1828, President John Quincy Adams signed a law granting full pay for life to surviving veterans of the Revolutionary War, whether disabled or able-bodied. It was the first of many instances of the U.S. government expanding compensation beyond those with service-connected injuries.

Congress expanded the scope of veterans' benefits during the Civil War. In 1862, President Lincoln signed a law providing pensions not only to disabled veterans of past wars, but also to veterans of all future military actions undertaken by the United States, so long as the claimant could demonstrate that his disability was the direct consequence of his military duty.

Lincoln used his second inaugural address to uphold the government's role in providing care to disabled veterans: "With malice toward none, with charity for all, with firmness in the right as God gives us to see

Figure 17. Survey Data on Importance of Health Reform to Veterans



Veterans are eager for private options, even if they include higher out-of-pocket costs. Opponents of VHA reform have long argued that veterans are happy with the system as it is. The Tarrance Group, in November 2014, conducted a survey of 1,000 veterans with a 3.1% margin of error. Tarrance found that 86 percent of veterans thought it "extremely" or "very important" to allow veterans to seek care from private physicians; 77 percent thought it "extremely" or "very important" to have alternative coverage options, even if that meant higher out-of-pocket costs. *(Source: Tarrance Group, Concerned Veterans for America)*

the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow, and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

In the nineteenth century, both federal and state governments sought to expand their role in the care of disabled veterans. As a supplement to providing financial compensation, governments sought to provide an early form of long-term care to veterans with service-connected injuries.

In 1827, architect William Strickland was tasked by the U.S. Navy with making "the necessary contracts for materials, and superintend the building of a 'permanent asylum for decrepid navy officers, seamen, and marines,' at Philadelphia." What became known as "old soldiers' homes" proliferated after the Civil War, to care for disabled and elderly veterans, and the widows and orphans of those who died in battle.

WORLD WAR I TRANSFORMS VETERANS' HEALTH CARE

As veterans returned home from the Great War, veterans' care underwent severe strain. In 1890, the U.S. Census recorded 1 million Union veterans. But 4.7 million Americans had been mobilized for World War I, from which 116,000 died and 204,000 returned wounded. American involvement in the war had drawn up and down so quickly that the government could not adequately prepare.

World War I made clear that veterans needed more than homes: they needed hospital care. The War Risk Insurance Act of 1917 provided federal financing for care of all service-connected injuries, whether through government-owned or private hospitals. Prior to that time, because voluntary (i.e., civilian) hospital beds were scarce, veterans needing hospital care received it from active-duty military hospitals. Furthermore, World War I veterans came home with two unusual health problems: tuberculosis, caused by chemical warfare, and "shell shock" from the unprecedented use of artillery and trenches.

By this time, veterans' financial and health care needs were being managed by five different government agencies: the Bureau of War Risk Insurance, the Public Health Service, the Federal Board of Vocational Education, the Bureau of Pensions, and the National Homes for Disabled Volunteer Soldiers.

This set of problems—the sudden burst of wartime activity; the unique medical problems of World War I veterans; the uncoordinated and overlapping administration of veterans' benefits; outdated civil-service laws; and the inherently slow-moving nature of government agencies—combined to renew outcry about the way veterans were treated after they returned home.

In response, in 1921 Congress established the U.S. Veterans' Bureau. The new Bureau was designed to provide a single point of responsibility for health care for wounded and disabled veterans, consolidating the government's risk insurance, public health, and vocational programs.

President Warren Harding appointed Col. Charles Forbes, a manager of a construction company in Washington state, to serve as the first director of the Veterans' Bureau. The Bureau was assigned a substantial budget to build hospitals for veterans around the country, in order to ensure that soldiers and sailors would receive high quality health care.

But few of those hospitals were completed. A congressional investigation found that Forbes had massively overpaid for land to build veterans' hospitals, and provisions to supply them, in exchange for kickbacks from landowners and manufacturers. The total taxpayer cost of Forbes' waste, fraud, and abuse amounted to $200 million, or $2.8 billion in 2015 dollars. He was sentenced to two years in Leavenworth Penitentiary.

THE VA'S CYCLE OF SCANDAL AND FAILED REFORMS

Almost from the very moment that the federal government committed to nationwide hospital care for veterans, there were complaints about the conditions at veterans' facilities.

In 1921, one witness told a Senate committee that care for veterans with tuberculosis and psychiatric conditions had become "so wholly inadequate as to amount to practically nothing."

In addition, veterans faced substantial delays in receiving compensation for hospital care, with one sen-

ator charging that veterans were being cared for by "incompetent political doctors" in the Public Health Service, political appointees rather than meritocratic ones.

Driven by these concerns, Congress folded the veterans' portion of the Public Health Service into the new Veterans Bureau. But the Charles Forbes corruption scandals, driven in large part by waste, fraud, and abuse in the construction of veterans hospitals, led to a second round of consolidation in 1930, and the formation of the Veterans Administration.

Bureau officials did strive to improve the quality of veterans' health care. In 1925, Frank Hines prompted a collaboration with the American College of Surgeons to improve the performance of veterans' hospitals. The Bureau established a section on medical research, and set up two residency programs for training in the neuropsychiatric disorders common among World War I veterans.

"However," notes Ronald Hamowy of the Independent Institute, "widespread criticism of the quality of medical care accorded veterans continued through the 1930s and 1940s. Complaints during this period were most often directed at the quality of medical facilities and at the poor qualifications of VA personnel."[60]

World War II introduced an even larger generation of veterans—nearly twenty million—into the VA system. Once again, observers began to complain of inadequate conditions, describing veterans' health care as "back waters of medicine" in "physical and scientific isolation." Albert Maisel, writing in *Readers' Digest*, decried the state of VA health care as "third rate treatment of first-rate men."[61]

> I have been shocked and shamed to discover that…service men, after they have received a veteran's honorable discharge, are suffering needlessly and, all too often, dying needlessly in our Veterans' Hospitals.
>
> Our disabled veterans are being betrayed by the incompetence, bureaucracy and callousness of the Veterans' Administration, the agency set up over 20 years ago to insure the finest medical care for them.
>
> We have never stinted the Veterans' Administration. We have given it over a quarter of a billion dollars for nearly a hundred great hospitals. Recently Congress appropriated over $105,900,000 just to run these hospitals. But conditions in these beautiful buildings are far worse than cold statistics can indicate.
>
> In every one of these hospitals that I have visited—from Minnesota to Massachusetts—I have found disgraceful and needless overcrowding.
>
> I have found doctors overloaded and hog-tied by administrative restrictions…nurses [who] did not bother to wash their hands after examining one patient with a contagious disease before turning to another.
>
> Then I have gone to many [civilian] state and county hospitals, just as tied down by government restrictions and labor shortages…Here there are lower death rates and higher cure rates. That is why I know that there is no excuse for the Veterans' Administrations' third-rate treatment of first-rate men.

In one of the first attempts at comparing VA health outcomes to those in voluntary hospitals, Maisel found that the civilian facilities were eleven times more effective than VA hospitals at treating tuberculosis.

The VA categorized as "tuberculosis specialists" physicians with one year of internship and four months' orientation, in contrast to the American Medical Association's stricter standards for residencies in thoracic surgery or infectious disease.

By this time—in part as a reaction to the Forbes-era scandals—the Veterans' Bureau had developed a thick layer of bureaucracy designed to prevent corruption and waste. "By 1949," notes Hamowy, "the agency was operating under the authority accorded it by more than 300 laws, providing benefits to nearly 19,000,000 living veterans and to dependents of deceased veterans," amounting to approximately 40 percent of the adult U.S. population.

In 1945, *New York Post* columnist Albert Deutsch testified before Congress that Charles Forbes' successor as VA director, Frank Hines, "placed excessive stress on paper work. Bureaucratic procedures were developed, which tied up the organization in needless red tape. Avoidance of scandal became the main guide of official action.

Anything new was discouraged: 'It might get us into trouble.' Routineers and mediocrities rose to high office by simple process of not disturbing the status quo. Good men were frozen out or quit…The agency increasingly was controlled by old men with old ideas."[62]

In response to these concerns, in 1946 President Harry Truman replaced Hines with Gen. Omar Bradley. In the two years following, the VA's headcount went from 65,000 to over 200,000. Its annual budget increased from $744 million in 1944 to $7.5 billion in 1946.

The sudden expansion did relieve the problem of overcrowding in VA hospitals. But a federal commission led by former President Hoover found that the government was not planning its new hospital construction in a systemic fashion, but rather a political one.

Hence, some areas had far too many hospital beds, and other areas too few; 81 percent of VA hospitals in the San Francisco Bay area were unoccupied, and 86 percent in the New York City area. The Hoover Commission recommended that the VA close 20 veterans' hospitals and construct no new ones. These recommendations were ignored.

Gen. Bradley did install consequential changes at the VA. Bradley created a Department of Medicine and Surgery within the VA, and severed the VA's medical staff from the federal Civil Service, with all its restrictions and regulations. These two reforms significantly improved the quality of care in VA facilities, as the VA began to draw from the same labor pool as voluntary hospitals.

In 1964, Congress passed the Gulf of Tonkin Resolution, authorizing U.S. military operations in Southeast Asia. While Vietnam veterans were fewer in number relative to the World War II generation, advances in battlefield medicine meant that a larger proportion of the former group survived the war, albeit with injuries and disabilities. In Vietnam, the ratio of veterans injured to those who died was 2.6 to 1, versus 1.7 to 1 in World War II.

The quality of VA-based care for Vietnam veterans also received critical treatment in the press, in Congress, and in the memoirs of Vietnam veteran Ron Kovic, *Born on the Fourth of July*, published in 1976.

Congress asked the National Research Council to form a blue-ribbon panel, organized by the National Academy of Sciences and led by Saul Farber of New York University, to study the VA's health care operations. The Academy's 313-page report, published in 1977, noted that the dramatic increase in the VA's budget had not solved the perception of poor quality at VA facilities:

> In the last decade, an influx of patients resulting from the Vietnam War drew public attention to some of the VA's problems. The controversy over their treatment sharpened the debate between the Congress and the Executive Branch on the resource requirements of the VA hospital system. Congressional committees responsible for veterans affairs and for VA appropriations were repeatedly told by veterans groups and medical schools that shortages of hospital staff and equipment were jeopardizing the quality of patient care in VA hospitals and forcing some VA hospitals to deny admission or outpatient services to veterans who needed care. Congressional hearings emphasized the disparity in staff-to-patient ratios between VA hospitals and community hospitals: VA hospitals were said to be greatly understaffed. These problems were said to persist despite the rapid growth of the VA's medical-care budget in recent years.

The panel found that the VA's post-World War II emphasis on hospital construction had another unintended consequence: the substitution of inpatient hospital care for outpatient doctors' office visits. The VA had comparatively few outpatient facilities, but an excess of inpatient hospital beds. This led VA facilities to hospitalize veterans who would normally be treated in doctors' offices, resulting in poorer outcomes and higher costs.[63]

In addition, the VA's excess hospital capacity led the agency to seek to expand the number of veterans eligible for VA care, leading to comparatively less emphasis on those with service-connected injuries. Today, 70 percent of the patients using VA facilities were not injured due to their military service.

The panel raised concerns about the "scarcity and geographic distribution of outpatient facilities," finding that "only 36% [of veterans] lived within 30 minutes of a clinic." In addition, the panel found that "there are strong indications that utilization of outpatient facilities is correlated with a hospital's inpatient admission and retention policies more closely than with the medical needs of the patients who apply for care."

In response to these and many other issues, the panel recommended that veterans' health care be integrated into the broader civilian health care system, one that had grown substantially since World War I. "VA policies and programs should be designed to permit the VA system ultimately to be phased in to the general delivery of health service in communities across the country," by utilizing "third-party insurers, both private and governmental, wherever such coverage is

available." Veterans' service organizations opposed these recommendations, and Congress did not take them up.

Without major structural changes, criticism of VA health outcomes and quality continued into the 1980s. In 1988, the Veterans Administration was elevated into a Cabinet-level department called the Department of Veterans Affairs. The VA's health care programs were consolidated into the Veterans Health Administration within this new department.

However, Cabinet status did not measurably improve the quality of VA health care. Meanwhile, the aging of the World War II population meant that the veteran population was declining in size; in addition, as the U.S. population moved south and west, older VA facilities in the Northeast were further underutilized, while VA hospitals in the younger parts of the country faced overcrowding. In the *New York Times*, fiscal scholar Richard Cogan said, "The real question is whether there should be a veterans health care system at all."[64]

A HIGH POINT IN THE NINETIES, FOLLOWED BY REGRESSION TO THE MEAN

An instructive bright spot for the VA emerged in 1994, when President Bill Clinton appointed Kenneth Kizer of the University of Southern California as Under Secretary for Health in the Department of Veterans Affairs. "There was universal consensus," Kizer told Phillip Longman, "that if there was one agency that was the most politically hidebound and sclerotic, it's the VA." But where others saw sclerosis, Kizer saw opportunity. "The basic thesis…was that we have to be able to demonstrate that we have equal or better value than the private sector, or frankly we should not exist."

Kizer introduced a substantial restructuring of the VA's operations, despite considerable internal resistance. (On his first day on the job, someone had vandalized his car and stolen the headrests.)

Kizer closed more than half of the VA's hospital beds between 1994 and 1998, emphasizing outpatient physician care over hospitalization. As a result, inpatient hospital admissions declined by 31 percent, and the number of hospitalization days decreased from 3,530 per 1,000 patients in 1995 to 1,333 in 1998: a drop of 62 percent.

In the 1970s, a group of entrepreneurial employees at the VA began secretly developing an early version of electronic patient records. Their effort was intensely resisted by the VA's leadership in the 1970s and 1980s, but the entrepreneurs eventually prevailed, establishing a free, open-source system called Veterans Health Information Systems and Technology Architecture, or VistA. Kizer reorganized the VA around Veterans Integrated Service Networks, or VISNs, to improve the coordination of care that veterans received. He deployed VistA and other modern tools to ensure that veterans were receiving care based on the best available scientific evidence.

Research by Kizer and others indicated that by the late 1990s, the VA was engaging in evidence-based medicine—such as providing aspirin to heart attack victims after they left the hospital—at higher rates than the Medicare program, which worked mostly through voluntary hospitals. One comparison of diabetic care at five VA medical centers to their commercially-insured counterparts suggested that the VA patients enjoyed better rates of blood glucose and cholesterol management.

While these studies were limited in scope, they represented the first meaningful instances of research indicating that VA health care could be the equal of private health care on some quality measures. In 2007, Philip Longman published a book entitled *Best Care Anywhere*, arguing not merely that VA health care was no longer inferior, but that the VA was the model that the rest of American health care should follow.

Kenneth Kizer stepped down as director of the Veterans Health Administration in 1999. In the ensuing years, problems once again began to crop up with the delivery of VA care, most notably the waiting-list scandal of 2014. "Since 2005, the VA Office of Inspector General (OIG) has issued 18 reports that identified, both at the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care," noted the VA's Acting Inspector General in a 2014 review.[65]

In retrospect, while the VA did improve the delivery of care at its facilities during Kizer's tenure, those improvements were more temporary than many had hoped. "VA officials have not been as closely focused on data, results, and metrics—performance measurement—as they once were," Kizer told the *New York Times* in 2014. "The culture of the VA has become rather toxic, intolerant of dissenting views and contradictory opinions. They have lost their commitment to transparency."[66]

THE 2014 VETERANS CHOICE ACT AND THE 2015 INDEPENDENT ASSESSMENT

In response to the waiting list scandal of 2014, Congress passed the Veterans Access, Choices and Accountability Act of 2014. VACAA can best be understood as a quarter-step in the direction of expanded choice for veterans.

The Act allows some veterans to gain a "choice card" to seek care outside of VA facilities if they meet a number of bureaucratic criteria, of which the VA remains the gatekeeper. Participation in the program by eligible veterans has been extremely low, due to confusing regulations and limited enthusiasm from VA staff, who are reluctant to lose patients to private-sector competitors.

Furthermore, the provisions of VACAA that assist veterans in obtaining health care outside of the VA system are of limited duration. Congress appropriated $15 billion under VACAA for the purpose of offering veterans health care through non-VA entities; the Congressional Budget Office projects that the bulk of these funds will be used up by the late 2010's.

Section 201 of VACAA required Congress to fund an independent assessment of the Veterans Health Administration. That assessment, totaling 4,000 pages authored by representatives of institutions such as McKinsey, the RAND Corporation, and the Institute of Medicine, was published in 2015.

The independent assessment highlighted serious, comprehensive, and overwhelming flaws in the VHA's structure and performance. VHA facilities' average score, under the assessment, was a C-minus.

VHA information systems were described as nearing obsolescence. "Solving these problems," said the report, "will demand far-reaching and complex changes that, when taken together, amount to no less than a systemwide reworking of VHA."[67]

Over the next several years, Congress will be faced with the unattractive and costly option of temporarily renewing VACAA, or enacting a permanent, long-term solution that improves access to care for veterans in a strategically sound and fiscally responsible manner, as prescribed in the independent assessment.

The Veterans' Independence Act contemplates just this sort of fundamental, carefully designed reform.

IMPEDIMENTS TO REFORMING VETERANS' HEALTH CARE

The VA has served an important role in offering health care services to veterans, especially those with service-connected disabilities and those without the means to afford private health coverage. The VA's involvement in long-term care for injured veterans dates back to the nineteenth century, and it is a role that fulfills a real need, given the woefully thin private market for long-term care insurance. However, it is unclear why veterans should be denied the opportunity to seek care outside the VA system, if that is what they wish to do.

Indeed, the VHA itself estimates that veterans enrolled in the VA health care system receive approximately three-quarters of their care outside the VA.

VA care may remain the equal of private care, for those who manage to get in the door. But the comparison of VA care to private care is not meaningful if veterans have to wait for months, or even years, to see a doctor.

In 1921, when the Veterans Bureau was created, civilian health care infrastructure was sparse. Today, the U.S. has the most developed health care infrastructure in the world; U.S. health care spending represents more than seventeen percent of the nation's economic output. There is no legitimate reason for veterans to wait in line for access to health care; there are many ways for veterans to gain that access, if they are given the means to do so.

And the VA does not only face challenges in delivering quality health care. As the Vietnam generation passes on, the size of the veteran population will shrink considerably. In 2009, there were twenty-four million U.S. veterans; by 2029, the VA expects that population to shrink to sixteen million.[67]

VHA hospital patient volume will shrink as well. Advances in battlefield and medical technology have also led to fewer hospitalizations and more care delivered in physician offices. Future wars could, of course, re-expand the veteran population, but this is not a possibility that the VHA can either predict or rely upon. Simply put, the VHA must get ahead of its demographic destiny, or face a future in which funding for veterans' health care will be crowded out by the need to maintain underused facilities.

Past efforts at addressing these problems, however,

have faced enormous resistance from a constellation of forces sometimes described as the "Iron Triangle."

"The VA and its advocates," wrote John K. Iglehart of the *New England Journal of Medicine* in 1985, "represent a classic example of an 'iron triangle' of interests that make their way through the Washington policy swirl. In this instance, the triangle consists of the agency itself, the congressional committees that oversee and often protect its interests, and veterans' service organizations, many of which operate under a federal charter...The interlocking nature of this influential triad is well reflected by the movement of numerous staff members between its organizations."[68]

Each corner of Iglehart's triangle has its own incentives to oppose VA reform. VA facilities employ thousands of individuals in certain congressional districts; elected officials oppose the closure of VA facilities in their localities. Employees at VA facilities understandably prefer the security of federal employment, and oppose efforts to rationalize the VA's workforce. Veterans' organizations in Washington are comfortable with their existing role in the existing ecosystem, and are naturally suspicious of change.

The prestige of certain veterans' organizations, combined with their skepticism of reform, has had a major impact on Congress. Lawmakers understandably value the endorsements of veterans' organizations. Indeed, in the recent past, some veterans' organizations have been able to review proposed budgets for the Department of Veterans Affairs, both from the White House and Congress, prior to the introduction of fiscal legislation.

A system in which veterans could gain control over their health care dollars would be inherently more responsive to veterans' needs than one in which decisions are made by a confluence of Washington interests. Veterans' organizations are mistaken if they see for themselves a diminished role in a reformed veterans' health care system. Indeed, the opposite is true; if veterans have a broader range of health care choices, they will actively seek guidance from traditional veterans organizations in navigating those choices.

Most importantly, the vast majority of rank-and-file veterans want those choices. In a national survey of veterans conducted in November 2014 by the Tarrance Group for Concerned Veterans for America (***Figure 17***), 88 percent of respondents agreed that eligible veterans should be given the choice to receive medical care from any source that they themselves choose.[69]

Veterans believed that they should have the option to seek the best possible care, even if that means getting that care outside a VA facility: 95 percent believing this option to be "extremely" or "very important."

91 percent supported allowing veterans to go to the doctors or hospitals closest to their homes, and 86 percent endorsed allowing veterans to use a private physician if they choose.

Strikingly, a large majority of veterans—77 percent—thought it "extremely" or "very important" to give veterans more choices in their insurance products, even if these alternatives involved higher out-of-pocket costs. Only six percent considered this option "not at all important."

PRINCIPLES AND OBJECTIVES OF VETERANS' HEALTH REFORM

A NUMBER OF CORE PRINCIPLES MUST GUIDE ANY effort to improve the quality and stability of veterans' health care.

First, the interests of veterans must come before the interests of the VHA as a government agency. Too often, the "iron triangle" has looked out for its own perceived institutional interests, with veterans' concerns on the periphery.

Second, the VHA should refocus its mission upon caring for veterans injured or disabled in the line of duty.

Veterans should be able to take advantage of America's world-class private health care infrastructure, and choose where to get their health care. But reforms must ensure that current veterans can retain the option of remaining in the traditional VA system, at no additional cost, if that is what they prefer.

Veterans' health reform cannot be seen as a source of spending reductions, but reform must be fiscally responsible. The VHA is quite well funded; the object of reform must be to increase the VHA's accountability for its performance and cost-effectiveness, and to reallocate the VHA's existing resources toward veterans' health care and away from underused facilities.

In 2014, in an effort to examine options for reforming veterans' health care, Concerned Veterans for America convened a task force entitled "Fixing Veterans Health Care." The task force was led by two lawmakers—for-

mer Senate Majority Leader Bill Frist (R., Tenn.) and former Rep. Jim Marshall (D., Ga.)—along with a former VHA Under Secretary for Health, Mike Kussman; the Senior Veterans Affairs Advisor at Concerned Veterans for America, Darin Selnick; and Avik Roy.

In February 2015, the task force published a detailed reform proposal, called the Veterans Independence Act, comprised of two core concepts. First, spin off the VHA's clinical facilities into an independent, integrated, government-chartered health care organization. Second, add on a new option for veterans to obtain private health coverage, while preserving the VA's traditional health insurance program.[70]

The task force's recommendations were designed to harmonize with those in the first edition of *Transcending Obamacare*; while veterans' health reform can be pursued separately from broader reform, reforms to the individual health insurance market, as contemplated by the Universal Tax Credit Plan, provide veterans with an additional option for private coverage on top of those designed specifically for veterans.

ACCOUNTABLE CARE FOR VETERANS

Some institutions, like California's Kaiser Permanente, have successfully integrated a health insurer with a provider of medical services. The theoretical advantage of a fully integrated system is that hospitals have less incentive to charge higher prices, knowing that doing so would increase the cost of their insurance product.

However, it is far from clear that such a model is workable for a government agency like the Veterans Health Administration, as the VHA does not have the political independence necessary to make economically efficient decisions. Furthermore, a fully self-contained system heavily restricts the ability of veterans to seek care in voluntary (i.e., civilian) hospitals and from private physicians. Congress must provide the VHA with the flexibility to make independent operating decisions, free of excessive regulatory and political interference.

There are several examples of corporations chartered and owned by the federal government. These corporations provide public services; however, unlike services provided directly by government agencies, chartered corporations are independent legal entities separate from the U.S. government. Government-chartered corporations often receive federal budgetary appropriations, but they can also have independent sources of revenue.

The most prominent example of a federally chartered corporation is the National Railroad Passenger Corporation (NRPC), which operates Amtrak. The construction of interstate highways and the emergence of air travel led to a steep decline in passenger rail ridership; by the late 1960s, most private intercity rail services were unprofitable. In order to avoid the possible collapse of the U.S. railroad industry, in 1970, President Nixon signed the Rail Passenger Service Act, which created the National Railroad Passenger Corporation.

While Amtrak continues to require federal subsidies—including $1.4 billion in congressional appropriations for 2017—the NRPC has succeeded in growing the passenger rail market. In 1972, Amtrak carried 15.8 million passengers; in 2014, it carried 30.9 million, with ticket revenues of $2.2 billion.

Because Amtrak receives congressional subsidies, it remains subject to oversight from Congress. But the NRPC has been able to invest in the heavily traversed Northeast Corridor between Washington and Boston, and to discontinue dozens of underused routes.

One of the principal problems with the delivery of health care in the United States is its uncoordinated nature. In particular, patients with multiple chronic conditions may be seeing multiple physicians who do not talk to each other, leading to overlapping prescriptions and, in some cases, dangerous mistakes. "Badly coordinated care, duplicated efforts, bungled handoffs, and failures to follow up result in too much care for some patients, too little care for others, and the wrong care for many," observed Katherine Baicker and Helen Levy in 2013.[71]

A number of health care systems–comprised of hospitals, outpatient physician clinics, and other facilities—have attempted to rectify this problem by using information technology and aligned financial incentives to coordinate care between different physicians and different treatment modalities.

Model practitioners of this approach—called "accountable care organizations"—include the Mayo Clinic in Rochester, Minnesota; the Cleveland Clinic in Ohio; the Geisinger Health System in central Pennsylvania; and Intermountain Healthcare in Utah Cen-

tral to the ACO approach is the use of primary care physicians, who serve as the primary coordinators of patient care.

The VA's health care facilities, in many ways, already incorporate some of the concepts utilized by accountable care organizations. In 2013, the VA employed 5,100 primary care physicians. The VA's hospitals and clinics are all owned by the same entity, and the VA's VistA electronic medical records system has helped the VA coordinate care for veterans with multiple medical conditions.

Formally organizing VA provider facilities along the ACO model could help improve veteran patient care within the VA system, and give the VA a natural set of private-sector benchmarks with which to assess its progress in improving health care delivery. An independent ACO for veterans could build centers of excellence around disciplines prevalent in the veteran population, such as traumatic brain injuries, spinal cord injuries, and post-traumatic stress disorder.

Finally, Congress would necessarily assign the VACO a discrete budget, independent of the VA's health insurance program, giving Congress insight into the cost-effectiveness of VA facilities.

VETERAN-CENTERED HEALTH COVERAGE

Under the Veterans Independence Act, veterans who are satisfied with their current VA health care would be able to maintain their use of existing benefits, with no cost-sharing. Importantly, however, this would not be veterans' only option.

The Veterans Independence Act offers veterans control of their own health care dollars, through the new Veterans Health Insurance Program (VHIP). Specifically, veterans would be able to take the funds spent on them through the VA system, and use those funds to purchase private health coverage, using premium support.

It is worth noting that the VA employees who care for veterans obtain their coverage via premium support. The Federal Employee Health Benefits Program, or FEHBP, is the oldest and most successful premium support program in the world. FEHBP was founded in 1959 to offer private health insurance to federal workers, including employees of the Department of Veterans Affairs. Today, approximately 8 million individuals—4 million federal employees and 4 million of their dependents—are enrolled in the program, at a projected annual cost of $49 billion in 2015.

Under VIA's premium support program, non-elderly veterans would gain the option to use VA funds to purchase private acute-care and long-term care insurance. Medicare-eligible veterans would be able to use VA funds toward their premium costs for supplemental "Medigap" coverage. All veterans who purchase private health coverage in this manner would continue to be able to use VA facilities, through insurance products that contract with the Veterans Accountable Care Organization, along with private health care providers.

Along with VHIP-specific coverage options that contract with VA providers, veterans could have the option of use their premium support to purchase coverage in the private non-group insurance market, with any savings deposited in a health savings account.

Importantly, veterans who are satisfied with traditional VA coverage would be grandfathered, unless they explicitly opt in to the premium support model. Eligible future veterans would be required to enroll in private coverage.

MANAGING THE TRANSITION

If more veterans have access to the private, voluntary U.S. health care system, it goes to follow that fewer veterans will use proprietary VA facilities. Already, as noted above, VHA enrollees receive roughly three-quarters of their care outside of the VA system. In 2011, a VHA survey found that 77 percent of VHA enrollees were enrolled in non-VA-based health insurance plans.[72]

And the high fixed costs of maintaining VA hospitals siphon funds away from the provision to veterans of high-quality health care; this problem will grow more acute if more veterans seek care outside the VA.

If we are to preserve the traditional VA model for those veterans who prefer it, we must manage the transition to a modernized system. The Veterans Independence Act employs several tools to do so.

First, the VIA proposes that Congress appoint an independent nine-member panel, modeled after the Defense Base Realignment and Closure Act of 1990 (BRAC), to recommend closing down underused VA fa-

cilities. Lawmakers understandably fight hard to preserve VA hospitals in their districts; a BRAC-like process could assist Congress and the VA in making decisions that best serve the interests of veterans and taxpayers.

Second, the VIA phases in the premium support option in the new Veterans Health Insurance Program. At first, only those veterans with service-connected injuries would be eligible for private coverage. After five years, the remainder of VHA enrollees would gain the private option. This five-year lag allows Congress and the VHA to reflect on unexpected effects of the new program, and adjust the VHA's planning accordingly.

Third, the new Veterans Health Insurance Program assures the Veterans Accountable Care Organization a privileged place within VHIP's private insurance products. Under the Veterans' Independence Act, privately covered veterans could use VACO facilities with no cost-sharing, whereas private facilities would require some co-pays and deductibles.

Fourth, the VIA contemplates the option of allowing VACO facilities to admit civilian patients, in regions where VACO patient volume is low. In the private sector, rising hospital consolidation has led to higher U.S. health care prices without evidence of improved quality. VACO facilities could restore competition to areas where mergers have eliminated it.

FISCAL CONSIDERATIONS

ALLOWING VETERANS TO GAIN PRIVATE COVERAGE AND private health care is not a free lunch. Maintaining the upkeep of proprietary VA facilities, while more veterans seek care elsewhere, could increase VA spending in the short term. But over the long term, the reformed system should be much more cost efficient, due to a lighter physical footprint and a more cost-effective insurance system.

It is widely believed that VA-based care costs less than the equivalent amount of care delivered in the private sector. However, a December 2014 report from the Congressional Budget Office found that "limited evidence and substantial uncertainty make it difficult to reach firm conclusions about those relative costs or about whether it would be cheaper to expand veterans' access to health care in the future through VHA facilities or the private sector."[73]

The VA, according to the CBO, "has provided limited data to the Congress and the public about its costs and operational performance," making direct comparisons to the private sector difficult. Furthermore, lower per-enrollee costs are only meaningful if the quality of care is equivalent or better.

Recent Congressional proposals to improve veterans' health care have been stymied by another problem: that a more attractive VA health care program would, by definition, attract more veterans to enroll, increasing its overall spending.

However, a well-designed reform can offset these higher VA costs, by savings from reduced enrollment in other federally subsidized health care programs, such as Medicaid, employer-sponsored insurance, Medicaid, and the Affordable Care Act (or the Universal Tax Credit Plan). These cost savings should be credited to the VA.

The Fixing Veterans Healthcare task force modeled the fiscal effects of their proposal using the same microsimulation methodology deployed in *Transcending Obamacare*, built by Stephen Parente and colleagues. That modeling indicates that the Veterans Independence Act can be deficit neutral, provided that VACO rationalizes its hospital and clinical capacity as veterans seek care elsewhere.

Based on fiscal modeling led by Stephen Parente, there are considerable grounds to believe that the Veterans Independence Act can be deficit neutral, provided that VACO rationalizes its hospital and clinical capacity as veterans seek care elsewhere.[73] Hence, expanding health care options for veterans can be done in a way that preserves traditional VA care for those who prefer it, without additional taxpayer costs.

Part Six

Making Innovative Medicines Affordable

The problem of high prices for branded prescription drugs is not going away. Indeed, over the last several years, the problem has gotten significantly worse, further threatening access to life-saving medicines for those with below average incomes. Contrary to conventional wisdom, the solution to high drug prices involves more economic freedom, not less.

According to the OECD, in 2013, U.S. drug spending amounted to $858 per capita, compared to $400 for 19 other advanced industrial nations. Since then, spending has increased 20 percent in the United States.[74]

Critiques of the high prices of U.S. branded prescription drugs have long been common the left, but not the right. This is in large part due to the fact that the left's most common solution to the problem—federal price regulation—is unattractive. But the unattractiveness of the left's favored solution has not made the problem go away.

U.S. DRUG SPENDING IS FAR HIGHER THAN COMMONLY BELIEVED

According to the official statistics compiled by the Centers for Medicare and Medicaid Services, American spending on prescription drugs appears quite manageable, representing 10 percent of national health expenditures. By comparison, hospital spending represents 32 percent of national expenditures.[75]

These figures, however, are an artifact of the way in which CMS categorizes medical spending. CMS' prescription drugs line item only includes retail drug spending, such as the purchase of prescription drugs from retail or mail-order pharmacies.

A significant portion of U.S. spending by hospitals is on prescription drugs; these costs are counted as hospital spending, not drug spending. Similarly, drug spending via physician services—such as intravenous infusions of cancer drugs in doctors' offices—is counted as physician spending, not drug spending. Hence, total prescription drug spending is at least 17 percent of total health expenditures, and possibly higher than 20 percent.[74-76] The U.S. Department of Health and Human Services estimates that drug spending exceeded $450 billion in 2015, of which approximately 40 percent is government spending.[76]

GENERIC COMPETITION: AN AMERICAN SUCCESS STORY

It is of note that spending on generic medicines represented about 2 to 3 percent of that total, despite the fact that prescriptions for generic drugs represent 90 percent of the prescription volume in the United States.[76] That is to say, U.S. drug prices are quite low in therapeutic areas where there is robust generic competition.

That is because, in 1984, Congress the Drug Price Competition and Patent Term Restoration Act, an unusually farsighted law most commonly known as the Hatch-Waxman Act. Hatch-Waxman created an abbreviated regulatory process for the approval of generic medicines, and also created greater transparency and certainty around pharmaceutical patent litigation. The end result has been the formation of a robust generic pharmaceutical industry. Today, it is common for the price of a drug to decline by 80 percent in the first year after generic competition ensues.

A limitation of Hatch-Waxman is that it only applied to *small molecules*, or medicines formed from relatively simple chemical compounds that can be synthesized in basic laboratories.

Large molecules—such as monoclonal antibodies and

other complex proteins—are not governed by the generic provisions in Hatch-Waxman, given the unique challenges in precisely regulating proteins for generic use. Recent legislation, such as the reauthorization of the Prescription Drug User Fee Act in 2012, aims to narrow the gap between generic competition for small molecules and large molecules. To date, however, generic or "biosimilar" competition for large molecules has been limited.

Take, for example, the market for treatments for multiple sclerosis, which is dominated by large molecules. In 1996, Biogen launched Avonex, a monoclonal antibody, for $8,723 per patient per year. In 2013, Biogen was charging $62,394 for exactly the same drug, even though numerous, more effective medicines had been launched in the intervening two decades (***Table 3***).[74]

In a consumer-driven technology market, such pricing practices would be inconceivable. Samsung, for example, would never be able to charge eight times the original price for a 20-year-old cellular phone. Nor would Samsung attempt to justify such price increases by citing "the cost of innovation," as drug companies do, even though Samsung's investment in R&D is also significant. In a consumer-driven market, businesses recongize that they must charge prices that consumers will be willing to bear, because otherwise they will fail to sell their products.

HIGH DRUG PRICES ARE DRIVEN BY FLAWED FEDERAL POLICY

One of the enduring myths of the U.S. pharmaceutical industry is that because drug prices are not regulated by the government, the sector is a "free-market" one. It is not. Indeed, federal policy is entirely responsible for the fact that branded prescription drugs cost so much more in the United States than they do in other advanced economies.

Third party purchase of third party insurance. The fact that the vast majority of Americans with health insurance did not purchase it for themselves, but rather had it purchased on their behalf by third parties such as employers and the government, is the principal driver of drug price inflation, as with other health care services.

Because most individuals are not aware of how much money is withdrawn from their paycheck to pay for health insurance—let alone how much of their premiums are driven by drug spending—they are more likely to complain if a needed drug is not covered by their health plan, than if the drug's price is high, but paid by the insurer (and eventually by the patient, in the form of higher premiums and taxes).

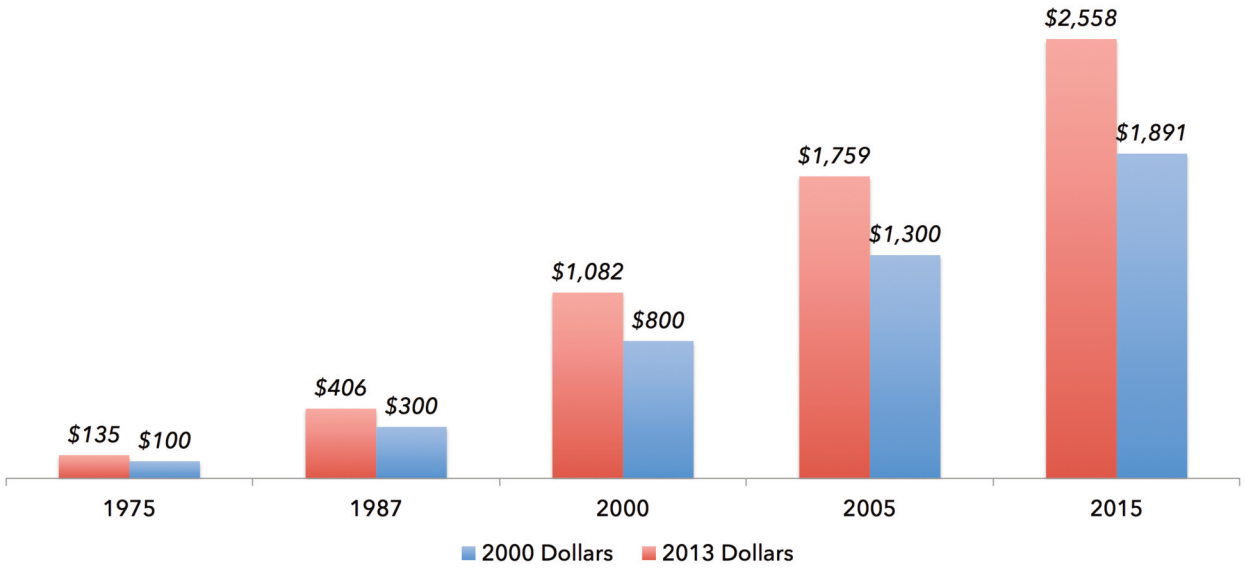
Federally enforced pharmaceutical monopolies and

Table 3. Initial and Current Annualized U.S. Prices of Common Multiple Sclerosis Drugs (vs. CPI)

Drug Name	Launch Date	Price at Approval	Price in 2013	Avg. Growth/Yr	Avg. CPI Drug Growth	Avg. CPI All Goods
Betaseron	7/23/1993	$11,532	$61,529	**21.0%**	4.8%	3.0%
Avonex	5/17/1996	$8,723	$62,394	**34.6%**	4.7%	2.8%
Copaxone	12/20/1996	$8,292	$59,158	**35.7%**	4.7%	2.8%
Rebif	3/7/2002	$15,262	$66,394	**28.1%**	3.6%	2.7%
Tysabri	11/23/2004	$25,850	$64,233	**16.2%**	3.3%	2.4%
Extavia	8/14/2009	$32,826	$51,427	**13.0%**	2.9%	2.0%
Gilenya	9/21/2010	$50,775	$63,806	**7.9%**	2.4%	2.2%
Aubagio	9/12/2012	$47,651	$57,553	**16.8%**	0.0%	1.1%
Tecfidera	3/27/2013	$57,816	$63,315	**13.8%**	1.0%	1.3%

CPI figures are for annualized inflation over the timeframe that the drug has been on the market, up to 2013.
Source: Hartung et al.,* Neurology*, May 26 2015; 84(21):2185-92..

Figure 18. R&D Expenditures per FDA-Approved Drug ($ Millions)



insurer antitrust regulations. There is much tradition, and policy justification, for granting patents—i.e., temporary monopolies—to developers of innovative new medicines.

However, it is not widely recognized that the federal government prohibits insurers from responding to these monopolies in the way they could in a free market. Insurers are prevented by federal and state antitrust laws from jointly negotiating reimbursement rates for innovative drugs in a given region. If they were free to do so, there would be a level playing field between drug manufacturers and insurers to negotiate market-based prices.

Federal and state drug coverage mandates. Federal law mandates that Medicare pay for most drugs, if they have been approved by the Food and Drug administration, regardless of price or clinical value. For example, because cancer is largely a problem of the elderly, drug manufacturers have effectively unlimited pricing power for oncology drugs in the U.S., because Medicare is required to pay for all oncology drugs and is prohibited from negotiating their price. Similarly, most Medicaid programs are required to reimburse for all drugs, though Medicaid drug prices cannot grow faster than inflation.

As noted in Part One, ACA regulations require that insurers cover "at least the greater of: (i) one drug in every United States Pharmacopeia (USP) therapeutic category and class; or (ii) the same number of prescription drugs in each category and class as the [essential health benefit] benchmark plan" in a given exchange. The net effect of this rule is to force insurers to cover many brand-name drugs that are not cost-effective, merely because they happen to be in a unique class.

Artificial monopolies for unpatented drugs. There a number of old drugs whose patents have long expired for which prices are extremely high, because FDA regulations effectively guarantee monopolies and prohibit competition.

For example, thalidomide, a drug that treats leprosy and multiple myeloma, is governed by an FDA "risk evaluation and mitigation strategy," in order to ensure that the drug is not administered to women bearing children, because of the risk of birth defects. Celgene, the manufacturer of thalidomide, holds patents around its REMS program, effectively barring other companies from producing FDA-approved thalidomide.

In 2005, the FDA annouced it would ban the use of chlorofluorocarbons in asthma inhalers. Though the underlying medicines most common to treat asthma have long been off-patent, the requirement for new

CFC-free inhalers led to market monopolies for companies like AstraZeneca.[77]

Colchicine, a drug first used to treat gout around 1500 B.C., has now been FDA approved at the agency's insistence, with market exclusivity granted to a small company called URL Pharma. URL initiated a 5,289 percent price increase after gaining exclusivity in 2009 for its branded version of colchicine, called Colcrys.[78] In 2012, URL was acquired by Takeda Pharmaceuticals for more than $800 million.

Most recently, Mylan attracted controversy for raising the price of its EpiPens, which deliver epinephrine in the event of a life-threatening allergic attack called anaphylaxis, from $100 to $600 per pen. Epinephrine, also known as adrenaline, was first isolated in 1901, and has long been off-patent. But Mylan's autoinjector has been approved by the FDA specifically for treatment of anaphylaxis, and the agency has made it extremely difficult for would-be competitors to gain approval for similar devices.

While none of these cases garnered the media attention that Martin Shkreli did for raising the price of Daraprim by 5,500 percent in 2015, the reality is that Shkreli was following pricing practices that are common in the industry.

Regulatory restrictions on biosimilar drugs. As noted earlier, the FDA has placed heavy restrictions on generic substitution for large molecules. Until very recently, generic copies of large molecules (often called "biosimilars") were required to go through the same cumbersome FDA process as innovative drugs, including large clinical trials.

The Biosimilar User Fee Act of 2012 charges biosimilar manufacturers user fees aimed at accelerating the FDA review process. However, therapeutic substitution of biosimilars for branded large molecule drugs remains cumbersome.

Ballooning drug development costs. The FDA places increasing burdens on drug developers each year, dramatically increasing the cost of late stage clinical trials. From 1999 to 2005, the number of median procedures per trial protocol—blood work, routine examinations, x-rays, and the like—increased by 65 percent.

The average clinical trial staff work burden increased 67 percent. The average length of a clinical trial increased by 70 percent. And due to more stringent FDA-mandated entry criteria for patients into a clinical trial, enrollment rates for trials declined by 21 percent, and retention declined by 30 percent.[79]

All of these incremental additional requirements by the FDA have led to exploding drug development costs. The Tufts Center for the Study of Drug Development estimates that it now costs $2.6 billion to develop an FDA-approved drug in 2013 dollars, inclusive of all of the failed drug candidates one has to study in order to achieve success (***Figure 18***).[80] That represents an increase from $1.8 billion in 2005, $1.1 billion in 2000, $400 billion in 1987, and $135 billion in 1975.

REMOVING FEDERAL OBSTACLES TO MARKET-BASED DRUG PRICING

There are a number of steps Congress could take to improve competition and accountability in the pharmaceutical industry. The most important would be to implement the Universal Tax Credit Plan, or something similar, so that individuals have more direct control over the health care dollars that are spent on their behalf.

Congress could create an exemption from antitrust regulation to private insurers in a given state or locality that wish to jointly negotiate drug prices with a branded drug manufacturer. Switzerland allows insurers this negotiating leverage with both drug manufacturers and health care providers.

Congress should enhance the ability of biosimilar manufacturers to compete with branded large molecules, and apply strict scrutiny to FDA regulations, like risk evaluation and mitigation strategy programs, that have created drug monopolies for older drugs. A number of policymakers have proposed assigning a fixed regulatory budget to executive agencies, and requiring that any regulation with an economic cost of more than $100 million be subject to an up-or-down vote in Congress.[81]

While Medicare and Medicaid should not be allowed to regulate pharmaecutical prices, Congress should eliminate the requirement that Medicare, Medicaid, and private insurers pay for branded drugs simply because they have been approved by the FDA. Physician and hospital services are not automatically reimbursed by these agencies, unless they have demonstrated clinical value, and sometimes not even

then. As the Universal Tax Credit Plan gradually transitions Americans to a competitive private insurance market, individuals would be free to choose plans that covered a broader or narrower set of branded drugs.

ACCELERATING MEDICAL INNOVATION

New therapies and medical technologies have been the primary driver of longer life expectancy in the West. The Affordable Care Act mostly ignores this fact, and indeed retards medical innovation, by punitively taxing emerging medical device and biotechnology companies. The Universal Tax Credit Plan repeals these taxes.

Though the United States urgently needs new treatments for common illnesses such as heart disease, stroke, and diabetes, the nation's system for drug approval discourages innovation and investment, especially for our most pressing public health challenges. The main culprit is the high cost of Phase III clinical trials, which are required for FDA approval of most drugs. For any given drug on the market, typically 90 percent or more of that drug's development costs are incurred in Phase III trials. These costs have skyrocketed in recent years, as noted above, exacerbating an already serious problem.[80]

The enormous cost and risk of Phase III trials deter researchers and investors from developing new medicines for the chronic conditions and illnesses that pose the greatest threat to Americans, in terms of health spending and in terms of the number of people affected. This avoidance, in turn, harms overall U.S. health outcomes and drives up the cost of health care.

The current Phase III trial system forces pharmaceutical and biotechnology companies to take enormous financial risks and burdens them with needless and unpredictable regulatory delays.

The current system has, in particular, prevented start-up biotech companies, mostly based in the United States, from challenging the dominance of large, multinational pharmaceutical concerns. It also, perversely, encourages more innovation in drugs for very rare diseases than it does in drugs for common conditions that afflict hundreds of millions of Americans.

The quintennially renewed Prescription Drug User Fee Act, and related legislation, governs the regulatory process for innovative medicines. The law is next up for renewal in 2017.

While the Universal Tax Credit Plan does not directly address FDA reform, as this is properly the province of the PDUFA process, it would be highly beneficial to replace the current "all or nothing" FDA approval system with one that reflects the realities of scientific research and the profiles of chronic long-term conditions.

Such a reform would allow drugs that have been found safe and promising (in Phase I and Phase II clinical trials) to win approval for limited marketing to patients. Doing this would give patients early access to innovative new therapies, while the FDA would retain the ability to collect information confirming the drugs' safety and effectiveness and to later revoke a drug's marketing authorization, when appropriate.

While the FDA currently has the legal power to create its own conditional approval process, it has little political latitude to do so. For this reason, we believe that Congress must create clear standards for such a pathway. Congressional action, through PDUFA legislation, would allow regulators and companies to develop new tools that are better suited to the economic realities of modern drug development.

A simple, but effective, way to streamline the FDA review process would be for Congress to require that the FDA automatically approve any drug for any indication that has been already approved by the European Medicines Agency (EMEA). The pan-European Union approval process is just as rigorous, and in some cases more so, than the United States', and giving companies the ability to file in one of these developed markets would significantly improve drug development times and financial risk.

Part Seven

Bringing the Digital Revolution to Health Care

The internet has revolutionized every sector of the global economy except one: health care. Even heavily regulated industries, like airlines and automobiles, have embraced concepts like mobile check-ins and driverless cars. So why is it that American health care has proven so intractably resistant to digital technology?

The most important reason is the one we have discussed at length in this manuscript: the inability of American patients to directly control their own health care spending. We can never have a patient-centered health care system if patients do not control the dollars being spent on their behalf.

And digital technology has the potential to do more to make health care affordable for those without coverage than any other innovation in public policy or private industry.

DIGITAL HEALTH AND THE CRITIQUE OF MARKET-BASED HEALTH CARE

Many observers—especially those aligned with the political left—argue that health care can never function like a conventional market. Certain structural aspects of health care, they say, prevent the efficient functioning of market forces and must be corrected by government action.

This argument has been espoused most notably by Stanford economist and Nobel laureate Kenneth Arrow. In 1963, the Ford Foundation approached Arrow, then known as a leading economic theoretician, about applying his ideas to the practical problems of health, education, and welfare. Arrow accepted the assignment and began studying the ins and outs of U.S. health care delivery.

In December 1963, Arrow published his seminal essay, "Uncertainty and the Welfare Economics of Medical Care," in the *American Economic Review*.[82] Health care, Arrow argued, diverges from traditional markets in important ways, concluding that "it is the general social consensus, clearly, that the laissez-faire solution for medicine is intolerable."

The essay, still widely read, is credited by many as having invented the field of modern health economics. But even as medicine has changed dramatically in the past half century and many of Arrow's observations seem increasingly outdated, his thesis remains at the heart of the ideological objection to market-driven health care.

According to Arrow, health care is subject to five distortions that prevent the efficient functioning of market forces:

Information is asymmetric. Medical knowledge is complicated: the physician knows much more than the patient about the treatment of disease; the buyer of medical services is thus at a disadvantage, relative to the seller. It is also difficult for patients to make independent decisions as to the best course of action. Payment by health insurers leads to further confusion because insurers know less than patients and physicians about the particularities of each case.

Demand is unpredictable. Demand for medical services is unpredictable and, therefore, differs fundamentally from other common expenses, such as food. In addition, access to health care is more critical than access to many consumer products.

Trust is unusually important. A patient cannot test-drive a surgical procedure before undergoing it: if the procedure fails, or has adverse consequences, he is stuck with the outcome. The patient must trust that the surgeon is competent. If he is not, the consequences for the patient can include serious injury or

death, for which there is no economic remedy.

Barriers to entry are high. Physicians must be licensed to practice medicine. To gain licensure, they must complete many years of training. As a result, the sale and consumption of medical services is constrained by the limited number of new doctors produced each year.

Paying for health care is not consumer-friendly. Patients now pay for health care after it is received. Patients also frequently pay indirectly for their care, via insurers. Further, patients are rarely able to shop around for a medical service based on price because there is little transparency in this area.

In health care, many of these distortions have considerably worsened since Arrow described them in 1963. But in other industries less dominated by government intervention, the internet has substantially eroded them.

KEN ARROW VS. THE INTERNET

Consider asymmetric information. It is not unusual for a buyer to have less information than a seller. The seller of a used car is likely to know more about that car's mechanical history than a buyer, hence the popularity of third-party services, such as Carfax. The phrase caveat emptor—"buyer beware"—dates back centuries and has been enshrined in U.S. law since at least 1817.

Thanks to the internet, it is now possible to review the mechanical histories of hundreds of cars online. Indeed, in many types of transactions, the buyer now has an advantage over an inexperienced seller because the buyer has access to a wealth of data with which to compare price and quality.

Arrow also expressed concern about the unpredictability of one's need for health care. But unpredictability, as an economic principle, is far less exotic today than it was in 1963. Advances in the pricing of options contracts have allowed individuals to assign prices to risk in almost every field of endeavor.

The last half-century has witnessed a proliferation of insurance products, addressing all sorts of unpredictability, including: traveler's insurance, extended warranties, overdraft protection, and malpractice insurance. All of these products can be priced, and compared, online, in ways that satisfy consumers.

Trust is another economic problem that technology has made great strides in addressing. Airbnb, the home-sharing website, encourages both lessees and lessors to rate each other online. In this way, Airbnb reduces the risk of bad customers invading one's home, as well as the risk of unscrupulous landlords failing to live up to consumers' expectations.

The internet's most profound impact on the non-health care economy involves reducing barriers to entry. Mom-and-pop craftsmen can start multinational businesses by selling their crafts worldwide on Etsy. More information is now available to non-professional investors. Authors can self-publish electronic books online. In most other sectors, consumers pay directly for goods and services, giving businesses a strong incentive to deliver those goods and services at an attractive price. But this is, of course, not what happens in U.S. health care.

Each barrier to a more innovative, competitive, affordable health care system exists for a reason. Privacy laws protect patients from having their sensitive medical records fall into the wrong hands. America's complex, inefficient method for subsidizing health coverage exists because Americans have understandably sought to protect the poor and vulnerable from unaffordable health care expenses. But the cumulative weight of these policies has been to make health care less innovative, less patient-centered, and less affordable.

Digital technology can solve many of the health care problems that Arrow identified before the information economy arose; outside of health care, technology has already largely solved them. If we wish to bring internet-like innovation to health care, it is worth exploring some notable areas in which government policy has obstructed digital health technology.

COMPETITION ON PRICE AND QUALITY

As noted elsewhere in this monograph, our "ninth-party" system for financing health care means that few suppliers of health care services and products have an incentive to compete on price and quality.

At the same time, patients ultimately pay for every health care product or service that they consume, through taxes, health insurance premiums, and out-of-pocket spending. David Goldhill, author of *Cata-*

strophic Care: Why Everything We Think We Know About Health Care is Wrong, estimates that the average American will spend "roughly $4 million in total" for his family's health care over the course of his life.[83]

The digital technology sector, by contrast, is largely driven by consumer decisions about how to spend money. Someone who buys a television on Amazon, rather than at a local store, typically does so because Amazon's price is better. Yet patients rarely take price into account when choosing a doctor or hospital because the vast majority of those costs are paid for by insurance and/or the government.

Some observers insist that high health care prices are necessary to fund innovation. Yet this is not generally true. As Clayton Christensen famously noted, disruptive innovation is driven by consumers' desire to seek out goods and services of lower price and comparable or higher quality.

Japanese automakers entered the U.S. market by making low-priced cars, like the Honda Accord, that were more reliable than their American competitors. For decades, Japanese cars were derided by U.S. automakers as "cheap imports."

Today, Toyota, Honda, and Nissan prosper in both the low- and luxury-ends of the market, while General Motors and Chrysler were bailed out by the government.

Google and Facebook are two of the most innovative companies in the world. Their core products—search engines and social networks, respectively—are free to the consumer.

Apple's products are often more expensive than their competitors'; but even iPhones of comparable quality decline in price over time, as they must, since newer models contain newer features and consumers have alternatives, thanks to price competition.

In 2007, the initial iPhone was launched with 8 gigabytes of memory and a 320-by-480 pixel screen for $599. In 2015, the iPhone 6s Plus was launched with 128 gigabytes of memory and a 1080-by-1920 pixel screen for $499. That is to say: in eight years, iPhone memory increased by a factor of 16, screen resolutoin increased by a factor of 13.5, while inflation-adjusted price decreased by 27.4 percent.

Why has that not happened in health care? Because nobody spends someone else's money as wisely as he spends his own.

Consider LASIK eye-correction surgery. LASIK is not covered by insurance because purchasing eyeglasses is much less expensive than LASIK. As a result, the LASIK market has behaved just like the conventional technology sector: over time, prices have gone down and quality has gone up. No LASIK provider or supplier complains that the decline in prices has led to less innovation.

TELEMEDICINE AND ACCESS TO CARE FOR RURAL AMERICANS

The high cost of U.S. health care is only one of the challenges for low-income Americans. Access to health care in America is also highly inconsistent. Those enrolled in Medicaid, and those without formal health insurance coverage, frequently face difficulty in obtaining needed care. The Association of American Medical Colleges believes that by 2025, the United States will lack between 46,000 and 90,000 physicians needed to meet patient demand.[84]

A collection of entrepreneurs has shown impressive promise in addressing both of these problems at the same time, using 20th- and 21st-century telecommunications technology to supplement—and sometimes replace—the traditional physician office visit with telephone calls and videoconferencing.

Telemedicine, as this field has come to be called, can expand access to care by distributing physician demand more evenly across underserved areas, such as rural communities, and across underserved time periods, such as nights, weekends, and holidays.

Furthermore, telemedicine is significantly less expensive than conventional care. According to an analysis by Dale Yamamoto of Red Quill Consulting, a typical visit to the emergency room for a commercially-insured patient costs $1,595; a visit to an urgent care clinic $116; and a physician office visit $98. The typical telemedicine visit costs between $40 and $50.[85]

Telemedicine could also significantly reduce wait times for physician care. In 2015, a group of scholars at the University of Pittsburgh, Harvard, and the RAND Corporation estimated that travel and wait times for physician care cost patients approximately $52 billion in 2010, primarily due to lost wages. Employed adults

lost 1.1 billion work hours in this manner, equivalent to the loss of 563,000 full-time workers.[86]

However, despite these attractive features, telemedicine has attracted controversy from those it may economically disrupt, and from regulators with ties to incumbent stakeholders. It has also elicited concerns from scholars who seek to ensure that telemedicine can improve the quality of health care.

"Telemedicine" is most commonly used as a term to describe a real-time interaction between a physician and a patient, either by telephones (i.e., audio only) or videoconferencing technology. It may seem odd to conceive of the telephone—invented in 1876—as a driver of technological change in medicine. And, indeed, for the majority of cases, an in-person encounter with a physician remains the gold standard of medical care.

But the confluence of Big Data and the internet has allowed entrepreneurs to deploy unused physician capacity over the telephone for health care problems of moderate to low severity. In a study published in *Health Affairs* examining the utilization of telemedicine by California public-sector workers, a majority of visits were for acute respiratory illnesses (31 percent), urinary tract infections and symptoms (12 percent), and skin problems (9 percent).[87]

The opportunity is significant; the Centers for Disease Control estimate that there are 1.25 billion ambulatory care visits per year in the U.S.; approximately one-third of those are addressable via telemedicine.

Authors of the *Health Affairs* study found that patients seen by physicians using telemedicine was at least equal to, and in some ways superior, to the care offered in the traditional, in-person setting. Within 21 days of the initial patient-physician encounter, only 6 percent of telemedicine patients required a follow-up for the same condition, versus 13 percent for office visits and 20 percent for emergency room encounters.

34 percent of telemedicine encounters took place on weekends and holidays, compared to 8 percent for physician offices and 36 percent for emergency rooms. In other words, patients who had difficulty seeing a physician outside of office hours could now use telemedicine to avoid the emergency room while still gaining the advice of a physician.

All the while, the *Health Affairs* authors found that "there is very little evidence of misdiagnosis or treatment failure in [telemedicine] visits."

CRITICISMS OF TELEMEDICINE

Telemedicine has been subject to a number of criticisms, some more legitimate than others.

The first is that there is no substitute for a real, in-person patient encounter, because there may be clues as to a patient's diagnosis and best treatment course that can only be elicited by an in-person examination. While this complaint is true in many areas of medicine, it is also true that telemedicine can play a very helpful role in several low-severity situations, such as bronchitis or a urinary tract infection. Furthermore, for those living in rural and underserved communities, the choice isn't between telemedicine and an in-person physician visit: it's between telemedicine and nothing, or between telemedicine and a long wait.

The second is that telemedicine introduces competition within the physician community. If out-of-state physicians can see a patient remotely, then local physicians will face more competition. While several medical groups and professional associations oppose physician competition, it is quite clearly in the interest of the consumer—the patient–to gain wider access to physician care than he does today.

The third is that telemedicine could be abused by those inappropriately seeking prescription pharmaceuticals. While this is certainly possible, it is well within the existing purview of state regulators to monitor physician drug prescribing so as to prevent abuse.

LIFTING REGULATORY BARRIERS TO TELEMEDICINE

Telemedicine is unusual in that both federal and state-based policymakers can play a role in enacting reform.

As seen above, state governments, through their licensing boards, can attempt to restrict the availability of telemedicine. As of January 2016, only Arkansas prohibits the practice, requiring a pre-existing in-person relationship in order to allow any interaction by telephone or videoconference. Idaho allows for physicians to issue prescriptions via telemedicine if there is video interaction as well as audio. Texas has attempted to restrict telemedicine in myriad ways. Most other states allow telemedicine of the variety practiced by Teladoc, MDLive, and other companies.

Another opportunity for states to improve opportunities for telemedicine is to harmonize state-based medical licensure. Because physicians engaging in telemedicine are required to be licensed to practice medicine in the state where a patient resides, states can accelerate the uptake of telemedicine in their states by making it easier for physicians in other states to gain licensure in theirs.

In September 2014, the Federation of State Medical Boards published the Interstate Medical Licensure Compact, with the goal of enabling participating states to streamline cross-licensure for physicians in their states. As of January 2016, twelve states have officially signed onto the Compact: Nevada, Idaho, Montana, Utah, Wyoming, South Dakota, Minnesota, Iowa, Wisconsin, Illinois, Alabama, and West Virginia. Another ten states—Washington, Colorado, Nebraska, Oklahoma, Kansas, Michigan, Pennsylvania, Vermont, New Hampshire, and Rhode Island—are actively considering legislation to do so.

Given that approximately 140 million Americans are on government-sponsored health coverage, a key barrier for telemedicine to overcome is reimbursement for telephone and videoconference-based patient interactions. States have the latitude to reimburse for telemedicine within their Medicaid programs, and most do, albeit at widely varying rates.

27 states and the District of Columbia have enacted laws requiring private insurers in their jurisdictions to provide coverage and reimbursement for telemedicine services that is comparable to that for in-person physician encounters.

Such "parity legislation" can, paradoxically, reduce the appeal of telemedicine, because it prevents insurers and providers from identifying economic efficiencies in the delivery of telemedicine. If telemedicine encounters and in-person encounters cost the same, there is little incentive for insurers to drive uptake of telemedicine.

Two reforms at the federal level, outside of judicial rulings, could play a significant role in improving the outlook for telemedicine. First, Congress could clarify the application of antitrust law to state medical licensing boards, so as to create a safe harbor for innovative telemedicine practices.

Second, greater uptake of bundled payment by the Medicare program could strongly encourage telemedicine, as paying for episodes of care encourages providers and Medicare-associated insurers to identify efficiencies in cost and quality.

For example, in the traditional fee-for-service Medicare system, the government will pay a hospital more money to care for a patient with a urinary tract infection if that patient fares worse over time, requiring more health care.

This gives the hospital a perverse incentive to perform badly. By contrast, if Medicare pays that hospital $1,000 for each patient with a urinary tract infection, the hospital generates more income if the patient recovers more quickly and if it deploys more cost-effective care, including telemedicine.

DIGITIZATION AND MOBILITY OF PATIENT RECORDS

One of the most significant deficiencies in the U.S. health care system is the degree to which patients do not own and control their own health care information. This makes it harder for patients to share their health records with new doctors, hospitals, or emergency rooms; it increases the likelihood of medical errors and repetitive care; and it makes the coordination of care difficult for patients with multiple physicians and/or multiple diseases.

Patients who are familiar with their own health history are in a better position to engage in their own health, and give their physicians useful information during interviews, and avoid harmful interventions that might otherwise be indicated by a patient's symptoms and clinical presentation.

Not all patients want to closely review their health records; for example, in a 2014 survey by Accenture, cancer patients were more likely than others to agree with the statement, "I trust that my medical records are accurate, so I don't need to access them."[88]

There are types of consumer data that are highly useful to businesses, such as those compiled by market research firms and advertisers based on income levels and consumption patterns. But it is understandable that consumers are not that interested in what businesses think they might want to buy in the future.

A certain level of disinterest in one's personal health records is to be expected. For example, a 2013 survey

by the American Bankers Association found that only 42 percent of U.S. consumers know their credit score, even though consumers have the right to one free credit report from each of the three major rating agencies each year.

Though it would be unrealistic to expect every patient to take great interest in his health records, there are clear and material benefits to patients gaining access to their health records, and so it is striking how infrequently it takes place. The Accenture survey found that 87 percent of patients wanted control over their own health data. However, according to a poll by the Office of the National Coordinator for Health Information Technology (ONC), only 21 percent of patients accessed their online medical records in 2014.

BARRIERS TO PATIENT HEALTH RECORD OWNERSHIP

Federal policy has erected important barriers to those who actively seek such access.

The first problem is third-party payment for third-party insurance. Providers of health care services, such as physicians, nurses, and hospitals, are paid by insurers and the government. Furthermore, insurers are predominantly retained by employers, not individuals; and government programs are funded by taxpayers, most of whom are not enrolled in those government programs.

Health care providers know that they are financially accountable to insurers and the government, and are therefore responsive to the concerns of these payors. However, the concerns of insurers and governments are not always aligned with the interests of patients. Providers and diagnostic companies have historically considered health records to be their intellectual property, not the patient's, even though patients are directly and indirectly paying for those services.

Patients have historically lacked the power to change insurers, or the market information needed to switch providers; hence, providers and payors rarely had the incentive to cater to patients' desire for their own records.

The second is Medicare's byzantine reimbursement policies. Historically, Medicare has run on a "fee-for-service" model in which providers were paid regardless of the quality with which providers delivered their services to patients. Medicare's reimbursement policies have proven highly influential in the private sector as well, leading to a broad culture of paying for quantity, not quality. As Medicare traditionally did not reimburse providers for making patient records accessible, providers did not focus on this nonremunerative task.

The third is federal laws regarding patients' rights to their own records. Not until the Health Insurance Portability and Accountability Act of 1996 did patients have the right to request copies of their health records from providers. HIPAA's so-called "Privacy Rule" gave patients the right to receive copies of their medical records in most circumstances. However, many providers were concerned that giving patients access to their records would increase malpractice litigation, and erected barriers to access.

For example, a law in New York state allows providers to charge as much as 75 cents per page to provide access to patient records. Since medical records have historically been paper-based, and are often lengthy, these reproduction costs made access to health records unaffordable for many patients.

The fourth barrier is the ability of different providers to exchange patient data. Paper-based patient data is inherently difficult to exchange; as providers have moved to electronic health records, the lack of widespread standards for patient data has proved problematic. The challenge of many providers to seamlessly exchange electronic patient data is often called interoperability or data liquidity. It's not necessary for the public sector to develop these standards; in the consumer electronics sector, for example, private manufacturers developed the compact disc, digital video disc, and Blu-Ray standards. However, federal efforts to encourage the use of electronic health records have made the emergence of standards more difficult.

PAST EFFORTS AT REFORM: HIPAA AND HITECH

Broadly speaking, there are two general approaches policymakers could take to address the problems with patient access to health records. The first would be to move away from third party payment of third party insurance, and move toward a system where individuals purchased their own insurance, and paid for more care directly. Reform in this direction has proven difficult over the last several decades.

The second would be to preserve our current way of

paying for health care, and instead add in layers of new federal rules mandating that providers make health records more accessible. Over the past 20 years, Congress and the Executive Branch have chosen this latter route, with mixed success. Their efforts have culminated in two major statutes that govern patient health records: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).

HIPAA was arguably the most significant piece of health care legislation in the 1990s, instituting changes to employer-based insurance and health savings accounts. Significantly, Title II of HIPAA was designed to lay down ground rules for the privacy and portability of patient medical records. As noted above, the law's "Privacy Rule" requires health care providers and other covered entities to offer patients access to their health records. However, providers were not required to do so in a timely manner or at an affordable price. As a result, the law did not result in a substantial increase in patient access to medical records.

The HITECH Act was passed as part of the American Recovery and Reinvestment Act of 2009, popularly known as the "stimulus bill." HITECH arguably represents the most profound federal change to health care delivery since HIPAA.

By emphasizing the development of electronic health records, HITECH was designed to make more feasible HIPAA's goal of granting patients access to their medical records. Furthermore, the law formally created the Office of the National Coordinator for Health Information Technology as a staff division within the U.S. Department of Health and Human Services, in order to focus federal efforts to establish the meaningful use of electronic health records.

The law strongly encourages physicians and hospitals to achieve "meaningful use" of interoperable electronic health records. The encouragement comes in the form of incentive payments by Medicaid and Medicare.

The HITECH Act and its attendant regulations specify three stages of "meaningful use" of electronic health records (EHR). Each stage is accompanied by a number of federal objectives that providers must meet in order to receive the incentive payments.

In Stage 1, in the years 2011 and 2012, providers were to focus on installing EHR systems. In Stage 2, for the year 2014, providers were to focus on ensuring that their EHR systems could communicate with those of other health care providers, including pharmacies and clinical laboratories. In Stage 3, for the year 2016, providers are to focus on improving health outcomes.

HITECH HAS LED TO INEFFICIENT CARE DELIVERY

However well-intentioned HITECH may have been, the law has come under withering criticism from health care providers, especially physicians, who say that the law forces them to spend time in front of their computers instead of interacting with patients. According to a survey of physicians published in Health Affairs, less than 20 percent of physicians express a desire to go back to paper medical records. However, these same physicians reported that the regulations promulgated in HITECH had profoundly decreased the efficiency of health care delivery:

Physicians noted important negative effects of current EHRs on their professional lives, and, in some troubling ways, on patient care. They described poor EHR usability that did not match clinical workflows, time-consuming data entry, interference with face-to-face patient care, and overwhelming numbers of electronic messages and alerts. Physicians in a variety of specialties reported that their EHRs required them to perform tasks that could be done more efficiently by clerks and transcriptionists.

The inability of EHRs to exchange health information electronically was deeply disappointing to physicians, who continued to rely on faxed medical documents from outside providers. Physicians also expressed concerns about potential misuse of template-based notes. Such notes, which contain pre-formatted, computer-generated text, can improve the efficiency of data entry when used appropriately.

However, when used inappropriately, template-based notes were described as containing extraneous and inaccurate information about patients' clinical histories, with some physicians questioning the fundamental trustworthiness of a medical record containing such notes. In addition, EHRs were reported as being significantly more expensive than anticipated, creating uncertainties about the sustainability of their use.

The HITECH Act shortsightedly emphasized physician entry of electronic patient data; the law created

unnecessary legal hurdles to deploying support staff for that purpose, freeing physicians to focus more directly on their patients.

The objectives contained in HITECH's "meaningful use" standards have turned out to be onerous and time-consuming as well; providers were defined as "failures" if they missed a single objective out of 15.

Another problem has been the cumbersome process for EHR vendors to gain federal certification, and thereby qualify for uptake under the "meaningful use" requirements. The certification process has rewarded established, well-connected businesses and hampered the ability of entrepreneurs to develop innovative approaches to EHR delivery, usability, and interoperability.

There is a pressing need for reform of federal laws pertaining to patient health records. The current regime is cumbersome for providers, and erects needless barriers to innovation that would seem bizarre to entrepreneurs in the conventional information economy.
Interoperability and data liquidity

A key difficulty in enhancing the utility of patient medical records—one that HITECH has not overcome—is the ability of those records to be used by multiple providers in the coordination of care. In the health IT community this is often described as "interoperability" or "data liquidity."

HITECH's rules and regulations regarding the meaningful use of electronic health records have contributed to this challenge. In addition, anti-kickback statutes prevent businesses from receiving revenue for simplifying the transfer of patient information between providers.

Another problem is that clinical data is inherently complex. Patient records can contain subjective and objective information; even objective information, such as blood pressure, can be measured using different techniques. Hence it is important for there to be widely accepted standards for the categorization of clinical data.

Under HITECH, the federal government has overly centralized and bureaucratized the development of interoperable electronic health records. Furthermore, the law has primarily rewarded purveyors of closed, proprietary EHR systems that cannot be improved by physicians, entrepreneurs, or freelance coders.

A better approach would be for the Office of the National Coordinator (ONC) to defer to national medical societies, such as the American Medical Association, the American College of Cardiology, and the American Society of Clinical Oncology, to develop and annually revise open-source standards for electronic health data in their respective fields.

Furthermore, Congress should liberalize federal EHR certification rules, in order to substantially reduce the barriers to new entrance that stem from federal compliance. Federally sanctioned EHR software should be required to deploy open-source architecture, in order to maximize the ability of innovators to build upon existing platforms.

It is possible to develop profitable EHR software using open-source architecture, as Athenahealth and other vendors have demonstrated.

One aspect of the HITECH Act could be enhanced: the so-called "Blue Button" initiative that allows patients to download or view their electronic health records from participating providers. Federal incentives have made the use of "blue buttons" widespread in Medicare; policymakers might consider rewarding providers who automatically give non-Medicare patients access to secure electronic health records as a default option.

Patients who do not want to view or harbor their health records would have the freedom to opt out of receiving them. Such a change could engender a dramatic increase in patient engagement with their medical data, and entrepreneurship with regards to housing, sharing, and analyzing medical records.

STRENGTHENING THE SECURITY OF PATIENT RECORDS WITH BLOCKCHAIN TECHNOLOGY

An emerging and promising technology for improving the digital security of electronic medical records is the blockchain, the cryptographic technology used in digital currencies such as Bitcoin and Ethereum.

Blockchain-based medical records, for example, would be nearly impossible to hack, especally if they required authorizations from both a patient and his doctor to access. The billing departments of insurers and hospitals could access the blockchain in order to audit a medical episode, and to dramatically reduce waste, fraud, and abuse.

DEPLOYING DIGITAL TECHNOLOGIES TO COORDINATE CARE

Innovation in software and data analytics is allowing entrepreneurs to develop methods of delivering highly customized goods and services to individual consumers. In theory, such methods are highly applicable in health care, where each patient has an individual profile that could benefit from customized treatment. However, a thicket of privacy laws, anti-kickback statutes, and other inefficiencies prevent patients from owning their health data, such as medical charts, to take advantage of new technologies.

IBM is developing software to combine patient interviews with a comprehensive review of the medical literature, in order to provide physicians with evidence-based suggestions regarding treatment algorithms. Such analyses ought to be available to patients, too—entrepreneurs could further analyze the cost-effectiveness of various treatments that a patient might consider. Yet such analyses are now difficult, if not impossible, to offer patients because patients do not own their medical data.

While some physicians may see third-party advice to patients as a threat to their authority, such software could likely do much to improve patient care by helping physicians and patients adhere to evidence-based guidelines, thereby reducing medical errors and improving clinical outcomes. One can envision a time when patients are more informed than physicians about patients' health profiles—asymmetry of information, but in the patient's favor.

One of the most high-profile problems in health care policy is coordinating care for patients with multiple chronic illnesses. A patient with diabetes and heart disease, for example, is likely to seek care from a primary care physician, an endocrinologist, a cardiologist, and a local hospital.

Frequently, these health care providers are independent of one another, and do not coordinate their actions with regards to the patient. This can lead to duplicative care, higher costs, and serious medical errors. For example, the endocrinologist may prescribe one set of pills, while the cardiologist prescribes another, while the primary care physician prescribes yet another. If any of these prescriptions overlap, the patient could suffer from a lethal overdose.

In 1999, the Institute of Medicine estimated that as many as 98,000 people a year die in hospitals as a result of preventable medical errors, with an additional cost of between $17 and $29 billion in additional care, lost income, disability, and lost productivity.[89]

"One oft-cited problem," wrote the authors, "arises from the decentralized and fragmented nature of the health care delivery system—or 'nonsystem,' to some observers. When patients see multiple providers in different settings, none of whom has access to complete information about the patient, it becomes easier for things to go wrong."

Unfortunately, federal law effectively prohibits the ability of technology companies to help providers coordinate care, because if a firm receives any sort of payment for acting as a middleman between two different health care providers, it risks running afoul of federal anti-kickback laws.

Anti-kickback statutes arose from an understandable desire to address unsavory practices in patient care. The problem arose when some specialists or hospitals would offer payments—or kickbacks—to other physicians for patient referrals, regardless of whether the referred services (or providers) were best for the patient. The Institute of Medicine has estimated that 30 percent of U.S. health spending—more than $900 billion a year—is wasted on medically unnecessary services, fraud, and bureaucracy.

The principle that doctors should only refer patients to other providers based on medical need dates back to the ancient Hippocratic oath to put the patient's interest above the physician's.

These practices are seen as less pernicious outside of health care. As a result, coordination of customer service is routinely achieved in the less-regulated, non-health care economy.

For example, even though airlines are highly regulated, if Delta Air Lines cancels a flight due to mechanical issues, it can electronically transfer passengers to American in exchange for a fee. Amazon coordinates consumer information between millions of sellers. Starwood Hotels and Resorts—the owner of the Westin and Sheraton hotel chains—is able to collaborate with American Express on a credit card product, in which consumers are incentivized to patronize both businesses at the expense of competitors.

Hence, the well-intentioned principle of preventing

kickbacks creates economic distortions. Simply imagine a world in which products like the Starwood American Express Card were illegal, or where American and Delta could not pay each other to accept stranded passengers. Paradoxically, the anti-kickback statute, designed to protect patients from corrupt physicians, is also harming patient care.

Anti-kickback laws have another deleterious effect. By prohibiting any economic incentive for care coordination, they incentivize hospitals and doctors to merge into oligopolistic entities. "Anti-kickback laws effectively prohibit hospitals from providing financial incentives to independent doctors who deliver efficient care," observes David Dranove of Northwestern University's Kellogg School of Management.[90]

While it is illegal for hospitals to provide those incentives to independent doctors, it is perfectly legal for hospitals to acquire physician practices and provide those incentives internally.

Thus, the anti-kickback statute provides a powerful legal incentive for hospitals to acquire physician practices, thereby reducing competition in the health care system and increasing costs. Indeed, as a consequence of the Affordable Care Act, a group of federal agencies, working in concert, issued a waiver from the anti-kickback statute to physicians and hospitals who merge under the guise of Accountable Care Organizations, ACA-sanctioned provider entities that seek to coordinate care for patients with multiple illnesses. Supreme Court Justice Louis Brandeis famously observed that "sunlight is said to be the best of disinfectants." Transparency and disclosure could provide a superior outcome for patients than criminalizing care coordination among independent providers.

The Centers for Medicare and Medicaid Services can retain the ability to prosecute corrupt physician practices without the aid of the anti-kickback and Stark statutes. Congress could replace those laws with provisions requiring physicians to disclose to their patients—and to CMS—any remuneration they receive for patient referrals. In this way, patients could judge for themselves whether or not the referral was justified, and CMS would acquire data with which to pursue clear instances of corruption.

Health care information technology remains decades behind IT in other sectors of the economy. Today, most patient referrals are still processed via fax machines and physical paper. By eliminating the chilling effect of the anti-kickback laws, technologists would be free to develop innovative new approaches to patient care coordination, deploying advanced computing power to identify potential medical errors and billing mistakes that could expose patients to large medical bills.

Instead of relying on the HHS Office of Inspector General to anticipate new technologies and modes of healthcare delivery, entrepreneurs could conceive of ways to coordinate care without fear or criminal prosecution. At the same time, both patients and policymakers could continue to pursue real instances of corrupt practices, thanks to transparency and disclosure.

Today, health care information technology is dominated by a few large companies, like Epic Systems Corporation. This is in part because disruptive innovators are stymied by the risk of federal criminal prosecution. It is impossible to calculate how many lives might be saved by digitally improved care coordination—but when it comes to replacing anti-kickback statutes with transparency provisions, the risks outweigh the rewards.

Part Eight

Other Reforms: The Gathering Storm of Hospital Monopolies

There are a number of additional things we can do to improve the quality and efficiency of health care in America. Malpractice reform is one; many physicians feel that the way they practice medicine isn't determined by the best interests of their patients, but by the best interests of their lawyers. But a far greater problem is the pricing power of hospitals. Hospitals are merging into large hospital systems, and using their market power to demand higher and higher prices from the privately insured and the uninsured.

A number of commentators have called attention to the vexing problem of "crony capitalism," whereby politically connected industries persuade the government to give them financial and regulatory advantages over competitors and taxpayers. There is no better candidate for that description in the United States than the hospital industry.

IT'S THE PRICES, STUPID

Nearly one-third of what the U.S. spends on health care is consumed by hospitals: in 2016, $1.1 trillion out of $3.4 trillion in total health spending.

Among the industrialized member countries of the OECD, the average hospital stay cost $6,222 and lasted 7.7 days in 2009. In the United States, the average hospital stay cost $18,142, despite lasting only 4.9 days. In other words, the average daily cost of a hospital stay in the U.S. was *4.6 times* the OECD average of industrialized nations. That disparity has persisted over the past decade.

Not only are U.S. hospital stays shorter in length; Americans use hospitals less frequently than their industrialized peers. In 2014, the United States had 12,901 hospital discharges for every 100,000 residents. This compares favorably with the OECD average of 15,462. As Gerard Anderson, Uwe Reinhardt, and colleagues explained in 2003, "on most measures of health services use, the United States is below the OECD median. These facts suggest that the difference in spending is caused mostly by higher prices for health care goods and services in the United States."[91]

Federal health care entitlements like Medicare and Medicaid have responded to the rising costs of hospital care by paying hospitals less for a wide range of services. Hospitals have responded, in turn, by raising the prices they charge to private insurers and the uninsured: a practice called *cost-shifting*.

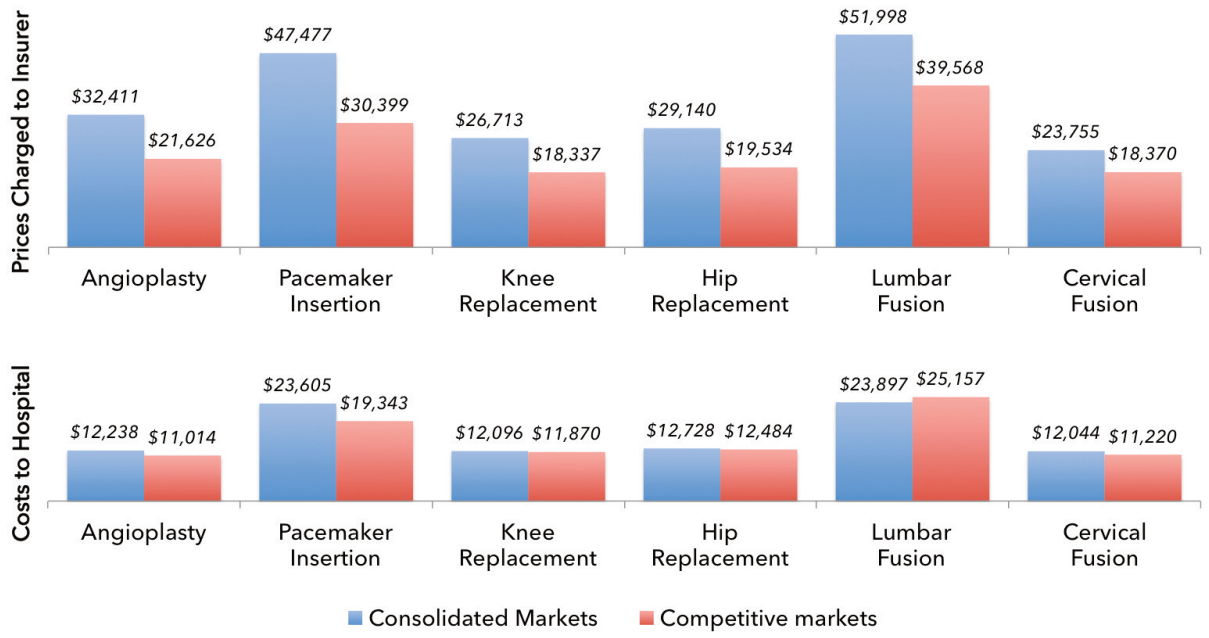
In his landmark 2013 article "Bitter Pill: Why Medical Bills Are Killing Us," Steven Brill described an uninsured patient who was charged $283 for chest X-rays by his Texas hospital; that hospital routinely bills Medicare $20 for the same service. The Texas hospital charged $15,000 for routine lab tests for which Medicare pays several hundred dollars. A Connecticut hospital charged another uninsured patient $158 for a routine test called a complete blood count, for which Medicare pays $11.[92]

Furthermore, there is no identifiable relationship between what hospitals charge for health care services and the quality that those hospitals provide. An analysis by Joe Carlson of *Modern Healthcare* of hospitals in 12 cities found, as so many others have, that "there is no consistent relationship between hospitals spending more to perform a procedure and their achieving better patient outcomes."[93]

HOSPITAL CONSOLIDATION IS DRIVING PREMIUMS UPWARD

Hospitals have come to recognize that by consolidating their market power, they can force private insurers to accept higher prices.

Figure 19. Consolidated Hospitals Charge 44% Higher Prices, Despite Similar Underlying Costs



Hospital monopolies and oligopolies exploit their market power to raise prices. In 2011, James Robinson of the University of California reviewed data from 61 hospitals in markets that were either highly concentrated (above-median HHI) or competitive (below-median HHI). He found that, for six common hospital procedures, hospitals in concentrated markets charged on average 44% higher prices, despite having only a 6% difference in underlying costs. Indeed, lower costs in competitive markets could be a sign that competition among hospitals not only lowers prices charged to insurers, but also motivates competing hospitals to lower their underlying costs. Because concentrated hospital systems enjoy more than double the profits per procedure of their competitive peers, concentrated hospitals have the extra resources to mount acquisitions of their less prosperous cousins, resulting in a vicious cycle of additional consolidation. *(Source: American Journal of Managed Care)*

In 2011, James Robinson of the University of California reviewed hospital prices charged to commercial insurers for six common procedures: angioplasty, pacemaker insertion, knee replacement, hip replacement, lumbar fusion, and cervical fusion. He found that, on average, procedures cost 44 percent more in hospital markets with an above-average degree of consolidation.[94]

For example, as illustrated in ***Figure 19***, in competitive hospital markets, the average hospital charged $18,337 for a knee replacement; in a consolidated hospital market, the average hospital charged $26,713: a premium of 46 percent.

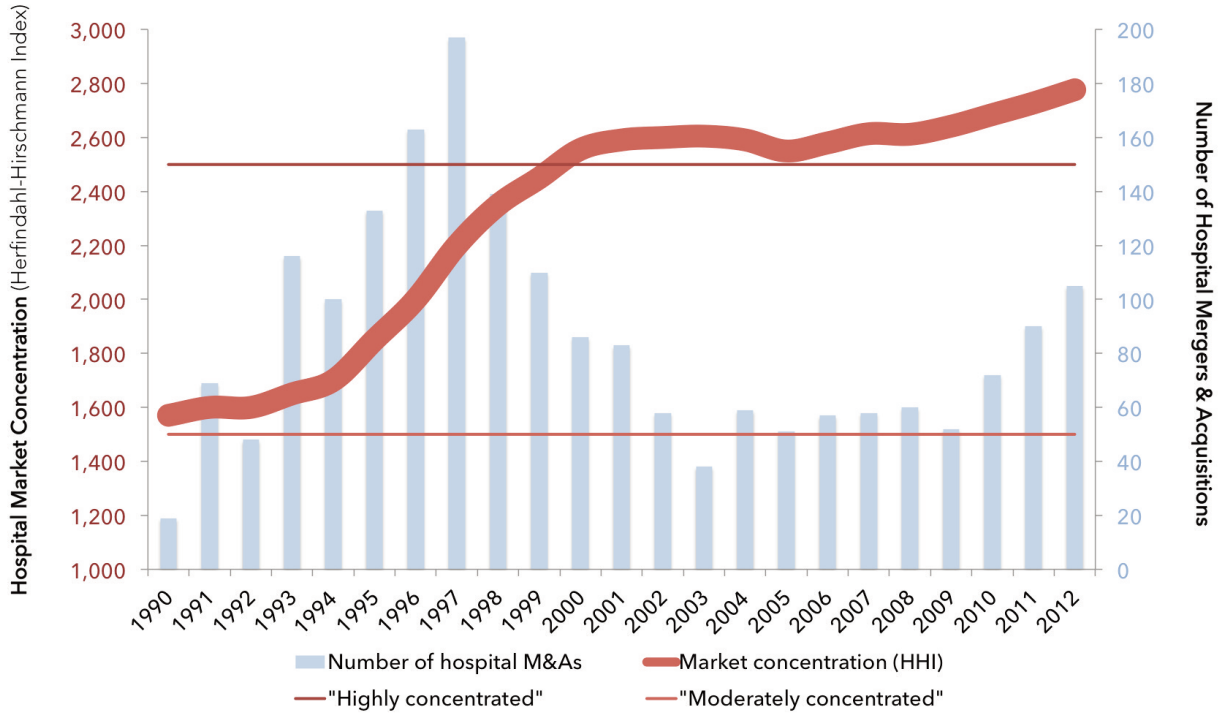
However, the average *cost* to the hospital for performing the knee replacement was nearly identical: $11,870 in competitive markets and $12,096 in consolidated markets.

In other words, nearly the entirety of the price premiums charged by consolidated hospitals flows down to the hospitals' bottom lines in the form of profit, or what most hospitals call "contribution margin." For the procedures studied by Robinson, consolidated hospitals earned more than twice their competitive peers in contribution margin.

The superior profitability of conslidated hospital systems leads to a vicious cycle, whereby weak hospitals in competitive markets either close or become vulnerable to acquisition by the larger, consolidated systems, making the problem even worse.

A substantial number of hospital mergers took place in the 1990s, in response to the rapid adoption of HMO-style managed care plans in the private insurance market. Insurers had initially succeeded at keeping prices down by restricting wasteful utilization of

Figure 20. Impact of Mergers and Acquisitions on Hospital Market Concentration, 1990–2012



A new wave of hospital mergers is driving market concentration higher. The blue bars denote the number of hospital merger and acquisition transactions in a given year; in the 1990s, penetration of managed-care insurers, with a mandate for more aggressive cost control, led hospitals to merge in response, strengthening their market power over the insurers. The Federal Trade Commission and the U.S. Department of Justice normally consider markets with HHI above 1,500 as "moderately concentrated" and markets with HHI above 2,500 as "highly concentrated," triggering antitrust litigation. However, consolidated hospital markets have largely avoided antitrust litigation. Today, more than half of the hospital markets in the United States have an HHI above 2,500, meaning that the DOJ and FTC would consider them to be "highly concentrated." *(Source: A. Roy analysis, Robert Wood Johnson Foundation, Martin Gaynor, Irving Levin Associates, HHS ASPE)*

costly services; hospitals, by consolidating their market power, could make up for this shortfall. In response to the Affordable Care Act, hospitals have once again undergone a wave of merger and acquisition activity.

A common way to measure the degree of hospital market concentration is to use the Herfindahl-Hirschmann Index, or HHI. An HHI score is the sum of the squares of the market share of each player in a given market. For example, in a market where there is only one hospital—a monopoly—with 100 percent market share, that market's HHI score is 10,000 (100 squared).

A market with only two hospitals, in which one has 60 percent share and the other 40 percent, has an HHI of 5,200 (60 squared plus 40 squared).

As noted in ***Figure 20***, the Federal Trade Commission considers markets to be "highly concentrated" if their HHI scores are 2,500 or higher.

In other industries, such as airlines or cell-phone carriers, the FTC routinely seeks to block mergers that would increase HHI scores above 2,500.

In the hospital industry, however, the median market HHI exceeded 2,500 in the year 2000, and reached 2,800 in 2013.

In other words, more than half of the hospital markets in the United States have reached a level of concentration that, in other sectors of the economy, would provoke an antitrust inquiry or lawsuit. Yet such litigation, in the hospital sector, has been scarce.

PROPOSALS FOR INCREASING COMPETITION AMONG HOSPITALS

There are a number of public policy tools that we can use to increase provider competition, thereby lowering health care prices for consumers.

1. Encourage new competitive entrants

Government policy discourages new entrants from competing against incumbent hospitals. Many states have *certificate of need* laws that require entrepreneurs to jump over high bureaucratic hurdles before they can build a new hospital.

The Affordable Care Act bars the construction of physician-owned hospitals that could, in many circumstances, offer valuable services at lower prices with higher quality.

The Universal Tax Credit Plan would repeal those sections of the Affordable Care Act that discourage and/or bar new hospital construction—provisions that were placed in the law at the behest of incumbent hospitals. While these bans would be lifted, insurers would be encouraged to prohibit physicians from referring patients to hospitals where they have an ownership stake.

2. Facilitate medical tourism and telemedicine

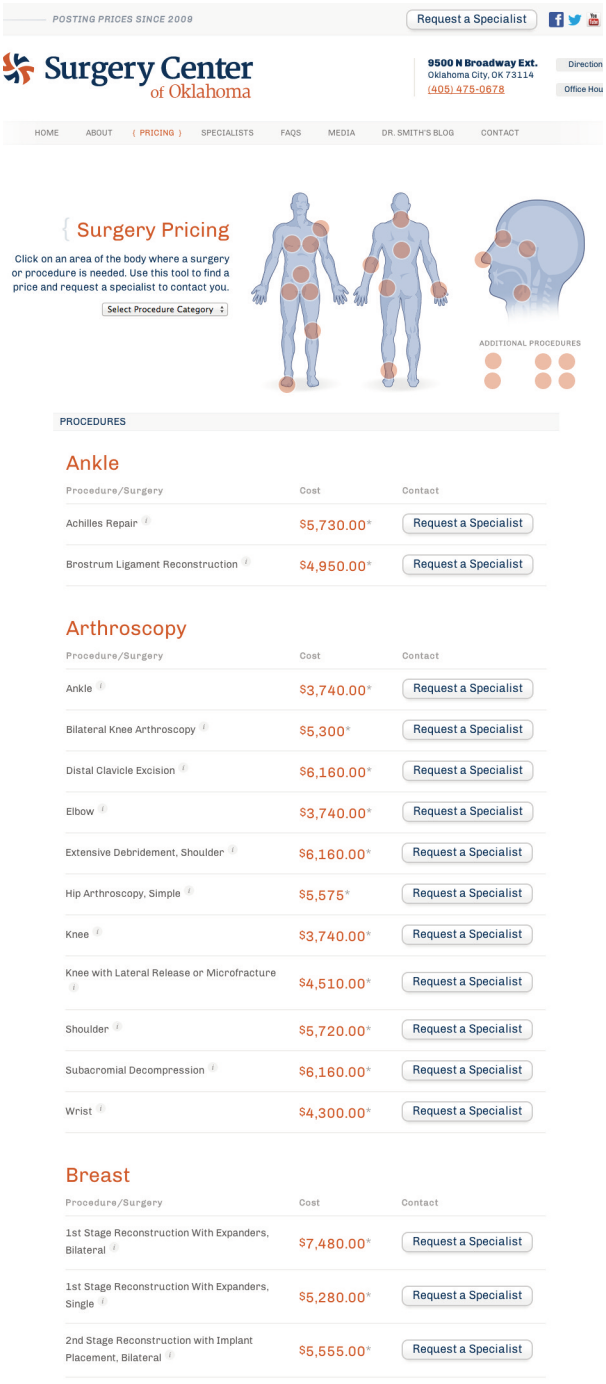
One important way to encourage hospital competition is to allow patients to obtain hospital-based care outside their local area: a practice called *medical tourism*.

For example, many Dallas-area businesses fly their employees to Oklahoma so that they may be treated at the Surgery Center of Oklahoma, which openly publishes the prices it charges for various common surgeries (***Figure 21***). The Surgery Center charges $8,000 for a hysterectomy, far less than the $40,000 to $50,000 commonly charged at Dallas-area hospitals.

The Universal Tax Credit Plan seeks to build on these developments by making it easier for individual market insurers to use *reference pricing* within and across state lines, and even across international borders.

For example, an individual market plan could give an able-bodied enrollee $8,750 for a hysterectomy—enough to travel to Oklahoma and undergo surgery there—or use the same amount of money to defray the cost of the same procedure in Dallas.

Figure 21. Promoting Provider Competition Through Price Transparency



Price transparency is an effective tool against hospital consolidation. The Surgery Center of Oklahoma publishes all its prices online. Dallas-based businesses are flying their workers to Oklahoma City, in a neighboring state, to take advantage of transparent–and far lower–prices for common procedures.

Reference pricing, in this way, opens up regional hospital monopolies to competition from hospitals in other markets.

Indeed, when the California Public Employees' Retirement System (CalPERS) adopted a form of reference pricing in 2008, its members found that costly hospitals were often willing to accept the reference price without additional charges.

From 2008 to 2012, CalPERS members enjoyed price reductions of 34.3 percent at high-cost facilities for orthopedic surgery, substantially reducing their premiums and out-of-pocket costs.[95]

One technical difficulty in encouraging cross-state hospital competition is *variation in medical licensing laws*. The Plan would instruct the Department of Health and Human Services to work with the various U.S. medical specialty societies, and relevant state agencies, to seek to harmonize state licensing laws and encourage cross-state reciprocity.

An important part of this effort would be to encourage states to liberalize *scope of practice regulations*, in order to allow nurse practitioners, physician assistants, pharmacists, and community health workers to provide care, appropriate to their training, at a lower cost than physicians can.

We could also do more to encourage *international medical tourism*, by liberalizing barriers that prevent American health insurers from paying for health care services received abroad.

3. Integrate the Veterans Health Administration into the broader U.S. health care system

As noted in Part Five, the Veterans Health Administration suffers from serious problems of redundancy, cost, quality, and access. It is time to consider integrating the Veterans Health Administration into the broader health care system.

In a reformed system in which veterans could gain access to private insurance options, civilians could also gain access to VA hospitals.

Indeed, VA hospitals could provide needed competition to private hospital monopolies. If the VA hospitals indeed offer higher quality at lower cost than civilian hospitals, the entire health care system would benefit from their competitive entry.

4. Discourage further hospital consolidation

The flip side of encouraging more hospital competition is *discouraging* more hospital consolidation. The Federal Trade Commission challenges a very small number of hospital mergers, despite the large amount of anticompetitive and rent-seeking activity among large hospital systems.

The Universal Tax Credit Plan would beef up the hospital industry staff of the FTC, so that the agency could do more to challenge anticompetitive hospital mergers. Expanding staffing at a government agency may seem like a counterintuitive way to increase market competition, but antitrust litigation is an important, and underutilized, tool for combating anticompetitive hospital practices.

Furthermore, the Plan would protect private-sector consumers from anticompetitive pricing practices by requiring hospitals in extremely concentrated markets—with an HHI above 4,000—to accept Medicare rates from the privately insured and uninsured. Rural communities, which naturally endure a less competitive hospital environment, might require a higher HHI threshold, such as 5,000.

This approach would have the added, salutary effect of discouraging anti-competitive hospital mergers, by preventing hospital monopolies from using their market power to extract higher prices from the privately insured.

REQUIRE FEDERAL HHS EMPLOYEES TO 'EAT THEIR OWN COOKING'

The Federal Employee Health Benefits Program, or FEHBP, was created in 1959 to provide employer-sponsored coverage to federal workers. Today, FEHBP covers approximately 4 million federal employees and 4 million of their dependents, at a projected annual cost of $49 billion in 2015.

According to a 2012 study by the Congressional Budget Office, the average employee of the federal government enjoys fringe benefits, such as health insurance, that are 48 percent more generous on average than those offered in the private sector.[96]

Most federal workers gain health coverage through FEHBP, which operates in a manner not unlike that contemplated by the Universal Tax Credit Plan.

Indeed, the Plan's reforms of the individual market would make that market more similar to the FEHBP model than it is today.

The implementation of the ACA exchanges, however, has placed the federal government in the odd position of regulating exchanges in which its employees do not participate. Migrating employees of the Department of Health and Human Services over to the exchanges would oblige them to "eat their own cooking," so that they can experience firsthand the impact of their regulations on individual market enrollees.

Such a program could be expanded to all federal employees, and used to align FEHBP insurance subsidies with those in the private sector.

MALPRACTICE REFORM

THE U.S. HEALTH CARE SYSTEM IS UNIQUELY VULNERable to frivolous malpractice lawsuits. An overwhelming majority of physicians believes that the fear of malpractice lawsuits leads them to engage in wasteful *defensive medicine* practices, such as ordering costly tests that, on average, are of marginal utility.

The Congressional Budget Office estimated that "the direct costs that providers will incur in 2009 for medical malpractice liability—which consist of malpractice insurance premiums together with settlements, awards, and administrative costs not covered by insurance—will total approximately $35 billion, or about 2 percent of health care expenditures."[97]

In 2010, Harvard's Michelle Mello, Amitabh Chandra, and Atul Gawande, along with David Studdart of the University of Melbourne, estimated that "overall annual medical liability system costs, including defensive medicine, are estimated to be $55.6 billion in 2008 dollars, or 2.4 percent of total health care spending."[98]

Hence, contrary to the perception of many physicians, tort reform cannot single-handedly solve the problem of costly U.S. health care services. Nonetheless, reform is warranted.

The Universal Tax Credit Plan would cap malpractice damages for any patient receiving a federal subsidy through Medicare, Medicaid, individual market coverage, or other federal programs. Other forms of malpractice reform would properly remain the province of the states, due to states' sovereignty on most issues of tort law.

Common federal reform proposals reviewed by the Congressional Budget Office include a cap of $250,000 on noneconomic damages and $500,000 for punitive damages. Malpractice litigation would carry a statute of limitations of one year for adults and three years for children from the date of discovery of an injury. The concept of "joint and several liability" could be replaced with a "fair share" rule, such that a physician's liability for malpractice damages would be limited to his share of the responsibility for the patient's injury.

In 2013, the CBO estimated that such reforms could reduce the deficit by a total of $64 billion from 2014 to 2023.

Conclusion

Financial Security for Americans—and America

The Universal Tax Credit Plan contemplates a broad range of far-reaching reforms to the U.S. health care system. It is therefore important to envisage the Plan's proposed reforms in the context of alternative proposals, long-term economic output, and political considerations.

COMPARING THE UNIVERSAL TAX CREDIT PLAN WITH CONGRESSIONAL ALTERNATIVES

In January 2014, three Republican U.S. senators—Tom Coburn of Nebraska, Richard Burr of North Carolina, and Orrin Hatch of Utah—proposed a plan to repeal and replace the Affordable Care Act, called the Patient Choice, Affordability, Responsibility and Empowerment Act ("Patient CARE Act").[99] One year later, a new version of the plan was published by Burr, Hatch, and Rep. Fred Upton of Michigan, as Sen. Coburn had retired.

Both versions of the Patient CARE Act would repeal most of the ACA, and replace it with a system of tax credits whereby individuals with incomes below 300 percent of the Federal Poverty Level could purchase health insurance plans of their choosing.

The tax credits would vary based on income level and age. Subsidy-eligible individuals who failed to sign up for a plan would be auto-enrolled in one, priced at the same level as the subsidy for which they qualified.

In addition, the Patient CARE Act would preserve the ACA's $716 billion in Medicare spending reductions over its first decade, by employing reforms previously proposed by the senators.

According to an HSI Network score of the current version of the proposal, using the same microsimulation model employed in this monograph, the Patient CARE Act would reduce the deficit by $534 billion over its first decade, by decreasing federal spending by $743 billion and decreasing federal tax revenue by $209 billion.[100]

(The previous version of the plan reduced outlays by $416 billion in its first decade, but increased revenues by $1.1 trillion, for a total deficit reduction of $1.5 trillion.)[101] HSI projects that, in 2020, Patient CARE would reduce the number of individuals with health insurance by 3 million relative to current law. It would reduce premiums for single individuals by 9 percent relative to the ACA.

Patient CARE would have a relatively neutral impact on provider access and health outcomes, as measured by the PAI and MPI indices.

In sum, in comparison with the Universal Tax Credit Plan, the Patient CARE Act in its first decade of enactment would reduce federal spending by more than the Universal Tax Credit Plan—$743 billion vs. $283 billion.

Patient CARE, as scored by HSI, would decrease federal tax revenues by $209 billion, relative to the Universal Tax Credit Plan's reduction in federal tax revenues by $254 billion (***Table 4***). The Universal Tax Credit Plan would cover 12 milion more people than the Patient CARE Act in 2020.

The Congressional Budget Office estimates that by 2017, 12 million U.S. residents will subscribe to subsidized insurance on ACA exchanges, with another 11 million enrolled in the ACA's expansion of Medicaid.

In 2016, House Speaker Paul Ryan (R., Wisc.) and his colleagues who lead the health care committees published "A Better Way," a series of proposals to apply premium support-based reforms to future retirees, and apply a "per capita cap" to Medicare enrollees that states could deploy to cover the costs of their care.

The House GOP proposal would also fully repeal the ACA, and replace the ACA's exchanges with a non-means-tested, refundable tax credit that would vary solely by the age of the recipient: $1,200 per year for those aged 18 to 34, $2,100 per year for those aged 35 to 49, and $3,000 per year for those aged 50 or older.

The House plan would significantly reduce insurance premiums; plans similar to ACA "Bronze" coverage would see premium decreases of 10 percent, while "Silver" plans would see decreases of 22 to 24 percent. The plan would reduce the deficit by $481 billion over ten years, driven primarily by reductions in spending on Medicaid and the smaller tax credits offered to the uninsured population. However, these smaller credits would lead to 2 million fewer individuals with health coverage relative to the ACA in 2020, and 11 million fewer relative to the Universal Tax Credit Plan.[102]

One important advantage of the Universal Tax Credit Plan over both the Senate and House GOP proposals is that because the Universal Tax Credit Plan does not require full repeal of the Affordable Care Act, the Plan can achieve its ends with far less disruption of Americans' existing coverage arrangements.

LONG-TERM FISCAL AND COVERAGE PROJECTIONS CONTAIN UNCERTAINTIES

We have estimated the fiscal effects of the Universal Tax Credit Plan over three decades, rather than the conventional ten years. This is important principally because America's fiscal instability is largely driven by its unfunded long-term liabilities. It is also important because the conventional ten-year budget-scoring window does not capture the gradual impact of the Plan's proposed reforms.

It is also important to acknowledge that there will always be considerable uncertainty around long-term fiscal projections.

The Congressional Budget Office assumes that, from 2016 to 2035, U.S. economic output will grow at an average nominal rate of 4.1 percent per year, and that inflation over the same period will approximate 2.4 percent per year.[103] If long-term inflation is higher, and/or long-term economic growth is slower, the U.S. fiscal picture will worsen considerably.

The ability of the Plan to render permanently solvent the Medicare Hospital Insurance Trust Fund is driven mainly by its proposal to raise the eligibility age of Medicare by four months per year.

If Medicare's eligibility age were raised more slowly—for example, by two months per year—the Plan would extend the solvency of Medicare, but not permanently.

In evaluating the Affordable Care Act and related reforms, the Congressional Budget Office has placed great weight on the work of MIT economist Jonathan Gruber, whose microsimulation model predicts much lower rates of health insurance enrollment if the ACA's

Table 4. Comparing the Universal Exchange Plan With the ACA and Two GOP Alternatives
(Senate 'Patient CARE Act' 2015; House 'A Better Way' 2016)

	ACA (Baseline)	Senate GOP	House GOP	Universal Tax Credit
Fiscal Performance in the First Decade				
Net reduction in federal outlays (billions)	$0	$743	$699	**$283**
Net reduction in federal revenues (billions)	$0	$209	$218	**$254**
Net federal deficit reduction (billions)	$0	$534	$481	**$29**
Coverage and Quality in 2020				
Impact on number of insured U.S. residents (millions)	0.0	-3.0	-2.0	**+9.0**
Impact on private premiums (single policy)	0%	-9%	-15%	**-18%**
Impact on private premiums (family policy)	0%	-1%	-18%	**-4%**
Patient-Provider Access Index (overall population)	0%	+4%	+1%	**+3%**
Medical Productivity Index (overall population)	0%	+2%	+4%	**+22%**

Table 5. Projected Impact of the Universal Exchange Plan on the Federal Deficit, 2016-2045
(In Billions; Numbers in Parentheses Denote Net Deficit Reduction)

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026–35	2036–45	2016–45
Outlays	($18)	($27)	($25)	($21)	($13)	($22)	($33)	($40)	($41)	($43)	($2,112)	($8,093)	**($10,488)**
Revenues	$67	($1)	$4	$8	$15	$20	$27	$32	$37	$44	$830	$1,415	**$2,498**
Net impact on deficit	$49	($29)	($21)	($13)	$2	($1)	($6)	($8)	($3)	$1	($1,283)	($6,677)	**($7,989)**

individual mandate were repealed.

The HSI microsimulation model used to consider the Universal Tax Credit Plan, combined with the individual market proposed by the Plan, predicts that the Plan can result in an expansion of coverage without an individual mandate. Were the CBO to evaluate the Universal Tax Credit Plan under its current microsimulation model, it is likely that the CBO would come to a different estimate of the Plan's coverage effects.

However, it is our view, based on many discussions with stakeholders, that a reformed exchange system, in which young people could purchase actuarially fair coverage, would work quite well without an individual mandate.

IMPORTANT POLITICAL CONSIDERATIONS

No proposal to reform the U.S. health care system is immune from trade-offs, and the Universal Tax Credit Plan is no different. We spend $3 trillion a year on health care; any attempt to reform this spending in a more cost-effective way will not necessarily appeal to stakeholders whose business models are predicated on increasing, not decreasing, health care spending.

In addition, the Universal Tax Credit Plan may fail to appeal to those with strongly partisan views of the proper course for health reform.

For example, while the proposal would repeal a number of controversial provisions of the ACA, such as its individual mandate and many of its tax increases, the Plan maintains a number of the ACA's important features, such as its use of refundable tax credits for the purchase of private health insurance by the previously uninsured, and its guarantee that every American can purchase health insurance, regardless of preexisting conditions.

The proposal would increase the progressivity of health care–related federal outlays and tax expenditures. It would reduce subsidies for health coverage for high-income employed and retired individuals, but spend more on health insurance for the poor and the uninsured.

However, the Plan would do so not by employing a single-payer, government-run system, but rather by migrating low-income Americans and younger retirees into private, consumer-driven health insurance plans. And it would reduce federal tax revenue by an estimated $2.5 trillion over thirty years.

Many people have justly criticized the ACA for its complexity and length. Legislative language for the Universal Tax Credit Plan, however, while not nearly as complex as the ACA's, will not fit onto two pages. The Plan seeks to expand coverage and reduce costs while minimizing disruption to the currently insured, an approach that requires addressing the existing complexities of the U.S. health care system, especially in the Medicaid program.

Those who believe that there is no legitimate role for the federal government in funding health coverage for the uninsured may not find it satisfactory that the Universal Tax Credit Plan preserves that role. Also left unsatisfied may be those who believe that the existence of private insurance companies is morally illegitimate.

In contrast to other areas of public policy, however, it is possible for both progressives and conservatives to achieve important objectives under the Universal Tax

Credit Plan. While proposals to fully repeal and replace the ACA are highly unlikely to obtain the 60 votes necessary to overcome a Senate filibuster, a market-oriented approach to reform that covers more people than the ACA could conceivably attract bipartisan support.

The Plan brings us closer to true universal coverage; it is estimated to increase by 12 million the number of U.S. residents with health coverage, and with the financial security that health coverage allows.

The Plan permanently stabilizes the fiscal condition of the United States, by reducing the federal deficit by approximately $8 trillion over its first three decades; and by, over the long term, encouraging U.S. gross domestic product to grow at a faster rate than federal health care spending. It sows the seeds for a consumer-driven health care revolution, one that could substantially improve the quality of health care that every American receives, and restore America's place as the world's most dynamic economy.

Most importantly, it addresses one of the most significant economic challenges facing low- and middle-income Americans: ensuring that every American has access to high-quality health coverage; now, and for decades to come.

Acknowledgments

I AM INDEBTED TO NUMEROUS INDIVIDUALS WHOSE contributions and feedback were essential to the development of this proposal. Their citations below should not be construed as endorsements of every, or any, aspect of the Universal Tax Credit Plan.

My colleagues at the Foundation for Research on Equal Opportunity—Kristen Soltis Anderson, Evan Baehr, Lanhee Chen, Emily Ekins, Juleanna Glover, Reihan Salam, and Scott Winship—provided invaluable guidance as I prepared the second edition of this manuscript.

Most importantly, FREOPP's Chairman and co-founder, Ames Brown, worked tirelessly to get our new think tank off the ground and commence its operations. Ensuring that every American has access to basic health coverage is of fundamental importance in expanding economic opportunity to those who least have it.

In 2012, Paul Starr of Princeton predicted that I, or someone like me, would one day pen this proposal. He was right. In the immediate aftermath of the 2012 presidential election, I wrote a number of articles, including one for *National Review* and one for *Forbes*, arguing that a reformed version of the ACA's exchanges could serve as the foundation for entitlement reform.

A Reuters op-ed that I coauthored with former Congressional Budget Office director Douglas Holtz-Eakin in 2013, entitled "The Future of Free-Market Healthcare," articulated some of the core principles of the Plan; the wide-ranging debate that followed provided the impetus for developing it further.

While he was director of the CBO from 2009 to 2015, Doug Elmendorf was generous and patient with my persistent inquiries.

Stephen Parente's HSI Network Health Policy Modeling Team, including Shelley Oberlin, Lisa Tomai, and Robert Book, conducted the critical modeling work used in assessing the Plan's impact on the federal deficit, insurance coverage, and premium costs.

Funding for their work—and for the publication of the first edition of this monograph—came from my former home, the Manhattan Institute, led by Lawrence Mone, Vanessa Mendoza, Howard Husock, and Paul Howard. Manhattan Institute fellow Yevgeniy Feyman's thorough review of my factual assertions and modeling work was a huge help. David Kimble found every single one of my typos, and justly rebuked my chaotic use of the hyphen.

Ryan Ellis and Grover Norquist of Americans for Tax Reform provided invaluable feedback regarding the tax-oriented aspects of the Plan. Dean Clancy recommended the idea of eliminating Medicare's enrollment mandate.

Numerous current and former congressional aides, including Gary Andres, Alec Aramanda, Courtney Austin, Brian Blase, Jonathan Burks, Sally Canfield, Stephanie Carlton, Chris Condeluci, Greg D'Angelo, Marty Dannenfelser, Mike Franc, Julie Goon, Jenifer Healy, Matt Hoffmann, Jay Khosla, John Martin, Joe Murray, Emily Murry, Gregg Nunziata, Monica Popp, Robb Walton, and Paul Winfree, provided insights into the history of previous legislative health reform efforts, and the prospects for future reform.

Mike Needham, Jason Yaworske, and Jacob Reses of Heritage Action also helped me think through congressional considerations.

Kyle Janek, executive commissioner of the Texas Health and Human Services Commission, and his team—Chris Traylor, Erica Stick, Mary Katherine Stout, Casey Haney, and Patricia Vojack—helped me think through some of the technical and administrative considerations regarding the Plan's Medicaid acute-care/long-term care swap.

Stuart Butler of the Brookings Institution pointed me to many of the opportunities for policy innovation with state-based management of long-term care.

Grace-Marie Turner of the Galen Institute and Ben Domenech of the Federalist provided needed encouragement. Harold Pollack of the University of Chicago helped to frame my thinking on health reform for the disabled.

Yuval Levin, editor of *National Affairs*, published three articles of mine—"Health Care and the Profit Motive" (Spring 2010), "Saving Medicare from Itself" (Summer 2011), and "Health Independence for Veterans" (Spring 2015), parts of which are excerpted in this monograph. Patrick Brennan, Dan Foster, Ezra Klein, Philip Klein, Megan McArdle, Jim Pethokoukis, and Peter Suderman were influential sounding boards.

Steve Forbes, Lewis D'Vorkin, Dan Bigman, and Matt Herper, my colleagues at *Forbes*, along with Rich Lowry and Reihan Salam, of *National Review*, provided me the platforms with which to research many of the concepts that surface in this Plan.

A number of my colleagues on the boards of the National Institute for Health Care Management—Michael Chernew of Harvard, Paul Ginsburg of the University of Southern California, David Helms of the LMI Center for Health Reform, Robert Kocher and Mark McClellan of the Brookings Institution, Uwe Reinhardt of Princeton University, Robert Reischauer of the Urban Institute, and Jamie Robinson of the University of California—challenged me with important questions and insights. I am grateful to Nancy Chockley, president of NIHCM, and Gubby Barlow, the former CEO of Premera Blue Cross, for introducing me to them. Another Blue Cross leader, Lori Shoaf of the Blue Cross Blue Shield Association, provided essential inspiration for this project.

After the initial version of the Plan was released, Ben Nelson, the former Governor and U.S. Senator from Nebraska, gave me detailed and constructive feedback on the Plan's proposed changes to the health insurance market and federal health care programs. So did Chris Jennings of Jennings Policy Strategies.

Most important of all, even though I spent most of the spring and summer of 2014 huddled at my desk, working on the first edition of this manuscript, Sarah Williams said yes when I proposed to her. As I finished the second edition over the summer of 2016, Sarah was preparing to bear our first child.

NOTES ON TYPOGRAPHY

THE BODY TEXT OF THIS MANUSCRIPT WAS TYPESET IN Caslon 540, designed by American Type Founders in 1902. Caslon 3, its boldface cousin, was designed by the same foundry in 1905.

The original version of Caslon, designed by William Caslon in 1722, is thought to be the first typeface native to England. The first two printings of the U.S. Declaration of Independence were set in Caslon.

Sans-serif text was set in Avenir Next, designed by Adrian Frutiger of Linotype GmbH in 2004. The cover title was set in the French *autoroute* type Caractères L2.

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About the Author

Avik Roy is the President of the Foundation for Research on Equal Opportunity (FREOPP), a non-profit, non-partisan think tank that conducts original research on expanding economic opportunity to those who least have it.

Roy's work has been praised widely on both the right and the left. *National Review* has called him one of the nation's "sharpest policy minds," while the *New York Times'* Paul Krugman described him as man of "personal and moral courage."

He has advised three presidential candidates on policy, including Marco Rubio, Rick Perry, and Mitt Romney. As the Senior Advisor to Perry's campaign in 2015, Roy was also the lead author of Gov. Perry's major policy speeches. The *Wall Street Journal* called Perry's address on intergenerational black poverty "the speech of the campaign so far."

Roy also serves as the Opinion Editor at *Forbes*, where he writes on politics and policy, and manages The Apothecary, the influential *Forbes* blog on health care policy and entitlement reform. NBC's Chuck Todd, on *Meet the Press*, said Roy was one "of the most thoughtful guys [who has] been debating" health care reform. MSNBC's Chris Hayes calls The Apothecary "one of the best takes from conservatives on that set of issues." Ezra Klein, in the *Washington Post*, called The Apothecary one of the few "blogs I disagree with [that] I check daily."

Roy is the author of *How Medicaid Fails the Poor*, published by Encounter Books in 2013. He serves on the advisory board of the National Institute for Health Care Management, and co-chaired the Fixing Veterans Health Care Policy Taskforce.

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He is a frequent guest on television news programs, including appearances on Fox News, Fox Business, NBC, MSNBC, CNBC, Bloomberg, CBS, PBS, and HBO.

From 2011 to 2016, Roy served as a Senior Fellow at the Manhattan Institute for Policy Research, where he conducted research on the Affordable Care Act, entitlement reform, universal coverage, international health systems, and FDA policy. Previously, he served as an analyst and portfolio manager at Bain Capital, J.P. Morgan, and other firms.

He was born and raised near Detroit, Michigan, and graduated from high school in San Antonio, Texas. *USA Today* named him to its All-USA High School Academic First Team, honoring the top 20 high school seniors in the country. Roy was educated at the Massachusetts Institute of Technology, where he studied molecular biology, and the Yale University School of Medicine.

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ISBN 978-168419122-2
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