

# TRANSCENDING OBAMACARE

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

**AVIK ROY**

*Senior Fellow, Manhattan Institute for Policy Research*



MANHATTAN INSTITUTE FOR POLICY RESEARCH



# TRANSCENDING OBAMACARE

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

**AVIK ROY**

*Senior Fellow, Manhattan Institute for Policy Research*



MANHATTAN INSTITUTE FOR POLICY RESEARCH

*Published by the Manhattan Institute for Policy Research*

Copyright © 2014—All rights reserved



# About the Author

**A**VIK ROY IS A SENIOR FELLOW at the Manhattan Institute and the Opinion Editor at *Forbes*. In 2012, Roy served as a health care policy adviser to Mitt Romney. NBC's Chuck Todd, on *Meet the Press*, described Roy as one "of the most thoughtful guys [who has] been debating" health care reform.

Roy is also principal author of *The Apothecary*, the influential *Forbes* blog on health care policy and entitlement 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."

In addition, Roy writes regularly for *National Review Online* on politics and policy. His work has appeared in *The Atlantic*, *USA Today*, *National Affairs*, and *The American Spectator*, among other publications. He is a frequent guest on television news programs, including appearances on Fox News, Fox Business, NBC, MSNBC, CNBC, Bloomberg, PBS, and HBO.



He is the author of *How Medicaid Fails the Poor*, published by Encounter Books in 2013, and a member of the Advisory Board of the National Institute for Health Care Management.

At the Manhattan Institute, Roy's research interests include the Affordable Care Act, universal coverage, entitlement reform, international health systems, and FDA policy.

Roy is the founder of Roy Healthcare Research, a consulting firm in New York. 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.

# Executive Summary

**I**N 2010, PRESIDENT OBAMA SIGNED INTO LAW the Patient Protection and Affordable Care Act, also known as the “Affordable Care Act,” the “ACA,” or “Obamacare.” The ACA will reduce the number of Americans without health insurance—an important goal—but it will do so by increasing the cost of U.S. health coverage. Increasing the cost of health coverage, in turn, will worsen two of the nation’s most important policy problems.

The first of those problems is the increasing unaffordability of private health insurance, a problem that is straining the budgets of middle-income Americans, and hampering social mobility. The second problem is the nation’s grave long-term fiscal instability, a problem primarily driven by government spending on health insurance and health care.

Indeed, the ACA will especially drive up the cost of private health insurance that individuals purchase directly. The law will dramatically expand 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 23 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.

The ACA’s supporters wrongly contend that the health law requires only minor tinkering in order to succeed. But the ACA’s critics, in seeking to re-

peal 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 Exchange 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 Exchange 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 Universal Exchange Plan would introduce major changes to the broad set of federal health care entitlements: Obamacare, Medicare, and Medicaid. The Plan uses a reformed version of the ACA’s health insurance exchanges as the basis for far-reaching entitlement reform.

The Plan would repeal many of the ACA’s cost-increasing insurance mandates, including the individual mandate. But it would preserve the ACA’s guarantee that every American can purchase coverage regardless of preexisting conditions. And it would utilize the concept of using federal pre-

mium support subsidies, on a means-tested basis, to defray the cost of private health coverage.

It would gradually migrate most Medicaid recipients, along with future retirees, onto these reformed exchanges. 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 en-

## 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.

### The Universal Exchange Plan's Key Reforms

Repeals ACA individual mandate, employer mandate, & all tax hikes except 'Cadillac Tax'  
Emancipates exchanges from costly federal regulation • Combats hospital monopolies  
Migrates most Medicaid enrollees and future retirees onto reformed exchanges

### 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

sure 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 would curb the pricing power of hospitals, cap malpractice damages, and accelerate 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 Exchange 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.

In 2011, the Singaporean government spent \$851 per capita on health care: less than 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 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 2012, Switzerland public entities spent approximately \$1,879 per capita on health care: 45 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 EXCHANGES: A NEW OPTION

THE UNIVERSAL EXCHANGE 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 would employ a revised version of the ACA's subsidized insurance exchanges as a mechanism for reforming entitlements, expanding coverage, and improving health care quality.

The Plan has five core elements:

**Exchange reform.** 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 exchanges and state-based insurance regulation. It expands the flexibility of insurers to design exchange-based 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 preserves the ACA's "Cadillac tax" on high-cost health plans, but 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 state-based exchanges, 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 exchange-based 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.

**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. And it accelerates the pace of medical innovation through reform of the Food and Drug Administration.

## ASSESSING THE PLAN'S FISCAL EFFECTS

WE ESTIMATED THE FISCAL EFFECTS OF THE Universal Exchange 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. We assumed 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 Exchange 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 onto the federally funded exchanges.
- 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 2014 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 Exchange Plan is that offering exchange-based 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.

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 Exchange Plan will increase average provider access—as measured by PAI—by 4 percent. Those individuals who migrate from the tradi-

tional Medicaid acute-care program onto the reformed ACA exchanges are estimated to experience a substantial improvement in PAI: 98 percent.

Over the entire non-elderly adult population, relative to current law, the Universal Exchange 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 ACA exchanges are estimated to experience a much more dramatic improvement in PAI: 159 percent.

The HSI microsimulation model indicates that the Universal Exchange Plan's reforms to the ACA exchanges 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 Exchange 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 EXCHANGE 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 4.2 percent per year, and that inflation over the same period will approximate 2.5 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 Ex-

change 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 Exchange 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 Exchange 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.

Most important, 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.





# Table *of* Contents

<b>INTRODUCTION</b>	<b>12</b>
 <b>PART ONE</b> Emancipating the ACA Exchanges	 <b>22</b>
 <b>PART TWO</b> Reforming Employer-Sponsored Health Insurance	 <b>32</b>
 <b>PART THREE</b> Medicaid Reform: Transforming Health Outcomes for the Poor	 <b>37</b>
 <b>PART FOUR</b> Medicare Reform: Ensuring the Permanence of Seniors' Health Benefits	 <b>44</b>
 <b>PART FIVE</b> Other Reforms: Tackling the High Cost of U.S. Health Care	 <b>49</b>
 <b>CONCLUSION</b> Financial Security for Americans—and America	 <b>56</b>
 <b>ACKNOWLEDGMENTS</b>	 <b>59</b>
 <b>ENDNOTES</b>	 <b>61</b>



# Introduction

**T**HERE IS NO ISSUE MORE IMPORTANT TO THE future of America than its long-term fiscal sustainability. And the long-term fiscal sustainability of the United States has been placed in jeopardy primarily by the structure and expense of America's federally sponsored health insurance programs.

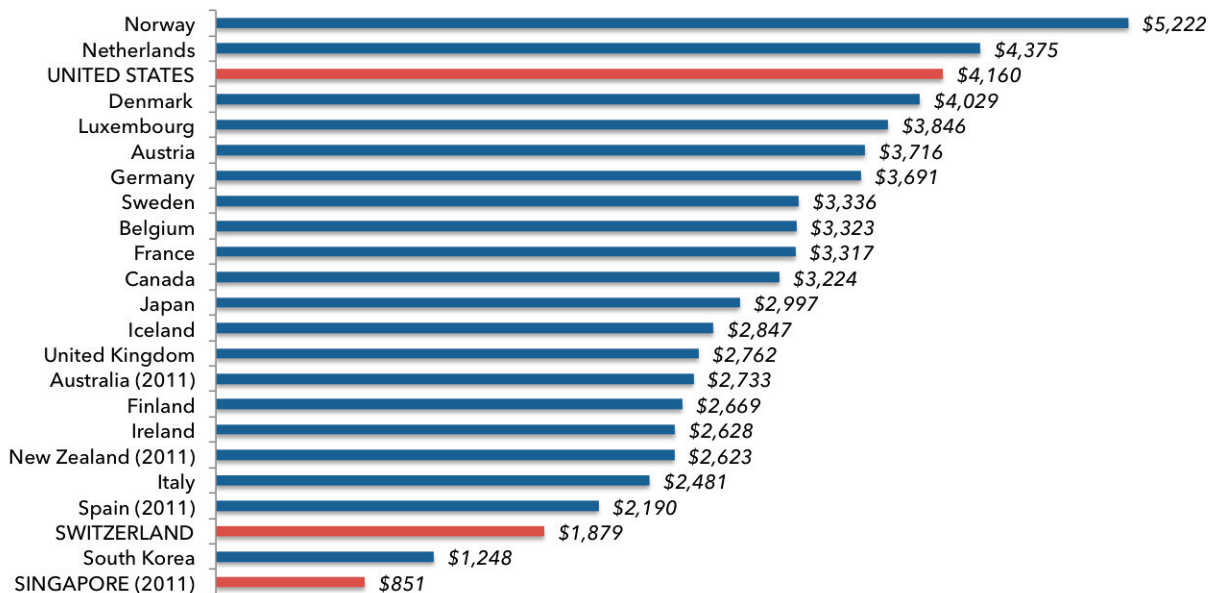
In addition, one of the principal economic challenges faced by middle- and lower-income Americans is the expense and instability of American health insurance. Health insurance keeps getting more and more expensive, forcing many families to choose between paying health care bills and buying other essential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

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.

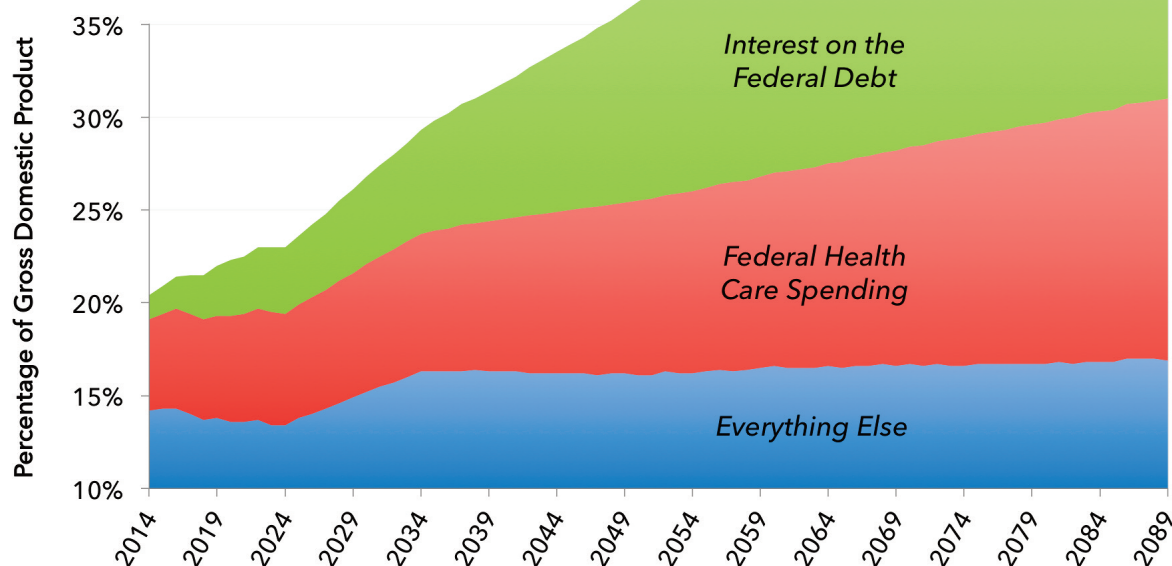
## THE HISTORICAL LEFT-RIGHT DIVIDE ON HEALTH CARE

FOR NEARLY A CENTURY, THE PROGRESSIVE MOVEMENT has sought to build a comprehensive, government-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

**Figure 1. 2012 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 spend far more than their European peers on health care. While single-payer systems like the U.K. and Canada 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 2014 Long-Term Federal Spending Projections (Extended Alternative Scenario)

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 2012, 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.<sup>1</sup> 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*).<sup>2</sup>

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.<sup>3</sup>

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.<sup>4</sup> 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 insur-

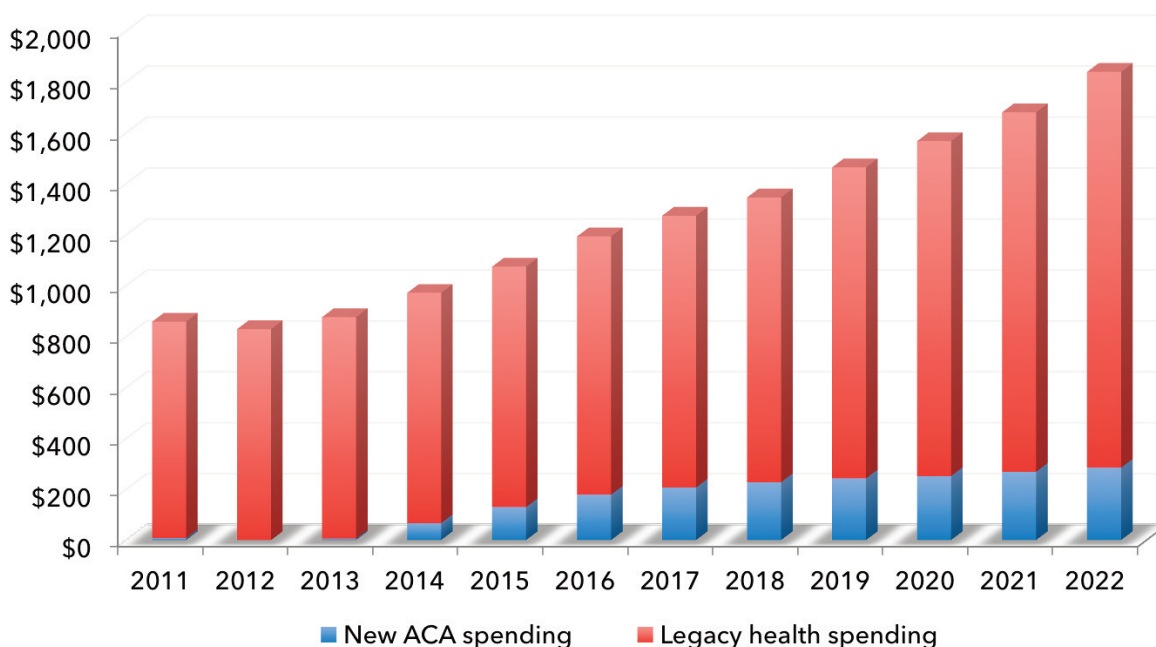
ance. A Manhattan Institute study found that, among those who purchase coverage on their own, the average state has seen an increase in underlying premiums of 41 percent in 2014 relative to 2013.<sup>5</sup> A follow-on study found that the average county will experience a premium increase of 49 percent over the same period.<sup>6</sup> Many individuals with employer-sponsored coverage are also experiencing increased health care costs under the law.

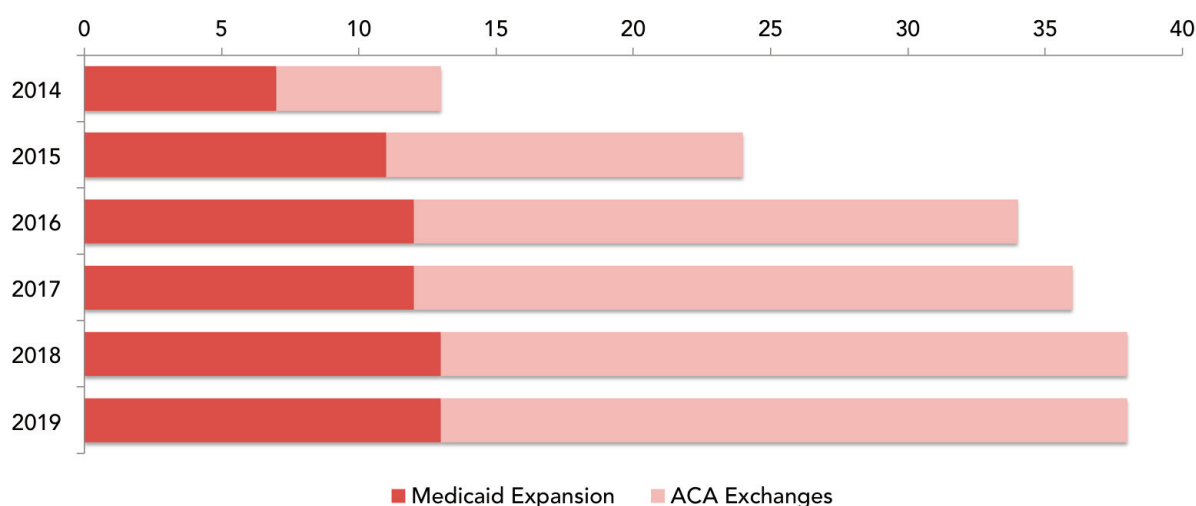
Despite the fact that the U.S. already spends an enormous amount on publicly financed health care, the ACA is slated to increase federal spending on health care by approximately 16 percent, when fully implemented. Hence, while the ACA may make a substantial dent in the number of Americans who are uninsured, it will do 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 will also increase 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 expands the ex-

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



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

isting, 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 two challenges: (1) repealing the ACA would cause a considerable amount of disruption to the 36 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.

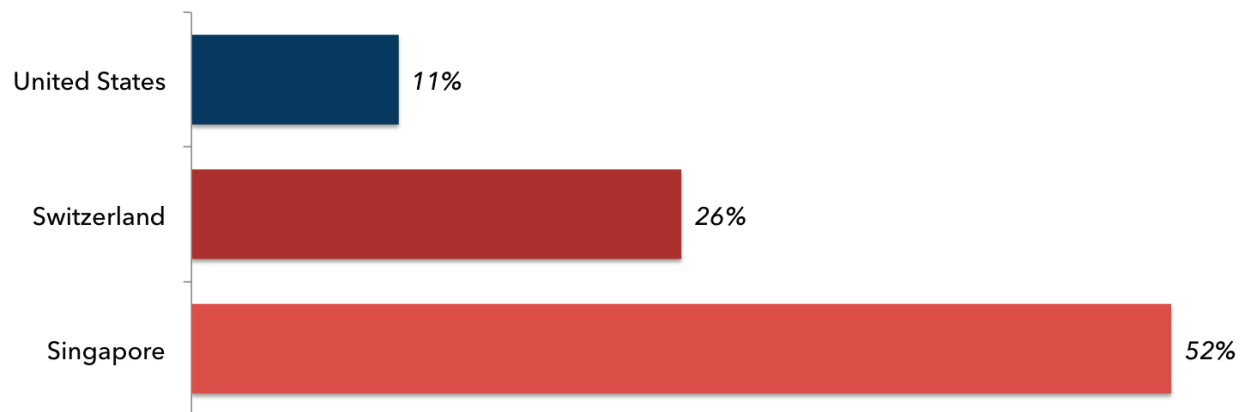
There is, however, a way to make substantial changes to the Affordable Care Act and also to the preexisting set of U.S. health care entitlements. By tackling both problems at once, such an approach could expand health coverage to higher levels than that of the ACA, while addressing the cost and quality 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 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 2011, the Singaporean government spent \$851 per capita on health care: one-fifth of what the U.S. spent, on a purchasing power parity-adjusted basis.<sup>7</sup>

Singapore has achieved this using a universal system of consumer-driven health care. The government funds catastrophic coverage for every Singaporean, 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)

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."<sup>8</sup>

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 fed-

eral health insurance subsidies, whereas nearly four-fifths of Americans do. In 2012, Switzerland public entities spent approximately \$1,879 per capita on health care: 45 percent of U.S. public spending.<sup>9</sup>

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.<sup>10</sup>

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 insurance exchanges 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 Wisconsin Rep. Paul Ryan, in several recent annual budget resolutions.

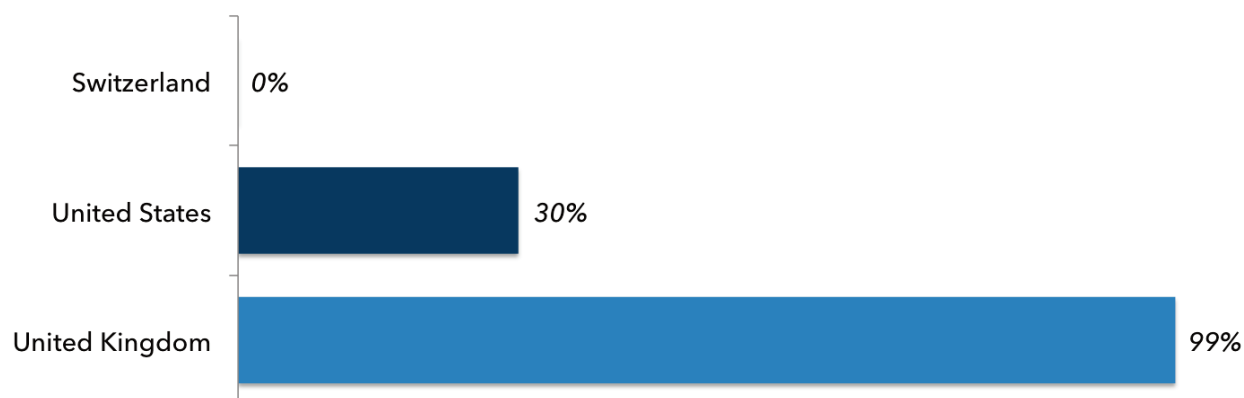
Premium support was also embraced by former Massachusetts Gov. Mitt Romney in his 2012 presidential campaign. And, as discussed above, the ACA's exchanges, designed to offer subsidized private coverage to the uninsured, are also modeled after the Swiss system.

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

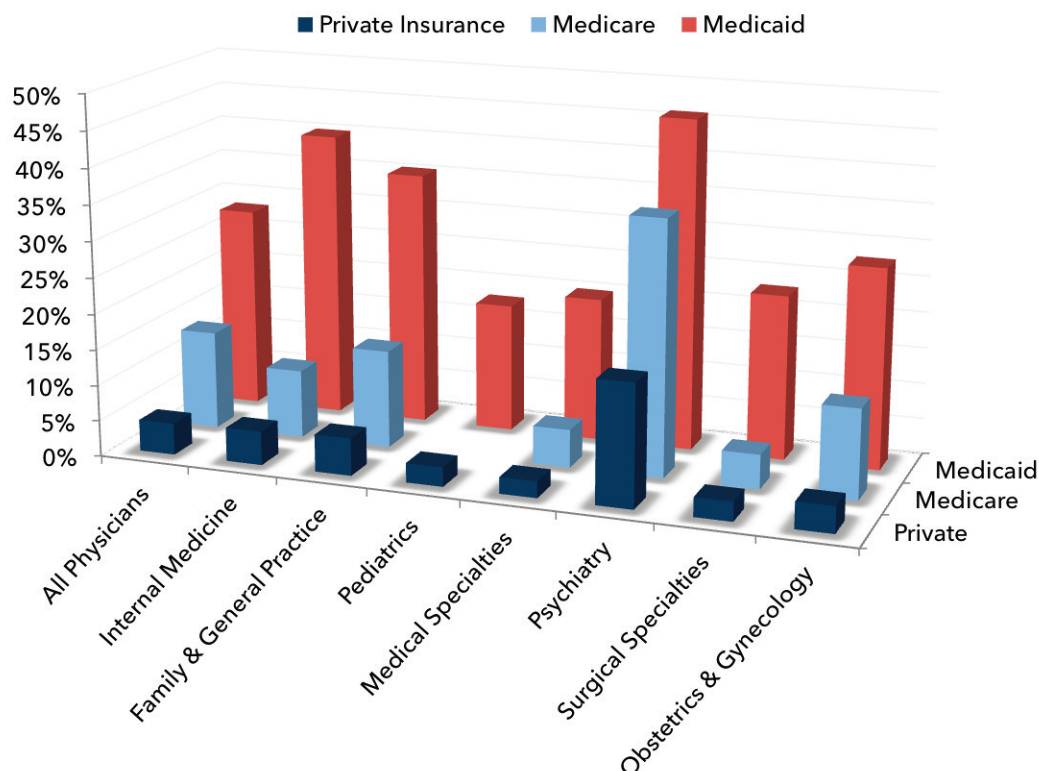
## UNIVERSAL EXCHANGES: A NEW HEALTH-REFORM OPTION

THIS MONOGRAPH PROPOSES A UNIVERSAL EXCHANGE 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

**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)

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 Exchange 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 a reformed version of the subsidized insurance exchanges, established by the ACA, as a mechanism for reforming entitlements, expanding coverage, and improving the quality of health care delivery.

There are five core elements of the Plan:

**Exchange reform.** 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 exchanges and state-based insurance regulation. It expands the flexibility of insurers to design exchange-based 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 would preserve the ACA’s “Cadillac tax” on high-cost health plans, but it repeals other taxes and reforms other regulations that arti-



cially drive up the cost of employer-based insurance.

**Medicaid reform.** The Plan migrates the Medicaid *acute-care* population onto the reformed state-based exchanges, 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 exchange-based 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.<sup>11</sup>) In total, these changes would make the Medicare Trust Fund permanently solvent.

**Other reforms.** The Plan tackles the growing problem of hospital monopolies that take advantage of their market power to charge unsustainably high prices. It reforms malpractice litigation in federal programs. And it accelerates the pace of medical innovation through reform of the Food and Drug Administration.

## ASSESSING THE PROPOSAL'S FISCAL EFFECTS

WE ESTIMATED THE FISCAL EFFECTS OF THE Universal Exchange 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 Exchange 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.

**Table 1.** Projected Impact of Universal Exchange 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%

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 Exchange 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 onto the federally funded exchanges.
- Over the first 30 years, the Plan will reduce federal spending by approximately \$10.5 trillion and federal revenues by approximately \$2.5 tril-

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

PREMIUM VS. CURRENT LAW	2016	2017	2018	2019	2020	2021	2022	2023	AVG. 2016–23
<b>Single Policies</b>	<b>-16.3%</b>	<b>-16.6%</b>	<b>-16.8%</b>	<b>-16.8%</b>	<b>-17.2%</b>	<b>-17.4%</b>	<b>-17.6%</b>	<b>-17.7%</b>	<b>-17.0%</b>
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%
<b>Family Policies</b>	<b>-3.4%</b>	<b>-3.5%</b>	<b>-3.5%</b>	<b>-3.5%</b>	<b>-3.6%</b>	<b>-3.6%</b>	<b>-3.6%</b>	<b>-3.7%</b>	<b>-3.6%</b>
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.*

lion, 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 2014 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 Exchange Plan is that offering exchange-based 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 Commonwealth Care exchange—improved health outcomes in that state.<sup>12</sup>

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.<sup>13</sup> As with the PAI, the MPI is benchmarked to health outcomes under Medicaid.

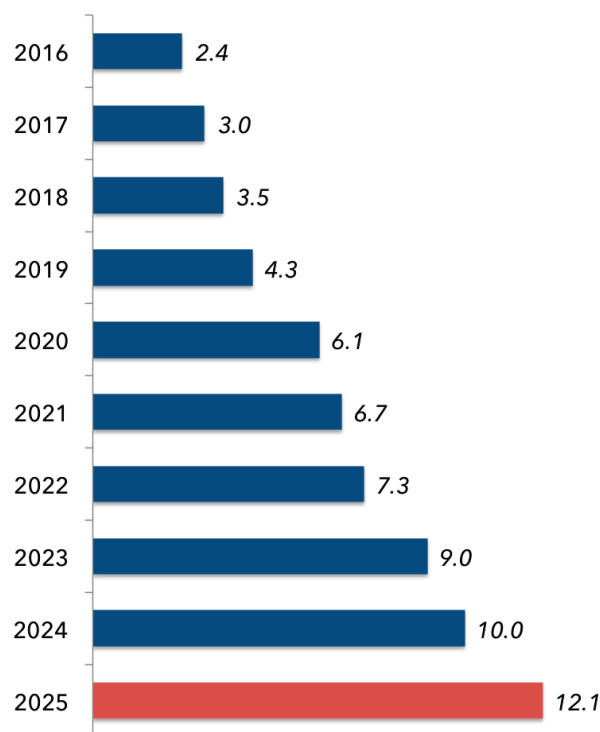
As summarized in *Table 1*, over the entire non-elderly adult population, relative to current law, we estimate that the Universal Exchange Plan will increase average provider access—as measured by PAI—by 4 percent. Those individuals who migrate from the traditional Medicaid acute-care program onto the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

Over the entire non-elderly adult population, relative to current law, the Universal Exchange 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 ACA exchanges 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 Exchange Plan can expand coverage, reduce the deficit, and improve access to care and health outcomes for the low-income population.

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



## MODELING THE EFFECTS OF EXCHANGE REFORMS ON COVERAGE AND INSURANCE PREMIUMS

THE HSI MICROSIMULATION MODEL INDICATES THAT the Universal Exchange Plan's reforms to the ACA exchanges 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 Exchange 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 Exchange Plan.

# Part One

## *Emancipating the ACA Exchanges*

**T**HE CONCEPT OF SUBSIDIZED HEALTH INSURANCE exchanges—in 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.

### **EXCHANGES' 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.<sup>14</sup> 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.<sup>15</sup>

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.<sup>16</sup>

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

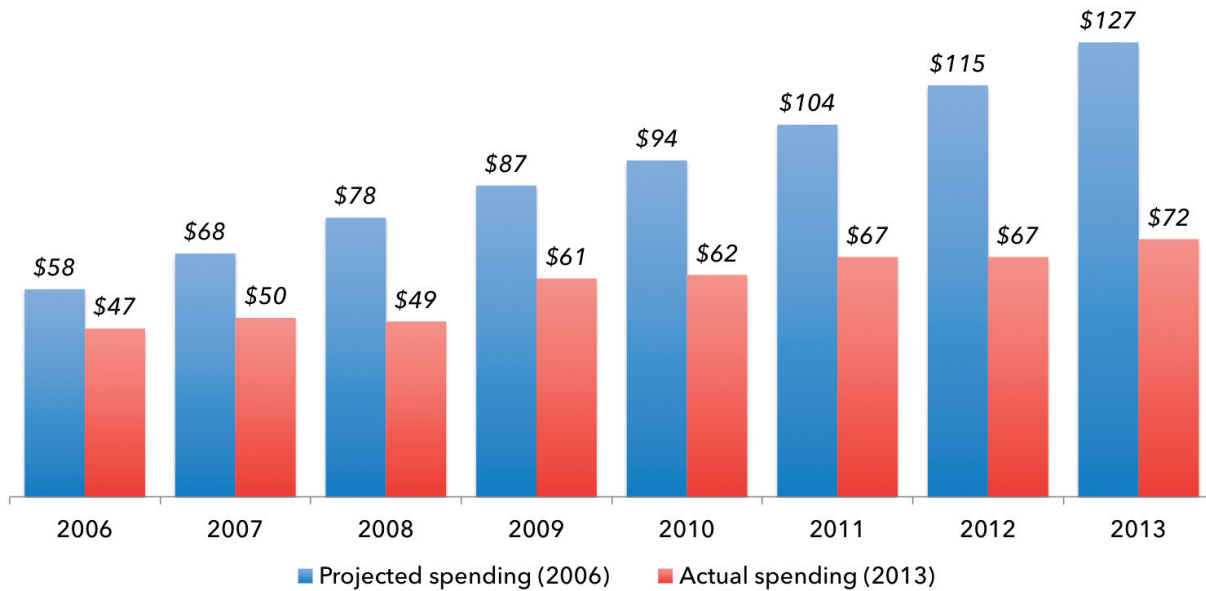
future seniors to purchase coverage on a “newly created Medicare Exchange”:<sup>17</sup>

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.

Exchanges have 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 is ex-

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

empt 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.<sup>18</sup>

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

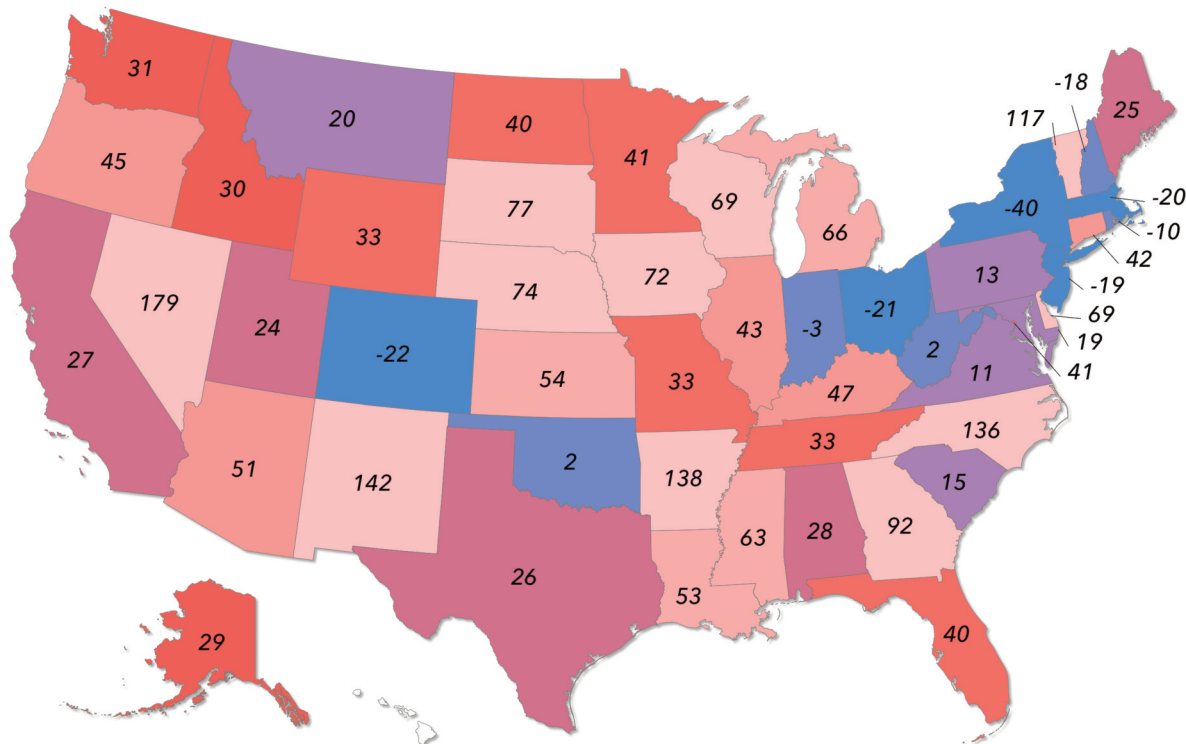
In the first instance, the Medicare Modernization Act of 2003, passed by a Republican Congress and signed into law by President George W. Bush, created a new Medicare prescription drug benefit using the premium support approach.

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

**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. (Source: Manhattan Institute)

purchased by interested individuals. The ACA exchanges, 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.<sup>19</sup> 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 EXCHANGE REFORM

THE UNIVERSAL EXCHANGE 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 Exchange Plan’s exchange reforms through a “repeal and replace” bill. The end result, in terms of the exchanges, would be identical.

Some observers have asked whether public exchanges are even necessary; 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—regulated insurance markets in the absence of exchanges.)

Under the Plan, state governments could apply for a waiver from the U.S. Department of Health and Human Services to opt out of setting up a government-sponsored exchange, 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.

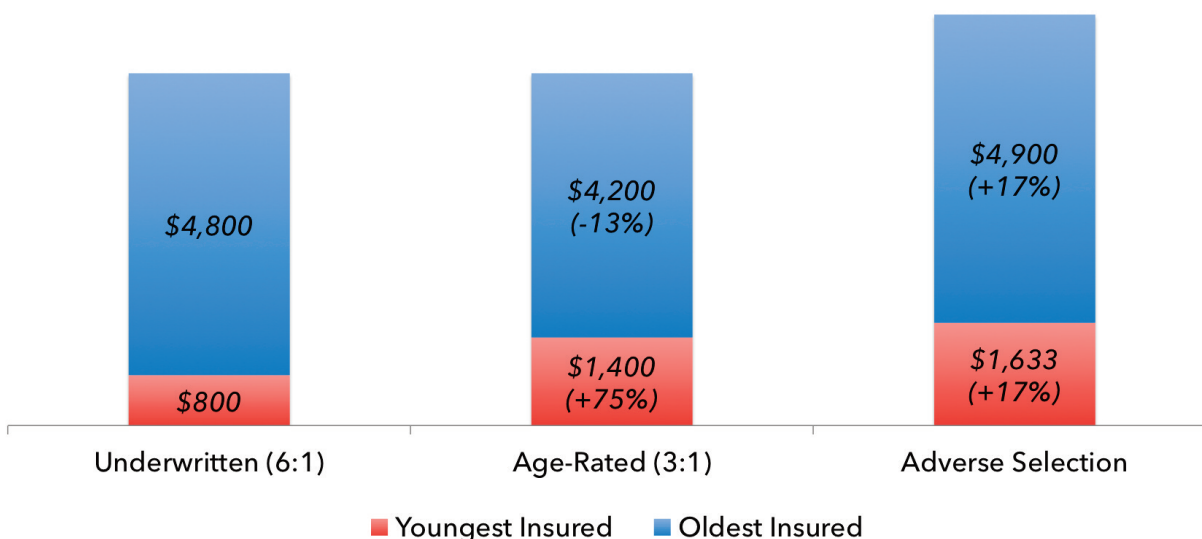
## PROPOSED CHANGES TO THE ACA EXCHANGES

### 1. *Preserve consumer protections*

The Universal Exchange 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 Exchange 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 exchange-based 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 enroll in the exchanges, this approach reduces average exchange premiums.

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

change 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 Exchange 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.<sup>20</sup>

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

Essential health benefit regulations would be clari-

fied 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 Exchange 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 Exchange 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 Exchange Plan repeals all of these taxes.

### 4. Return insurance regulatory authority to the states

The Universal Exchange 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 exchange-based 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 Exchange 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 exchanges.

### 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 Exchange 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 Exchange 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 Exchange 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

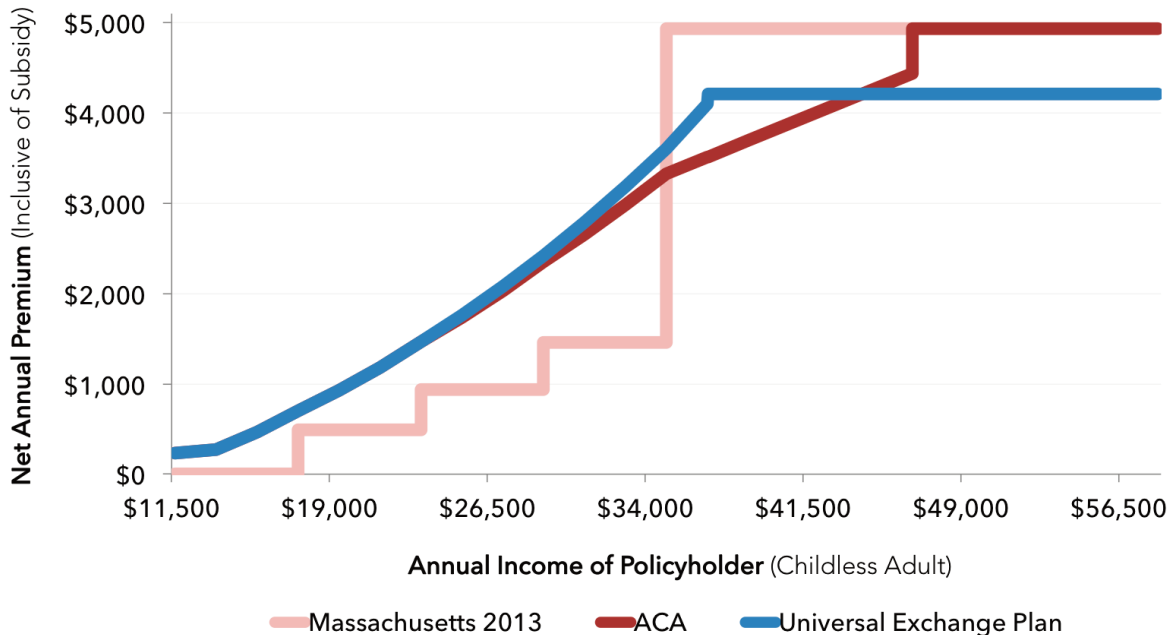
The Affordable Care Act includes cost-sharing subsidies to defray the costs of deductibles, co-pays, and

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 Exchange 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 Exchange Plan



**Mitigating the disincentives for self-advancement.** In 2017, the Congressional Budget Office projects that the average exchange subsidy will be \$4,930 per person per year. 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 \$3,471, 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 \$495. The Universal Exchange Plan seeks to mitigate the effect of the ACA subsidy cliff by adjusting the income-based formula for determining premium subsidies. Under the Plan, in this illustrative example, the subsidy cliff is only \$112.

## 7. Reform exchange premium subsidies

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 \$3,471. 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 \$495.

The Universal Exchange Plan reforms the ACA subsidy scale, so as to take advantage of the fact that Mas-

sachusetts 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.)<sup>21</sup>

Under the Universal Exchange 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 \$112.

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 383 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 Exchange Plan, the income thresholds used to determine exchange subsidy levels would be adjusted each year so as to ensure that the overall growth in subsidy spending comports with the inflation-based index described in the Affordable Care Act.

## 8. Repeal the individual mandate; reform open enrollment

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 is 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 would be 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. The Con-

gressional Budget Office projects that the average premium of the benchmark second-lowest-cost Silver plan on the exchanges will be \$4,400 in 2016, rising to \$6,900 in 2024.

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 Exchange 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.

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.

For 2014, the ACA exchanges' open enrollment period lasted for more than six months: from October 2013 to April 2014. For 2015, the period is scheduled to last for two months: from November 15, 2014 to January 15, 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.<sup>22</sup> 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.

### 9. Enact exchange 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 exchange 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*

**M**ORE AMERICANS OBTAIN HEALTH COVERAGE through their employers than through any other source. According to the Census Bureau, 171 million U.S. residents obtained employer-based coverage in 2012, while 51 million obtained coverage through Medicaid; 49 million through Medicare; and 14 million through military health benefits. An additional 31 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.

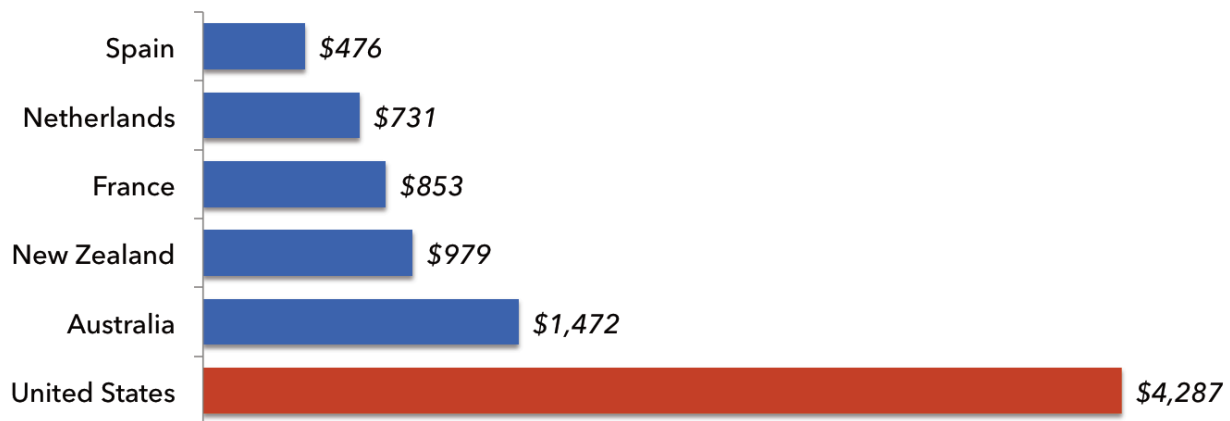
Insurers also face less competition and are less consumer-oriented, since they are at less risk of losing their customers. And, as noted above, because workers do not choose their own insurance, they are less likely to have plans that suit their needs.

### THE ACA ‘CADILLAC TAX’ ON HIGH-VALUE HEALTH PLANS

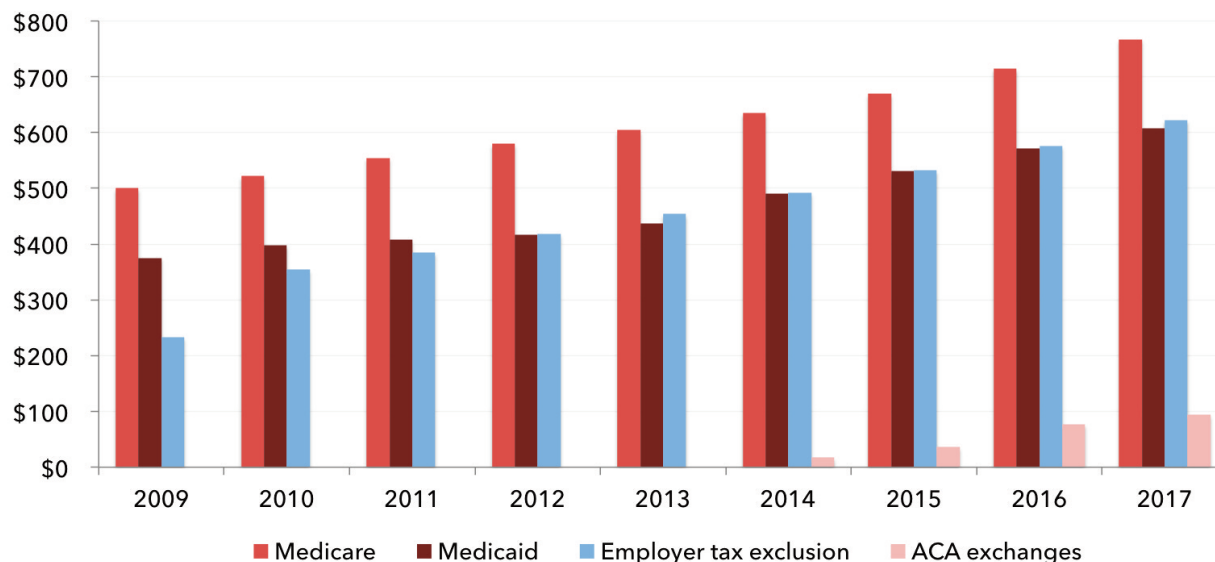
MOREOVER, BECAUSE EMPLOYER-SPONSORED insurance is tax-exempt, employers have a major incentive to provide generous benefit packages. For example, a worker who pays federal and state income taxes at a combined rate of 30 percent will net \$7,000 for every \$10,000 his employer provides in gross salary. 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, and into health care, even if those workers would ben-

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



**U.S. hospital prices are extreme.** In 2009, the average hospital stay in the U.S. was 4.9 days long, compared to an average of 7.7 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)

efit 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 2014, the federal government will subsidize employer-sponsored coverage by \$434 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.<sup>23</sup> In addition, as shown in *Figure 14*, state and local governments will lose an estimated \$57 billion in 2014 tax revenue because of the employer tax exclusion.<sup>24</sup>

At nearly \$500 billion a year, then, the size of the tax expenditure for employer-sponsored coverage is larger than 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 is scheduled to go into effect in 2018; it applies 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).<sup>25</sup>

The Universal Exchange Plan moves the Cadillac tax forward one year, so that it goes into effect in 2017 at the thresholds originally set for 2018. Furthermore, the Plan eliminates most of the special-interest exceptions the ACA makes for particular labor unions, while pre-

serving those for genuinely high-risk occupations such as law enforcement and fire protection.

An alternative to preserving the Cadillac tax, as described above, would be to apply a fiscally equivalent cap on the size of the employer tax exclusion.

That cap would mitigate certain burdens that the Cadillac tax places on employers, since they usually assume some share of the cost of an employee's policy.

## 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 non-partisan studies. An Urban Institute study published in July 2013 found "that the ACA can achieve all its major objectives without the employer mandate."<sup>26</sup> 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.<sup>27</sup>

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.<sup>28</sup>

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.<sup>29</sup>

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."<sup>30</sup>

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 Exchange 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 Exchange Plan’s exchange-based 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 Exchange 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 Five of the Universal Exchange 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*

**M**EDICAID, 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 2014, a slight majority of states has 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.<sup>31</sup>

Other studies have found similar results. A University of Virginia study published in the *Annals of Surgery* ex-

amined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.<sup>32</sup>

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).

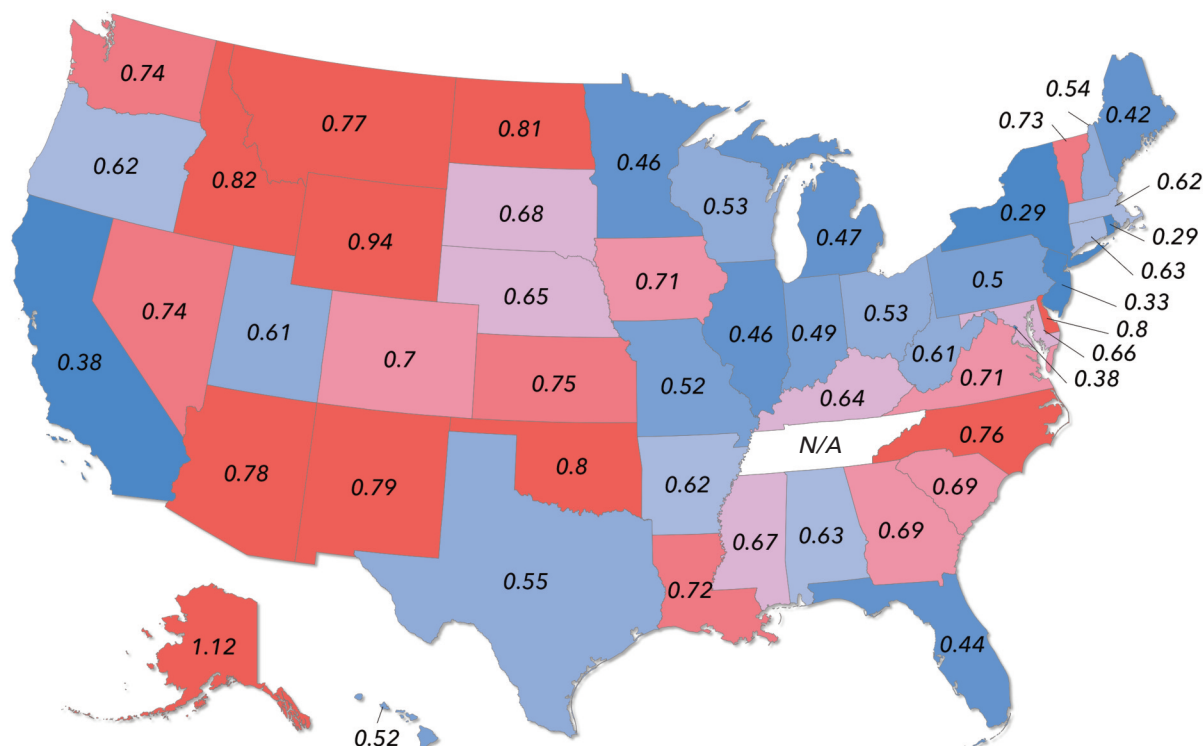
They then examined three measurements of surgical outcome quality: the rate of in-hospital mortality; average length of stay in the hospital (longer stays in the hospital are a marker of poorer outcomes); and total costs.

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.<sup>33</sup> 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.<sup>34</sup>

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.<sup>35</sup>

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.<sup>36</sup>

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.<sup>37</sup>

### 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.<sup>38</sup>

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.<sup>39</sup>

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.<sup>40</sup>

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, pub-

lished 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.<sup>41</sup>

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.<sup>42</sup>

### 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.”<sup>43</sup> In addition:

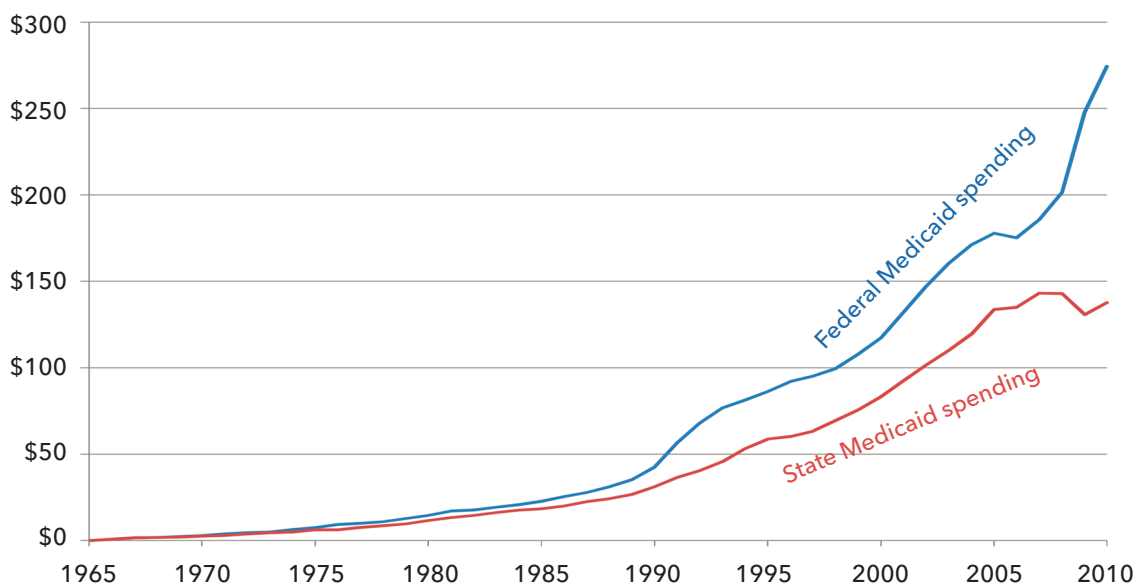
States became highly creative in obtaining Medicaid for health services—such as visits to the school nurse by low-income children—that were previously fully funded with state and local resources. This search for federal dollars, referred to as “Medicaidization,” brought dozens of new provider types and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

THE AFFORDABLE CARE ACT’S SUBSIDIZED HEALTH INSURANCE EXCHANGES, as reformed by the Universal Exchange 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.

(For the purposes of simplicity, when this document refers to “Medicaid” it is referring to both the adult Medicaid program and the related CHIP.)

The Universal Exchange Plan achieves this by seeking to migrate the entire Medicaid acute-care population onto the reformed exchanges.

(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 Exchange 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 exchange plan in their states. Those who wished to remain in Medicaid, and not migrate onto the exchanges, 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 onto the exchanges, the Universal Exchange 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 onto the exchanges, 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 under the exchanges (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 onto the exchanges 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 Exchange 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 exchanges.

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.<sup>44</sup> 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.<sup>45</sup>

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.”<sup>46</sup> 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. Maryland, for instance, imposes a 6 percent sales tax and a 2 percent premium tax, amounting to an additional \$1,200 per family. If that family is in the 25 percent federal tax bracket, these state taxes also result in \$484 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 \$1,200 in sales and premium taxes, might be 60 percent subsidized by the federal government, leading to \$720 in additional federal spending.

The state government, by contrast, makes money on this deal: \$1,200 in additional tax revenue, and \$480 in additional Medicaid spending, for a net gain of \$720.

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 Exchange plan renders all federally subsidized health insurance plans—from Medicare, Medicaid, CHIP, exchanges, 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 Exchange 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 Exchange 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.<sup>47</sup>

*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 EXCHANGES

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 Exchange Plan, all of these “dual eligible” individuals would be migrated onto the exchanges, 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 exchange 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*

**W**HILE 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 predict that the Medicare Trust Fund will run out of money in 2030.

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, recently 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."<sup>48</sup>

### **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 opportu-

nity 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.<sup>49</sup>

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.”<sup>50</sup>

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—\$635 billion in 2014—Medicare does not provide catastrophic coverage against long-term hospitalizations. In 2014, Medicare’s Part A hospital insurance covers the first 60 days of a hospitalization, with a \$1,216 deductible. The next 30 days include a coinsurance fee of \$304 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 \$458 million in Medigap royalties, nearly twice the \$266 million the organization received in membership dues.<sup>51</sup>

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.<sup>52</sup>

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 ACA exchanges.

The Universal Exchange 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, between 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 on the reformed ACA exchanges, employer-sponsored coverage, or 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 Exchange 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 subsidized insurance exchanges—as reformed by the Universal Exchange 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 exchange plan under the Universal Exchange 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 migrating to the exchanges.

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 exchange-based premium subsidies 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 Exchange 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 Exchange 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 insur-

ance 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 Exchange 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.”<sup>53</sup>

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.<sup>54</sup>

The Universal Exchange 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;<sup>55</sup>

though the plaintiffs appealed to the Supreme Court, the high court declined to hear the case.<sup>56</sup>

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.<sup>57</sup>

The Universal Exchange 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 Exchange 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.<sup>58</sup>

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.<sup>59</sup> Other federal 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 Exchange 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 over-

lapping benefits and differing physician networks, care for these vulnerable individuals is often of poor quality and excessive cost.

Under the Universal Exchange Plan, these “dual-eligible” individuals would be migrated entirely onto the exchanges, 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 exchange 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 Exchange 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

## *Other Reforms: Tackling the High Cost of U.S. Health Care*

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 2014, \$973 billion out of \$3.1 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.

Not only are U.S. hospital stays shorter in length; Americans use hospitals less frequently than their industrialized peers. In 2011, the United States had 12,549 hospital discharges for every 100,000 residents. This compares favorably with the OECD average of 15,561.

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."<sup>60</sup>

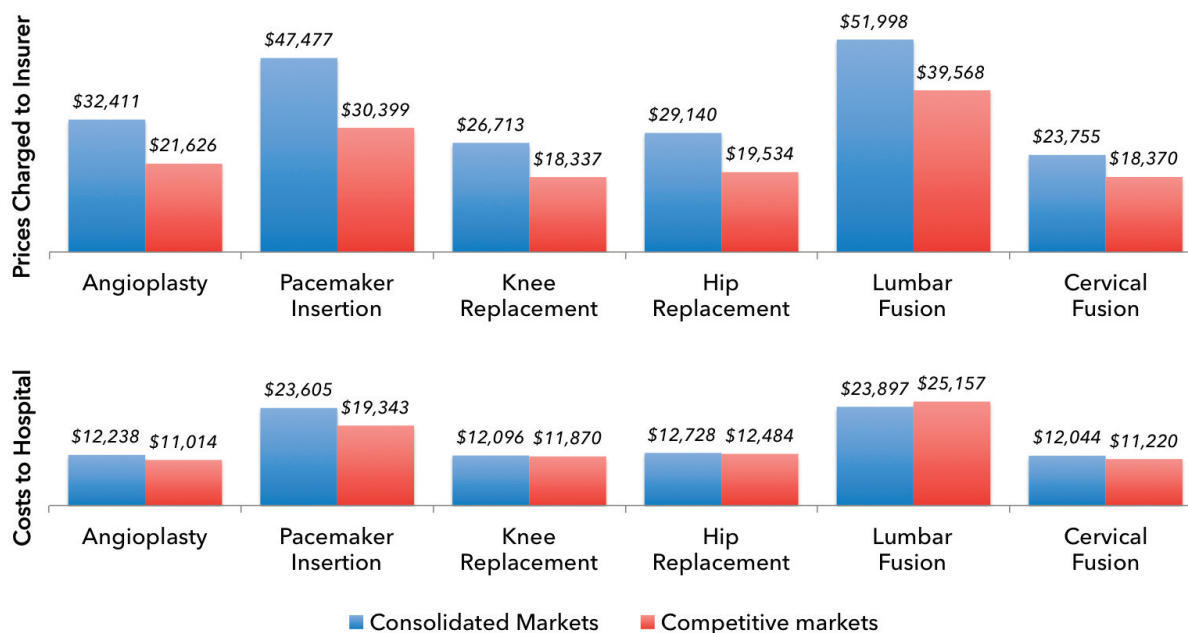
Federal health care entitlements like Medicare and Medicaid have responded to the rising costs of hospital care by paying hospitals less for a wide range of services. Hospitals have responded, in turn, by raising the prices they charge to private insurers and the uninsured: a practice called *cost-shifting*.

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.<sup>61</sup>

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."<sup>62</sup>

### **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 17.** 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.<sup>63</sup>

For example, as illustrated in *Figure 17*, 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.

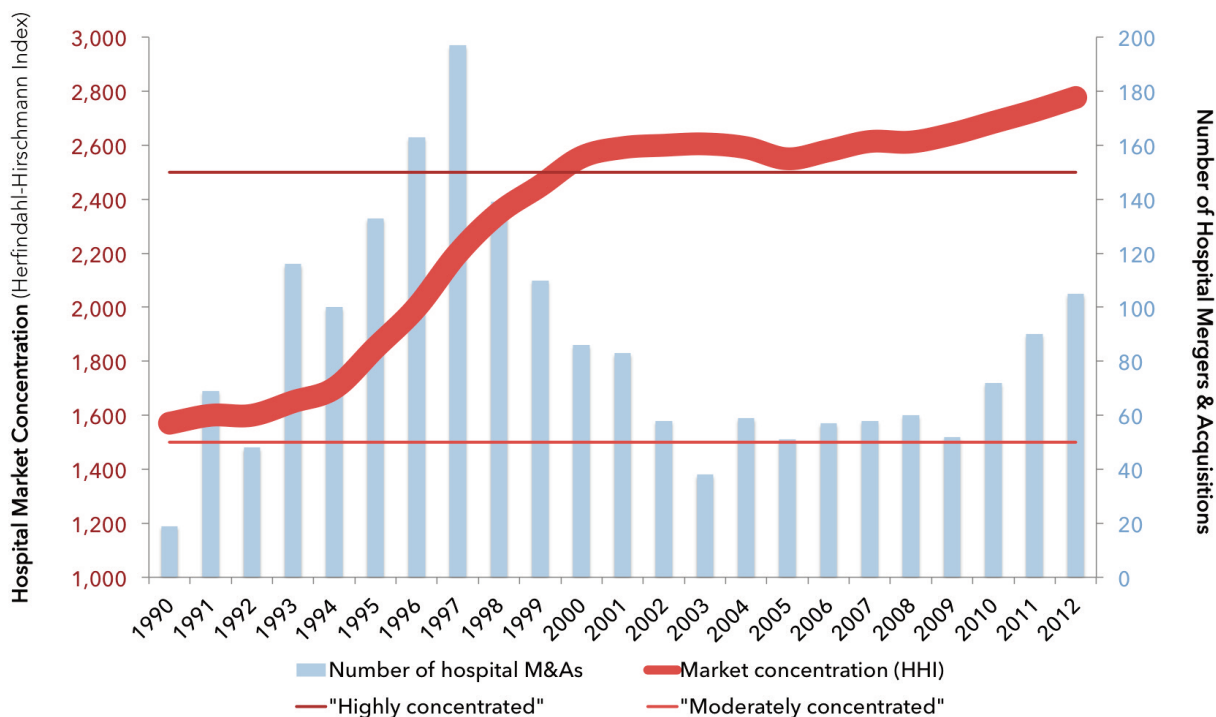
However, the average *cost* to the hospital for performing the knee replacement was nearly identical: \$11,870 in competitive markets and \$12,096 in consolidated markets.

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 consolidated 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 18.** 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 18*, 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 Exchange 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

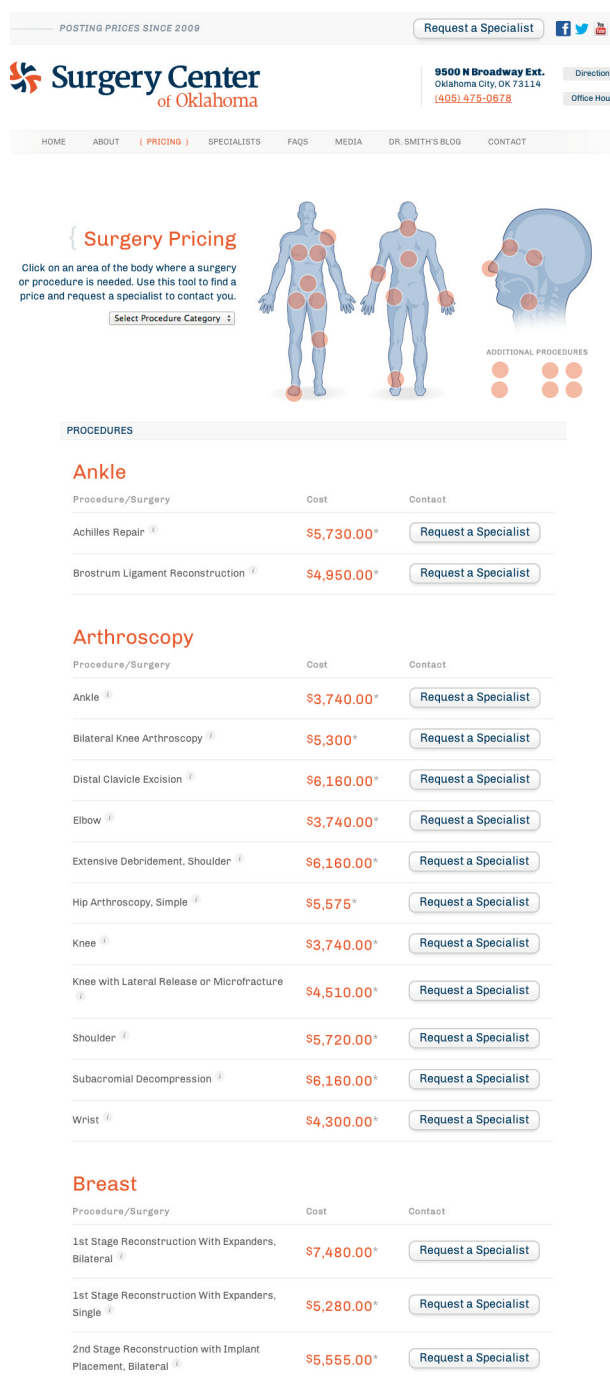
One important way to encourage hospital competition is to allow patients to obtain hospital-based care outside their local area: a practice called *medical tourism*.

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 19*). 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 Exchange Plan seeks to build on these developments by making it easier for exchange-based insurers to use *reference pricing* within and across state lines, and even across international borders.

For example, an exchange-based 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 19.** 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.<sup>64</sup>

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***

In 1930, President Herbert Hoover created the Veterans Administration in order to organize the various federal services being offered to veterans, including health care. By 1947, though hospital beds were scarce throughout the country, the VA was operating 97 acute-care facilities.

At a time when U.S. hospital infrastructure was poorly developed, it made sense for the VA to build its own hospitals. Today, however, the Veterans Health Administration suffers from serious problems of redundancy, cost, quality, and access. In May 2014, it emerged that a number of VA hospitals had maintained secret waiting lists in order to conceal delays in treating veterans with life-threatening illnesses. Many veterans died awaiting access to VA health services.

The quality of care at VA hospitals is a matter of controversy. Some studies indicate that VA health outcomes are superior to those of civilian hospitals; however, there is now much documented evidence that VA hospital officials have manipulated outcome and quality statistics for financial gain.

What is clear is that the geographic dispersion of VA hospitals, their poor productivity, and inadequate capacity have been entirely unacceptable, and reflective of fundamental structural flaws within the VA.

It is time to consider integrating the Veterans Health Administration into the broader health care system.

The federal government, instead of being required to maintain a separate health insurance system for veterans, could offer veterans the choice of a fiscally and actuarially equivalent subsidy with which to purchase coverage on the reformed ACA exchanges. Doing this would give veterans a much broader selection of hospitals and physicians from which to seek needed care.

In addition, VA hospitals could provide needed competition to private hospital monopolies, if VA hospitals were allowed to treat civilians as well as veterans. 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.

To better manage these transitions, the Veterans Health Administration—currently a subsidiary of the Department of Veterans Affairs—would ideally be transferred to the Department of Health and Human Services.

### ***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 Exchange 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.<sup>65</sup> Most federal workers gain health coverage through FEHBP, which operates in a manner not unlike that of subsidized insurance exchanges.

Indeed, the Universal Exchange Plan’s reforms of the ACA exchanges would make them more similar to the FEHBP model than they are today.

However, the implementation of the ACA exchanges 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 exchange 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.”<sup>66</sup>

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.”<sup>67</sup>

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 Exchange Plan would cap malpractice damages for any patient receiving a federal subsidy through Medicare, Medicaid, exchange-based 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.

## ACCELERATING MEDICAL INNOVATION

WHILE INSURANCE COVERAGE IS THE FOCUS OF THIS monograph and so many others in health policy, we forget that medical innovation—new therapies and medical technologies—has 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 Exchange 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, exacerbating an already serious problem.<sup>68</sup>

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 quinquennially 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 Health 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.



# Conclusion

## *Financial Security for Americans—and America*

**T**HE UNIVERSAL EXCHANGE 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 EXCHANGE PLAN WITH A GOP SENATE ALTERNATIVE**

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”).<sup>69</sup>

The Coburn-Burr-Hatch proposal 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 Coburn-Burr-Hatch proposal 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 Coburn-Burr-Hatch proposal,<sup>70</sup> using the same microsimulation model employed in this monograph, the Patient CARE Act would reduce the deficit by \$1.5 trillion over its first decade, by decreasing federal spending by \$416 billion and increasing federal tax revenue by \$1.1 trillion.

(A plausibly modified version of the Patient CARE Act, eliminating the proposal's net tax increase, would reduce the deficit by \$416 billion over ten years.)<sup>71</sup>

HSI projects that, in 2023, Patient CARE would expand insurance coverage by 3.1 million relative to current law. It would reduce premiums for single individuals by 8 percent and for families by 1 percent relative to the ACA. Coburn-Burr-Hatch 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 Exchange Plan, the Coburn-Burr-Hatch plan in its first decade of enactment would reduce federal spending by more than the Universal Exchange Plan—\$416 billion vs. \$283 billion. Coburn-Burr-Hatch, as scored by HSI, would increase federal tax revenues by \$1.1 trillion, relative to the Universal Exchange Plan's reduction in federal tax revenues by \$254 billion (*Table 3*).

Coburn-Burr-Hatch would expand coverage by less than the Universal Exchange Plan in 2023—3.1 million vs. 9.0 million—and have little impact, either positively or negatively, on provider access and health outcomes. Coburn-Burr-Hatch is estimated to reduce the cost of private health coverage, but the Universal Exchange Plan reduces premiums by more than twice as much.

One important advantage of the Universal Exchange Plan over the Coburn-Burr-Hatch proposal is that because the Universal Exchange Plan does not require repealing the Affordable Care Act, the Plan can achieve its ends with substantially less disruption of Americans' existing coverage arrangements.

The Congressional Budget Office estimates that by 2017, 25 million U.S. residents will subscribe to health coverage on ACA exchanges, with another 12 million enrolled in the ACA's expansion of Medicaid.



## LONG-TERM FISCAL AND COVERAGE PROJECTIONS CONTAIN UNCERTAINTIES

WE HAVE ESTIMATED THE FISCAL EFFECTS OF THE Universal Exchange 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 4.2 percent per year, and that inflation over the same period will approximate 2.5 percent per year.<sup>72</sup> 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 individual mandate were repealed.

The HSI microsimulation model used to consider the Universal Exchange Plan, combined with the exchange reforms 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 Exchange 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 Exchange 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.

**Table 3.** Comparing the Universal Exchange Plan With the ACA and a Senate GOP Alternative  
(Exclusive of Net Tax Increase from Senate GOP Alternative)

	ACA (BASELINE)	SENATE GOP ALTERNATIVE	UNIVERSAL EXCHANGE
<i>Fiscal Performance in the First Decade</i>			
Net reduction in federal outlays (billions)	\$0	\$416	\$283
Net reduction in federal revenues (billions)	\$0	\$0	\$254
Net federal deficit reduction (billions)	\$0	\$416	\$29
<i>Coverage and Quality in 2023</i>			
Impact on number of insured U.S. residents (millions)	0.0	+3.1	+9.0
Impact on private premiums (single policy)	0%	-8%	-18%
Impact on private premiums (family policy)	0%	-1%	-4%
Patient-Provider Access Index (overall population)	0%	-0%	+3%
Medical Productivity Index (overall population)	0%	-1%	+22%

**Table 4.** 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)

In addition, the Universal Exchange 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 Exchange 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 com-

plexities 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 Exchange 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 Exchange Plan.

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.

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



# 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 Exchange Plan.

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 production of this monograph—came from 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.

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.

The current director of the CBO, Doug Elmendorf, was generous and patient with my persistent inquiries.

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. Lanhee Chen of the Hoover Institution lent me his insights into malpractice reform.

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 Heartland Institute provided needed encouragement.

Yuval Levin, editor of *National Affairs*, published two articles of mine, "Health Care and the Profit Motive" (Spring 2010) and "Saving Medicare from Itself" (Summer 2011), parts of which are excerpted in this monograph. Patrick Brennan, Dan Foster, Ezra Klein,

## Acknowledgments

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.

Harold Pollack of the University of Chicago helped to frame my thinking on health reform for the disabled.

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 James 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 for introducing me to them.

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 this manuscript, Sarah Williams said yes when I proposed to her.

## 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.



# Endnotes

- <sup>1</sup> Organization for Economic Co-operation and Development, *OECD Health Statistics 2014*. <http://www.oecd.org/els/health-systems/health-data.htm>.
- <sup>2</sup> Elmendorf D *et al.*, The 2014 long-term budget outlook. Congressional Budget Office. 2013 Sep; <http://www.cbo.gov/publication/45471>.
- <sup>3</sup> Elmendorf D *et al.*, Updated estimates of the insurance coverage provisions of the Affordable Care Act. Congressional Budget Office. 2014 Mar; <http://www.cbo.gov/publication/45159>.
- <sup>4</sup> Roy ASA, The Medicaid mess: how Obamacare makes it worse. Manhattan Institute. 2012 Mar; [http://www.manhattan-institute.org/html/ir\\_8.htm](http://www.manhattan-institute.org/html/ir_8.htm).
- <sup>5</sup> Roy ASA, 49-state analysis: Obamacare to increase individual-market premiums by average of 41%. *Forbes*. 2013 Nov 4; <http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly>.
- <sup>6</sup> Roy ASA, 3137-county analysis: Obamacare increased 2014 individual-market premiums by average of 49%. *Forbes*. 2014 Jun 18; <http://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49>.
- <sup>7</sup> World Health Organization, *World Health Statistics 2014*. 2014 May; <http://www.who.int/mediacentre/news/releases/2014/world-health-statistics-2014/en>.
- <sup>8</sup> Haseltine WA, *Affordable Excellence: The Singapore Healthcare Story*. Brookings Institution. 2013 Apr; <http://www.brookings.edu/~media/press/books/2013/affordableexcellence/affordableexcellencepdf.pdf>.
- <sup>9</sup> The OECD incorrectly lists Switzerland's 2012 public health expenditures per capita at \$4,001, due to a statistical anomaly. Switzerland has an individual mandate; the OECD defines state health expenditures to include insurance premiums that the government requires individuals to pay, even if that spending is on private insurance. That is a debatable approach from the OECD, because the spending goes directly to the insurers, without the government as a redistributor. Based on figures compiled by Paul Camenzind for the Commonwealth Fund, actual Swiss public spending—excluding privately paid insurance premiums—is 30.9 percent of national health expenditures. So, the correct public expenditure figure is \$1,879: 30.9 percent of Swiss national health expenditures of \$6,080 per capita, adjusted for purchasing power parity.
- <sup>10</sup> Herzlinger RE and Parsa-Parsi R, Consumer-driven health care: lessons from Switzerland. *Journal of the American Medical Association*. 2004 Sep 8; 292(10): 1213–20.
- <sup>11</sup> The employed spouse of a Medicare-eligible retiree can retain her plan as supplemental coverage.
- <sup>12</sup> Roy ASA, Romneycare improved health outcomes, thanks to private-sector coverage. *Forbes*. 2014 May 7; <http://www.forbes.com/sites/theapothecary/2014/05/07/romneycare-improved-health-outcomes-thanks-to-private-sector-coverage>.
- <sup>13</sup> Parente ST, Measuring medical productivity to gauge the value of Medicare. *Minnesota Medicine*. 2013 Apr; <http://pubs.royle.com/publication/?i=152300&p=48>.

- <sup>14</sup> Aaron HJ and Reischauer RD, The Medicare reform debate: what is the next step? *Health Affairs*. 1995 Winter; 14(4): 8–30.
- <sup>15</sup> Enthoven AC, Consumer-choice health plan: inflation and inequity in health care today: alternatives for cost control and an analysis of proposals for national health insurance. *New England Journal of Medicine*. 1978 Mar 23; 298(12): 650–58.
- <sup>16</sup> Breaux JB *et al.*, Building a better medicare for today and tomorrow. National Bipartisan Commission on the Future of Medicare. <http://thomas.loc.gov/medicare/bbmtt31599.html>.
- <sup>17</sup> Ryan PD *et al.*, The path to prosperity: fiscal year 2015 budget resolution. House Budget Committee. 2014 Apr 1; [http://budget.house.gov/uploadedfiles/fy15\\_blueprint.pdf](http://budget.house.gov/uploadedfiles/fy15_blueprint.pdf).
- <sup>18</sup> Romney WM, Massachusetts health care reform. Heritage Foundation. 2006 Jan 26; <http://www.heritage.org/events/2006/01/massachusetts-health-care-reform>.
- <sup>19</sup> Roy ASA, 3137-county analysis: Obamacare increased 2014 individual-market premiums by average of 49%. *Forbes*. 2014 Jun 18; <http://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49>.
- <sup>20</sup> Patient Protection and Affordable Care Act, §1311(d)(3)(B).
- <sup>21</sup> Elmendorf D *et al.*, Options for reducing the deficit: 2014 to 2023. Congressional Budget Office. 2013 Nov; <http://www.cbo.gov/budget-options/2013/44891>.
- <sup>22</sup> Starr P, Averting a health care backlash. *The American Prospect*. 2009 Dec 7; <http://prospect.org/article/averting-health-care-backlash-0>.
- <sup>23</sup> Barthold TA *et al.*, Estimating the revenue effects of the administration's fiscal year 2008 proposal providing a standard deduction for health insurance: modeling and assumptions. Joint Committee on Taxation. 2007 Mar 20; <https://www.jct.gov/publications.html?func=startdown&id=1447>.
- <sup>24</sup> Avik Roy extrapolation of analysis by Selden TM and Gray BM, Tax subsidies for employment-related health insurance: estimates for 2006. *Health Affairs*. 2006 Nov/Dec; 25(6): 1568–79.
- <sup>25</sup> For a good primer on the “Cadillac tax,” see Piotrowski J, Health policy brief: excise tax on “Cadillac” plans. *Health Affairs*. 2013 Sep 12; [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=99](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=99).
- <sup>26</sup> Blumberg LJ *et al.*, It's no contest: the ACA's employer mandate has far less effect on coverage and costs than the individual mandate. Urban Institute. 2013 Jul 15; <http://www.urban.org/publications/412865.html>.
- <sup>27</sup> Blumberg LJ *et al.*, Why not just eliminate the employer mandate? Robert Wood Johnson Foundation. 2014 May; <http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/05/why-not-just-eliminate-the-employer-mandate-.html>.
- <sup>28</sup> Elmendorf D *et al.*, The effects of the Affordable Care Act on employment-based health insurance. Congressional Budget Office. 2012 Mar 15; <http://www.cbo.gov/publication/43090>.
- <sup>29</sup> Elmendorf D *et al.*, Analysis of the Administration's announced delay of certain requirements under the Affordable Care Act. Congressional Budget Office. 2013 Jul 30; <http://www.cbo.gov/publication/44465>.
- <sup>30</sup> Greenstein R and Solomon J, Finance Committee makes flawed employer requirement in health reform bill still more problematic. Center on Budget and Policy Priorities. 2009 Oct 21; <http://www.cbpp.org/cms/index.cfm?fa=view&id=2921>.
- <sup>31</sup> Baicker K *et al.*, The Oregon experiment—effects of Medicaid on clinical outcomes. *New England Journal of Medicine*. 2013 May 2; 368(18): 1713–22.
- <sup>32</sup> LaPar DJ *et al.*, Primary payer status affects mortality for major surgical operations. *Annals of Surgery*. 2010 Sep; 252(3): 544–51.
- <sup>33</sup> Kelz RR *et al.*, Morbidity and mortality of colorectal carcinoma surgery differs by insurance status. *Cancer*. 2004 Nov; 101(10): 2187–94.



- <sup>34</sup> Giacobelli JK *et al.*, Insurance status predicts access to care and outcomes of vascular disease. *Journal of Vascular Surgery*. 2008 Oct; 48(4): 905–11.
- <sup>35</sup> Roetzheim RG *et al.*, Effects of health insurance and race on early detection of cancer. *Journal of the National Cancer Institute*. 1999 Aug; 91(16): 1409–15.
- <sup>36</sup> Kwok J *et al.*, The impact of health insurance status on the survival of patients with head and neck cancer. *Cancer*. 2010 Jan; 116(2): 476–85.
- <sup>37</sup> Allen JG *et al.*, Insurance status is an independent predictor of long-term survival after lung transplantation in the United States. *Journal of Heart and Lung Transplantation*. 2011 Jan; 30(1): 45–53.
- <sup>38</sup> Gruber J and Rodriguez D, How much uncompensated care do doctors provide? National Bureau of Economic Research. 2007 Nov; <http://www.nber.org/papers/w13585>.
- <sup>39</sup> Boukus E *et al.*, A snapshot of U.S. physicians: key findings from the 2008 Health Tracking Physician Survey. Center for Studying Health System Change. 2009 Sep; <http://www.hschange.com/CONTENT/1078/1078.pdf>.
- <sup>40</sup> Bisgaier J and Rhodes KV, Auditing access to specialty care for children with public insurance. *New England Journal of Medicine*. 2011 Jun; 364: 2324–33.
- <sup>41</sup> Bisgaier J *et al.*, Disparities in child access to emergency care for acute oral injury. *Pediatrics*. 2011 Jun; 127(6): e1428–35.
- <sup>42</sup> Liu JH *et al.*, Disparities in the utilization of high-volume hospitals for complex surgery. *Journal of the American Medical Association*. 2006 Oct; 296: 1973–80.
- <sup>43</sup> Domenici PV *et al.*, Restoring America's future: reviving the economy, cutting spending and debt, and creating a simple, pro-growth tax system. Bipartisan Policy Center. 2010 Nov; <http://bipartisanpolicy.org/projects/domenicirivlin-debt-reduction-task-force>.
- <sup>44</sup> Holahan J, Restructuring Medicaid through a swap: an alternative to a block grant. Urban Institute. 2011 Apr; <http://www.urban.org/UploadedPDF/412327-restructuring-medicaid-through-swap.pdf>.
- <sup>45</sup> Holahan argues for a different, somewhat more complex, swap, under which: (1) acute-care and dual-eligible Medicaid spending would be transferred fully to the federal government; (2) long-term care spending would shift to state funding supplemented by a federal closed-end matching grant; (3) Medicaid disproportionate share hospital payments would be eliminated or greatly reduced; (4) state “claw-back” funding for non-dual-eligible acute-care Medicaid where needed as a fiscal offset. Holahan does not propose migrating the acute-care Medicaid population onto the ACA exchanges.
- <sup>46</sup> Simpson AK *et al.*, The Moment of Truth. The National Commission on Fiscal Responsibility and Reform. 2010 Dec; [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf).
- <sup>47</sup> Roy ASA, How Americans game the \$200 billion-a-year ‘disability-industrial complex.’ *Forbes*. 2013 Apr 8; <http://www.forbes.com/sites/theapothecary/2013/04/08/how-americans-game-the-200-billion-a-year-disability-industrial-complex>.
- <sup>48</sup> Paletta D, Medicare, Social Security disability fund headed in different directions. *The Wall Street Journal*. 2014 Jul 28; <http://online.wsj.com/articles/medicare-social-security-headed-in-different-directions-1406564712>.
- <sup>49</sup> Steuerle CE and Rennane S, Social Security and Medicare taxes and benefits over a lifetime. Urban Institute. 2011 Jun 20; <http://www.urban.org/publications/412281.html>.
- <sup>50</sup> Teles SM, Kludgeocracy in America. *National Affairs*. 2013 Fall; <http://www.nationalaffairs.com/publications/detail/kludgeocracy-in-america>.
- <sup>51</sup> Roy ASA, How the AARP made \$2.8 billion by supporting Obamacare's cuts to Medicare. *Forbes*. 2012 Sep 22; <http://www.forbes.com/sites/aroy/2012/09/22/>

- the-aarps-2-8-billion-reasons-for-supporting-obamacares-cuts-to-medicare.
- <sup>52</sup> Finkelstein A, The aggregate effects of health insurance: evidence from the introduction of Medicare. *The Quarterly Journal of Economics*. 2007. 122(1): 1-37; <http://qje.oxfordjournals.org/content/122/1/1.short>.
- <sup>53</sup> Sparrow MK, Criminal prosecution as a deterrent to health care fraud. Testimony before the Senate Committee on the Judiciary: Subcommittee on Crime and Drugs. 2009 May 20; <http://www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony>.
- <sup>54</sup> Parente ST *et al.*, Assessment of predictive modeling for identifying fraud within the Medicare program. *Health Management, Policy and Innovation*. 2012 Dec 11; 1(2): 8–37.
- <sup>55</sup> *Hall v. Sebelius*, Appeal from the United States District Court for the District of Columbia. 2012 Feb 7; [http://www.cadc.uscourts.gov/internet/opinions.nsf/890596479218E0818525799D00548389/\\$file/11-5076-1356903.pdf](http://www.cadc.uscourts.gov/internet/opinions.nsf/890596479218E0818525799D00548389/$file/11-5076-1356903.pdf).
- <sup>56</sup> *Hall v. Sebelius*, Appeal to the Supreme Court of the United States. 2013 Jan 7; <http://www.supremecourt.gov/Search.aspx?FileName=/docketfiles/12-262.htm>.
- <sup>57</sup> DeMint JW *et al.*, The Retirement Freedom Act. S. 1317 in the 112<sup>th</sup> Congress. 2011 Jun 30; <http://www.govtrack.us/congress/bills/112/s1317/text>.
- <sup>58</sup> Physician shortages to worsen without increases in residency training. Association of American Medical Colleges. 2010 Jun; [https://www.aamc.org/download/153160/data/physician\\_shortages\\_to\\_worsen\\_without\\_increases\\_in\\_residency\\_tr.pdf](https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf).
- <sup>59</sup> Dower C, Graduate medical education (updated). *Health Affairs*. 2012 Aug 31.
- <sup>60</sup> Anderson GF *et al.*, It's the prices, stupid: why the United States is so different from other countries. *Health Affairs*. 2003 May; 22(3): 89–105.
- <sup>61</sup> Brill S, Bitter pill: why medical bills are killing us. *Time*. 2013 Feb 20.
- <sup>62</sup> Carlson J, You don't always get what you pay for. *Modern Healthcare*. 2013 Oct 26; <http://www.modernhealthcare.com/article/20131026/MAGAZINE/310269941>.
- <sup>63</sup> Robinson JC, More evidence of the association between hospital market concentration and higher prices and profits. National Institute for Health Care Management. 2011 Nov; <http://www.nihcm.org/images/stories/NIHCM-EV-Robinson-Final.pdf>.
- <sup>64</sup> Robinson JC and Brown TT, Increases in consumer cost sharing redirect patient volumes and reduce hospital prices for orthopedic surgery. *Health Affairs*. 2013 Aug; 32(8): 1392–97.
- <sup>65</sup> Elmendorf D *et al.*, Comparing benefits and total compensation in the federal government and the private sector: working paper 2012-04. Congressional Budget Office. 2012 Jan 30; <http://www.cbo.gov/publication/42921>.
- <sup>66</sup> Elmendorf D *et al.*, Options for reducing the deficit: 2014 to 2023. Congressional Budget Office. 2013 Nov; <http://www.cbo.gov/budget-options/2013/44891>.
- <sup>67</sup> Mello MM *et al.*, National costs of the medical liability system. *Health Affairs*. 2010 Sep; 29(9): 1569–77.
- <sup>68</sup> Roy ASA, Stifling new cures: the true cost of lengthy clinical drug trials. Manhattan Institute. 2012 Apr; [http://www.manhattan-institute.org/html/fda\\_05.htm](http://www.manhattan-institute.org/html/fda_05.htm).
- <sup>69</sup> Coburn TA *et al.*, The Patient Choice, Affordability, Responsibility, and Empowerment Act: a legislative proposal. 2014 Jan; [http://www.hatch.senate.gov/public/\\_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf](http://www.hatch.senate.gov/public/_cache/files/bf0c9823-29c7-4078-b8af-aa9a12213eca/The%20Patient%20CARE%20Act%20-%20LEGISLATIVE%20PROPOSAL.pdf).
- <sup>70</sup> Parente ST and Holtz-Eakin DJ, The Patient Choice, Affordability, Responsibility, and Empowerment Act. Center for Health Economy. 2014 Jan

30; <http://healthandeconomy.org/the-patient-choice-affordability-responsibility-and-empowerment-act>.

<sup>71</sup> The increase in tax receipts under the Patient CARE Act is driven almost entirely by capping the tax exclusion for employer-sponsored insurance. According to aides to Senators Coburn, Burr, and Hatch, their proposal was not designed to raise taxes. Hence, a revised, revenue-neutral version of the Patient CARE Act would reduce the deficit by \$416 billion over ten years (the size of the proposal's spending reductions, with no additional tax revenue included).

<sup>72</sup> Elmendorf D *et al.*, The 2014 long-term budget outlook. Congressional Budget Office. 2013 Sep; <http://www.cbo.gov/publication/45471>.

## ABOUT THE MANHATTAN INSTITUTE

“When some future historian chronicles...New York City’s intellectual life during the last two decades of the twentieth century, his first task will be to explain why the policies that helped transform the nation’s greatest metropolis were hatched not by the professoriat...or in the editorial pages of the *New York Times*, but rather by the independent cadre of thinkers...associated with the Manhattan Institute.”

—Sam Tanenhaus, “*A Laboratory For Change*”

FOR OVER 30 YEARS, THE MANHATTAN INSTITUTE has been an important force in shaping American political culture and developing ideas that foster economic choice and individual responsibility. We have supported and publicized research on our era’s most challenging public policy issues: taxes, health care, energy, the legal system, policing, crime, homeland security, urban life, education, race, culture, and others. Our work has won new respect for market-oriented policies and helped make reform a reality.

The Manhattan Institute is located in New York City, and produces ideas that are both literally and figuratively outside the Beltway. We have cultivated a staff of senior fellows and writers whose provocative books, essays, reviews, interviews, speeches, and op-ed pieces communicate our message and influence the debate. These fellows work in the Institute’s six policy centers, which study and promote reform in areas ranging from health care, higher education, legal policy, urban development, immigration, energy, and the economy.







*Manhattan Institute for Policy Research*  
52 Vanderbilt Avenue, New York, New York 10017  
(212) 599-7000

*[www.manhattan-institute.org](http://www.manhattan-institute.org)*  
Twitter: @Avik @ManhattanInst



MANHATTAN INSTITUTE FOR POLICY RESEARCH