



Improving Health and Health Care

An Agenda for Reform

JOSEPH ANTOS
JAMES C. CAPRETTA
LANHEE J. CHEN
SCOTT GOTTLIEB
YUVAL LEVIN
THOMAS P. MILLER
RAMESH PONNURU
AVIK ROY
GAIL R. WILENSKY
DAVID WILSON

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Executive Summary

Despite, and in a sense because of, the enactment of the Affordable Care Act (ACA) in 2010, US health care is still badly in need of reform and revitalization. Instead of more federal regulation and subsidies, what US health care needs is adoption of market principles, starting with broad empowerment of the patient-consumer. The proposals advanced in this volume would replace many counterproductive and outdated federal policies with practical, market-based reforms that aim to provide all Americans with access to high-quality health care at affordable prices.

Replacing the ACA. The starting point for renewing American health care must be replacement of the ACA with a genuine, consumer-driven approach to expanding health insurance coverage. The ACA moved power and authority over the direction of US health care from consumers, employers, and the states to the federal government. A replacement plan must be built on a more decentralized approach, with consumers given the ability to make choices for themselves and authority returned to the states to oversee health care markets.

Most Americans get their health insurance today from their employers, and that should not change with a new reform plan. Employers should be free to organize health insurance offerings that are attractive to their workers. The existing federal tax break for employer-paid premiums should be retained. The only modification should be an upper limit to inject additional cost discipline into the most expensive plans.

Those Americans without access to employer coverage should be given a refundable, age-adjusted tax credit that is set roughly equal to the average tax break for an employer plan. These tax credits could be used to purchase any health insurance plan approved for sale in a state.

All Americans should be given continuous coverage protection in an ACA replacement plan. This rule would protect persons with preexisting conditions from being charged more, or denied coverage, based on their health status so long as they have not experienced long breaks in insurance enrollment.

States could also boost insurance enrollment by assigning persons who are eligible for the tax credits but have failed to pick an insurance policy to a default insurance plan. The upfront deductibles for these insurance plans would be set as necessary to ensure the premiums for enrollment would be equal to the federal tax credit, thus ensuring no additional premium would be required from a person assigned to a default plan.

Medicaid. Medicaid has experienced rapid cost growth over many years, even as the services it provides to lower income households are far from adequate. A fundamental problem is the split financial responsibility for the program. The federal government pays for about 60 percent of all state Medicaid spending, with no upper limit on total cost. The federal government points to its financial stake in the program as a rationale for imposing an extensive web of rules on the states. At the same time, states find it easier to maximize federal Medicaid funding rather than implement difficult measures to improve the cost-effectiveness of the program.

Reform of Medicaid must start with changing how the federal government pays for its share of total cost. The program should be divided into its two distinct subparts, one for able-bodied adults and their children and the other for the disabled and elderly. The federal government should make fixed, per capita payments to the states based on historical spending patterns for the program's two population groups. States would be given much more authority to manage the program without federal interference.

Able-bodied adults and children who are eligible for Medicaid would get the federal tax credit as a base level of support for health insurance. Medicaid would then serve as a supplement to the credits. The presumption would be that these Medicaid enrollees would be given the same insurance choices as other state residents receiving the federal tax credit.

States would be allowed to implement major changes in Medicaid support for the disabled and elderly without the need of prior federal approval. This would allow implementation of changes giving beneficiaries, and their caregivers, more control over what services they procure, and from whom they procure them.

Medicare. Medicare is pivotal to an effective reform of US health care because of its dominant regulatory role. Medicare's rules for paying hospitals, physicians, and other service providers heavily influence how care is delivered to all patients, not just Medicare enrollees.

The program would improve if there were fewer regulations and more emphasis on market-based reforms. The starting point should be conversion of the program, on a prospective basis, to a premium support model. Beneficiaries would be entitled to a fixed level of federal support for their insurance and would be given the opportunity to pick from a number competing insurance options, including the traditional program and private insurance plans.

Other changes in Medicare are also necessary, including updating the statutory benefit to rationalize the program's cost-sharing requirements in a benefit that combines hospitalization coverage with outpatient and physician care, changing the rules for supplemental coverage to encourage cost sensitivity at the point of services, eliminating unnecessary bureaucratic controls, and gradually increasing the age of eligibility.

Health Savings Accounts (HSAs). HSAs should be a central component of health care in the United States. The accounts provide strong incentives for their owners to seek the best value for their health care purchases, and they provide a ready vehicle for providing additional protection against high medical expenses. Existing rules should be modified to allow all Americans to make annual contributions to an HSA, and a new, one-time federal tax credit would provide a strong incentive for those without accounts to establish them. HSAs should also be fully integrated into the Medicare and Medicaid programs.

Additional Reforms. The federal government exerts substantial control over the training of new physicians through outdated funding streams through the Medicare program. There is no evidence that approach improves the quality of the nation's physician corps. The federal role should be reduced by cutting the funding substantially and converting what remains to a discretionary grant program.

A comprehensive reform plan should also reform the health insurance benefit for federal employees so that it operates like a defined contribution program. The government's contribution would be fixed for every geographic area of the country and would not increase with the expense of the plan chosen by a worker. Health services for the nation's veterans should also be modernized so that veterans can more easily access high-quality care in the private sector, with the Department of Veterans Affairs focused more on the services that are essential and cannot be replicated elsewhere.

Federal data on health care costs and clinical outcomes should be made more widely available to private-sector companies and researchers. These data can speed up the process of assessing the cost-effectiveness of various health procedures and products and thus also stimulate better decision making by consumers.

Summary of Recommendations

Principles for Reform

1. Citizens, not government, should control health care.
2. Government subsidies should come in the form of defined contribution payments.
3. Move power and control from the federal government to individuals, families, and states.
4. Suppliers of medical services must have more freedom to innovate and provide better services to patients and consumers.
5. Reform must improve the federal fiscal outlook by reducing long-term health obligations.

Replacing the Affordable Care Act with More Effective Reforms

1. Retain the tax preference for employer-paid premiums, with an upper limit.
2. Provide refundable tax credits to households without access to employer coverage.
3. Allow states to regulate insurance offerings and to establish mechanisms for consumer choice of plans.
4. Provide “continuous coverage protection” for persons with preexisting conditions.
5. Allow states to adopt a default enrollment program.
6. Allow for a gradual transition from ACA subsidies.

Medicaid Reform

1. Pursue separate reform strategies for Medicaid’s two distinct parts.
2. Finance Medicaid with fixed federal funding per Medicaid enrollee.
3. Integrate acute care Medicaid into market-driven health insurance reform.
4. Empower the disabled and frail elderly (and their families and caregivers).

Medicare Reform

1. Adopt the premium support reform model.
2. Improve the competition between Medicare Advantage and fee-for-service (FFS).

3. Promote consumer decision making.
4. Modernize Medicare's benefits.
5. Reform Medigap and other supplemental coverage.
6. Reform Medicare's payment policies, and eliminate unnecessary bureaucratic controls.
7. Provide greater administrative flexibility in local markets.
8. Gradually raise the eligibility age to 67.
4. Allow HSAs to use nontraditional payment methods (non-FFS).
5. Include HSAs in Medicaid reform.
6. Integrate HSAs into Medicare.
7. Allow withdrawals tax-free at age 75+ (above a minimum balance).
8. Allow tax-free HSA rollovers to designated HSAs at death.

Promoting Lifelong Enrollment in Health Savings Accounts (HSAs)

1. Provide a one-time federal tax credit matching enrollee contributions to HSAs.
2. Eliminate the minimum deductible requirement for a universal HSA contribution allowance of \$2,000/\$4,000.
3. Increase the maximum contribution limits for persons with high-deductible health plans by \$2,000/\$4,000.

Additional Reforms

1. Phase out existing federal funding of graduate medical education, and replace a small portion of it with annual appropriations and performance-based grants.
2. Reform the Federal Employees Health Benefits Program.
3. Integrate veterans into mainstream coverage and care, and refocus Veterans Administration health care.
4. Improve the transparency of useful cost and quality data.

Considerations and Principles for Reform

Principles for Reform

1. Citizens, not government, should control health care.
2. Government subsidies should come in the form of defined contribution payments.
3. Move power and control from the federal government to individuals, families, and states.
4. Suppliers of medical services must have more freedom to innovate and provide better services to patients and consumers.
5. Reform must improve the federal fiscal outlook by reducing long-term health obligations.

The debate over, and ultimate enactment of, the Affordable Care Act (ACA) once again has brought to the surface the deep divide in American health care policy. The divide has often been described as government versus the market, and that is indeed a good summation of the differing perspectives even if it sometimes papers over the true nature and complexities of the opposing points of view.

The provision of health services, like all other goods and services within the national economy, must take place in the context of the reality of limited resources. The key question is how those resources might be best allocated to maximize the quality, availability, affordability, and realized patient value of care. This question unavoidably comes down to who is in charge of making decisions about the allocation of those scarce resources.

In this report, we make a series of policy recommendations that are informed by our firm belief that US health care would be far better, of higher quality, and less burdensome in terms of costs, if citizens, in

their roles as patients and consumers of health services, rather than their national government, were ultimately in charge of making the important decisions of how to allocate scarce resources, both between health care and other priorities and, within the health sector, among competing options for delivering services to the empowered citizen-patients.

What follows here is a short summary of some of the considerations that inform our thinking on this important subject and the guideposts that we employed to help us develop the policy recommendations that are presented in the following sections.

Markets versus Government Control

The health care debate begins from something of a common definition of the problem to be solved and divides along fairly familiar political differences about how our economy works. Liberals and conservatives

alike start from the fact that our system of health care financing is broken in its orientation and grossly inefficient, which leaves costs too high (and often rising too quickly) and therefore makes coverage and care unaffordable. This leaves too many people unable to buy insurance or pay for care and leaves the federal government and state governments increasingly struggling to pay for the programs of public health insurance provision. These problems and challenges quite predictably lead to a frenzied search for ways to slow the pace of rising costs without undermining health care quality and realized patient value.

Liberals and conservatives alike start from the fact that our system of health care financing is broken in its orientation and grossly inefficient.

It should be no surprise that there are serious disagreements among analysts and policymakers about how to go about increasing health care quality while moderating cost escalation.

One side tends to believe that the nation's health sector is wasteful because it is chaotic and unfocused—too many players are doing too many things in too many different ways, and because none is moved by a dominant concern for the public interest, the system is a costly mess. In this view, the system would be much more efficient if it were made more orderly—directed by the federal government and political processes that define the public good; governed by a single set of rules; managed by supposedly knowledgeable experts who are said to understand what kinds of care are cost-effective, with just a few large providers of insurance (if not one huge provider) using their weight in the market to compel lower prices and more efficient delivery of services.

This vision is roughly what the ACA aims to make a reality: to increase access to insurance and restrain the growth of health care costs by putting the health sector under tight government supervision, making the government a larger buyer and provider of coverage. It

involves a vast expansion of Medicaid, more price controls and payment regulations in Medicare, and a system of highly regulated state insurance exchanges that will gradually transform the private insurance sector into a system of public utilities.

Those opposing centralized government control have a very different perspective. They believe that the health sector is inefficient not because of a lack of government control but because the government has already exerted excessive levels of control and has put in place policies that create inefficient distortions in the marketplace. The dominant fee-for-service structure of Medicare (which pays doctors by how much they do rather than how efficiently they work), the design of Medicaid (which allows state officials to increase spending at the federal government's expense), and the powerful tax incentive for employer-provided insurance (which has historically encouraged high-premium insurance plans that prevent consumers from making purchasing decisions and thus prevents the emergence of a real market) all make for a badly broken health sector incapable of finding paths to efficiency in the ways that a market economy normally does.

What is needed is a real market in which insurers compete for empowered consumers and therefore have a reason to offer attractive patient-centered products at a low price and in which consumers have strong incentives themselves to seek out the best, most cost-effective, ways of getting the care they want and need. This kind of market would empower health care providers to find more efficient, innovative ways of organizing their work.

The health care proposals from those who have opposed the ACA as flawed health care policy, including the recommendations that follow in this volume, aim to increase access to coverage and care and restrain the growth of health costs by providing patients and consumers with real and valuable choices, making the health sector more competitive and therefore more innovative. This involves turning today's health care entitlements and strictly controlled insurance and medical services sectors into highly competitive markets in which empowered patient-consumers are actively engaged and health

care providers and insurers have broad latitude to experiment with different avenues to compete to drive increased efficiency for the patient-consumer and best quality outcomes.

The struggle between the two competing visions for US health care has been a fairly one-sided affair. The proponents of more federal control and regulation have won most of the battles, most recently with the passage of the ACA. The result has been a steady, decades-long march toward more consolidated federal control over all aspects of financing and the consumption of health care services.

But this steady increase of federally centered control has not successfully addressed the basic problem of the inefficiency of American health care and therefore its unsustainable cost. The fundamental problem with reliance on centralized control over a sector of the economy as complex and vast as health care is that no person or bureaucracy could possess the requisite knowledge to properly set the dials of control to achieve the best balance of cost and quality. Moreover, what is understood about effective medical care is changing far too rapidly for a governmental bureaucracy to keep up.

The error of excessive reliance on prescriptive public policy to control vast and complex areas of economic activity has long been understood. F. A. Hayek described it well more than half a century ago:

The unfortunate fact is that, in the majority of fields, the most effective, certain, and speedy way of reaching a given end will seem to be to direct all available resources toward the now visible solution. To the ambitious and impatient reformer, filled with indignation at a particular evil, nothing short of the complete abolition of that evil by the quickest and most direct means will seem adequate. If every person now suffering from unemployment, ill health, or inadequate provision for his old age is it once to be relieved of his cares, nothing short of an all-comprehensive and compulsory scheme will suffice. But if, in our impatience to solve such problems immediately, we give government exclusive and monopolistic powers, we may find that we have been shortsighted.¹

The Distorting Effects of Expansive, Government-Subsidized Third-Party Insurance

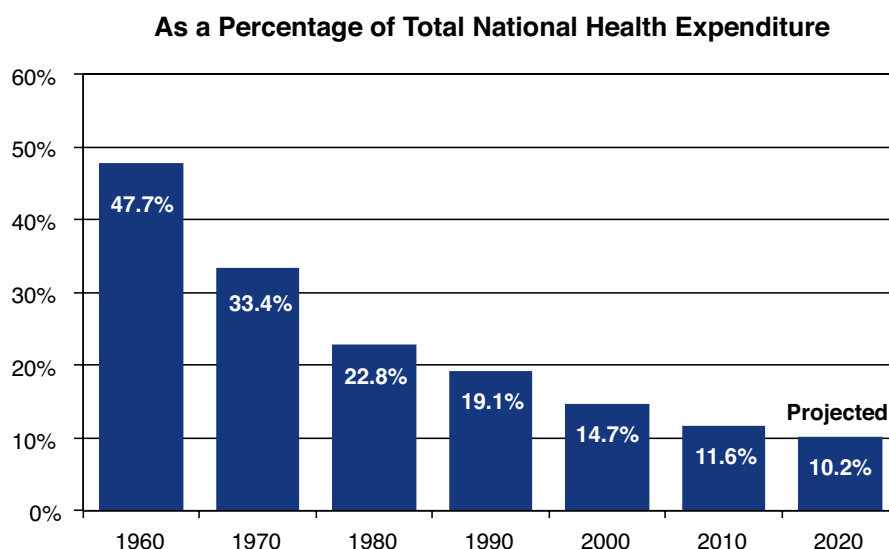
Health care policy debates in the United States are dominated by discussions of health insurance coverage and the terms under which insured consumers enroll in these plans.

Enrollment in health insurance is certainly important for securing access to lifesaving medical care. But the heavy emphasis on health insurance enrollment as an end in itself in public policy has also distorted the marketplace for actual medical services and thus made it more difficult for the supply side of the market equation—the physicians and the networks of hospitals and clinics they work in—to provide to consumers the high-quality, innovative services they want and need.

The quality of medical care and services in the United States has much to commend it. The country has, by a wide margin, the most highly trained physicians in the world, as well as a network of sophisticated clinics and inpatient institutions that is unrivaled. Moreover, the US is home to a vibrant biological and pharmaceutical product industry.

And yet, despite these strengths, there is plenty of reason to worry that the provision of health services to the US population is far from what it could and should be. Many studies have demonstrated the uneven quality of care provided by US clinicians.² The consumer experience can be maddening, with piles of meaningless paperwork, endless bureaucracy, duplicative tests, poor communication, and fragmentation among physicians, often resulting in poor service. The technology revolution, which has swept through and upended most service industries, has barely made a dent in the manner by which medical services are provided to patients, which looks today too much like it did a few decades ago.

In a functioning marketplace, the suppliers of products and services strive to innovate and provide high-quality services to their customers because that is the way to stimulate demand and thus achieve sufficient profits to be sustainable. A company does well only if it is able to convince a sizable number of consumers that what it is offering is worth whatever the consumer must pay to get it.

Figure 1. Out-of-Pocket Consumer Spending on Health Services

Source: National Health Expenditures (Historical Tables and Projections), Centers for Medicare and Medicaid Services.

But the health sector is different from the rest of the US economy because the consumption side of the marketplace is dominated by third-party insurance payments. Consumers pay very little directly to their physicians and the suppliers of medical services that care for them. Instead, third-party insurance pays the vast majority of the medical bills on their behalf.

This is by design. In 2012, about 242 million Americans under the age of 65 were enrolled in health insurance, and 92 percent of them were in plans subsidized by the federal government.³ Enrollees in employer-sponsored insurance plans numbered 156 million. Employer-paid premiums are excluded from workers' taxable compensation for purposes of both the income and payroll tax. Over time, this tax break has encouraged employers to substitute expansive health insurance coverage for higher wages.

Beyond job-based coverage, another 66 million people were enrolled in Medicare, Medicaid, or the military health insurance system. In each of these insurance programs, the consumers pay very little at the point of the service.⁴

The diminished role of the patient-consumer is evident in national statistics. As shown in figure 1, in

1960, consumer out-of-pocket spending for medical care accounted for nearly 48 percent of all spending on health in United States. By 2000, the percentage of national health expenditures paid for directly out of consumers' pockets was down to under 15 percent, and in 2010 it was just 11.6 percent. And the actuaries at the Center for Medicare and Medicaid Services (CMS) project out-of-pocket spending will fall to 10.2 percent of overall expenditures in 2020.

The displacement of the patient-consumer and the active patient-physician relationship has had debilitating and costly consequences. The terms by which physicians are delivering services to patients are now heavily influenced by the fine points in their contracts with employers and insurance companies, not solely by the quality commitments they make to their patients.

Medicare's Dominant Regulatory Architecture

The federal government's reach into the operations of the health sector is enhanced significantly through the Medicare program. Since the program was enacted

in 1965, the Medicare bureaucracy has erected a vast web of payment rules and regulatory requirements that permeate the health sector. Physicians, hospitals, nursing homes, hospices, outpatient clinics, labs, device manufacturers, and every other supplier of clinical services must contend with the methods by which Medicare approves and pays for services. For many providers the revenue coming from Medicare is necessary to sustain most aspects of the medical services industry, and therefore the government has substantial leverage to dictate the terms under which payments are made.

Moreover, Medicare's influence intentionally extends well beyond just those supplying services to the program's enrollees. Private insurers piggyback on Medicare's payment framework to compensate physicians and hospitals. According to a recent study, payments to physicians by private insurers closely track adjustments in Medicare's physician fees over time, a strong indication that most insurers are piggybacking on Medicare's payment formulas.⁵ Similarly, the vast majority of private insurers use Medicare's Diagnostic-Related Group payment structure to make payments to hospitals for inpatient services.

The dominant position of Medicare's payment and regulatory rules is a major impediment and burden to innovation and customer-focused service delivery in the health sector. Physicians or other entrepreneurs seeking to provide a new and better method of taking care of patients, perhaps using information technology, are immediately faced with the question of whether or not Medicare will pay for what they are planning to offer. Bringing new, simpler approaches to the marketplace is therefore less a question of selling the idea to the patient-consumer but of convincing the Medicare bureaucracy that what is being proposed is worthy of reimbursement or payment.

Unfortunately, it is always easier and less risky for the bureaucracy to slow changes rather than to approve them. Thus, there is a strong, inherent bias in US health care in favor of incumbents and against new entrants and new ways of providing patient care.

Planning Underway for Even More Consolidated Federal Control

The ACA was a large step toward full federal control of US health care—but it was not the final step. Proponents of the ACA are now planning the next rounds of legislative and executive action, focused mainly on how the federal government can enhance its power in the name of cost control.

That planning was on full display in a February 2015 pronouncement from Department of Health and Human Services Secretary Sylvia Burwell. She announced that her department was moving forward on a cost-control agenda predicated on imposing federally determined models of care on physicians and hospitals. In other words, the federal government is planning to establish, through regulations, what it considers best practices in the organization of care delivery systems and then will use its various regulatory powers, especially through Medicare, to force hospitals and physicians to comply with its preferred vision for medical care.

The ACA was a large step toward full federal control of US health care—but it was not the final step.

In addition, many champions of the ACA are also now calling for a “global budget” in health care, enforced with Medicare-style payment rules that apply to private and public spending.⁶ This global budget can be enforced rather easily by extending Medicare's payment rules into the plans offered on the ACA's exchanges and then also into the employer market through the additional regulatory powers given to the federal government under the ACA.

Proponents of market-driven health care must be cognizant that, as has been the case for many decades now, health care policy will not remain settled and unchanged in the years ahead. Advocates of centralized control will advance their next-stage agenda for extending the reach of the federal government, and it likely will be put into effect absent a compelling alternative plan.

Consumers Want Better Health, Not Health Insurance

The central focus of the ACA and, in fact, the central focus of many health care reform efforts has been to decrease the number of Americans without health insurance protection. That is understandable in a narrow sense because lack of insurance coverage (in the current system) can leave households with restricted access to care or with large, unaffordable debts.

But this near-exclusive focus on health insurance is also ironic because, in truth, consumers generally are not all that interested in health insurance. What they care about is better health and access to care. They enroll in health insurance because they perceive insurance to be a necessary, if sometimes distasteful, step in ensuring access to needed care, especially in a crisis. For the average American, then, enrollment in health insurance is not an end in itself but a means to a more important end—getting high-quality medical care when it is needed.

The good news for consumers is that advances in information technology and medical discovery hold the promise of transforming medical care in the United States in the coming years for the better. The bad news is that current arrangements, which emphasize third-party payment and a complicated and unproductive web of government regulation governing how providers of services get paid, will continue to slow the pace of progress.

Allowing the full potential of innovation to improve medical care and the promotion of better health will require empowering both patient-consumers and suppliers of services to make decisions and come together in a more flexible and powerful marketplace built on a patient-centered relationship that emphasizes engagement and responsibility.

For patient-consumers, that means promotion of more direct and more flexible methods for purchasing services, rather than sole reliance on restrictive insurance coverage. A move toward defined-contribution support for health services would promote more direct consumer control, as would accelerating the trend toward high-deductible insurance coupled

with health savings accounts (HSAs), increased investment in health and well-being, and direct-pay primary care options. The number of Americans enrolled in HSA-qualified arrangements has increased rapidly in recent years, from 3.2 million in January 2006 to 17.4 million in January 2014.⁷ But even more enrollment in these plans will be needed to tip the balance of the marketplace toward the empowered patient-consumer and away from central government control and preferences for how medical care is delivered.

Suppliers of medical care also need to be given much greater freedom to develop entirely new ways of taking care of patients. Reform of Medicare to give patient-consumers rather than the Medicare bureaucracy control over the use of resources will be especially important in allowing new ways of delivering care to emerge and thrive, as will the loosening of restrictions imposed by many states that stifle the kinds of care licensed and qualified practitioners can provide to patients, inclusive of alternative payment methods.

Distribution of Power and Control in a Democratic Society

Also at stake in the health care debate is something that goes beyond strict assessments of the quality or efficacy of health care services: the question of the proper role of citizens and government in the distribution of power and control over matters that are crucially important both to families and to society as a whole. The consolidation of control over health care in federal bureaucracies distorts the proper relationship between citizen and state by making citizens dependent and vulnerable to the decisions of those holding political power.

A much healthier balance focused on the empowered citizen-patient-consumer would ensure that, ultimately, free citizens would have the final say on matters of such import, and that the government's role would be strictly confined to educating and aiding consumers as they make choices for themselves and their families.

Principles for Reform

The considerations discussed here can be summarized in five important principles that guide the development of an overall plan for reform:

1. Empowered Citizens, Not Government Agencies, Should Control Health Care.

Placing the citizen at the center of decision making in health care is the proper starting point for reform. It ensures that decision making about what constitutes high-value health services is placed in the hands of those that are directly affected and in the best position to make intelligent judgments over a sustained period of time. It also ensures that citizens are ultimately calling the shots over the matters that are central to their individual ability to have full and productive lives.

2. Government Subsidies Should Come in the Form of Defined Contribution Payments.

Any federal subsidization of health care should take the form of defined contributions to support consumer choices in highly competitive open markets rather than defined benefits to control provider behavior in highly restricted captured markets. That subsidy would not vary based on a person's choices of coverage or where they get their care. Those selecting more expensive options would pay for the added cost out of their own pockets. Those choosing low-cost, high-value options would pocket the savings, ideally in personal health savings accounts.

The key point is that each component of federal support would move in the direction of a greater patient-consumer orientation, so that everyone enrolled in job-based plans, the individual insurance market, Medicare, or Medicaid would realize greater self-determination and active responsibility in how they receive and participate in the management of their health care and, in turn, their health and well-being.

3. Reform Should Move Power and Control from the Federal Government to the States and the

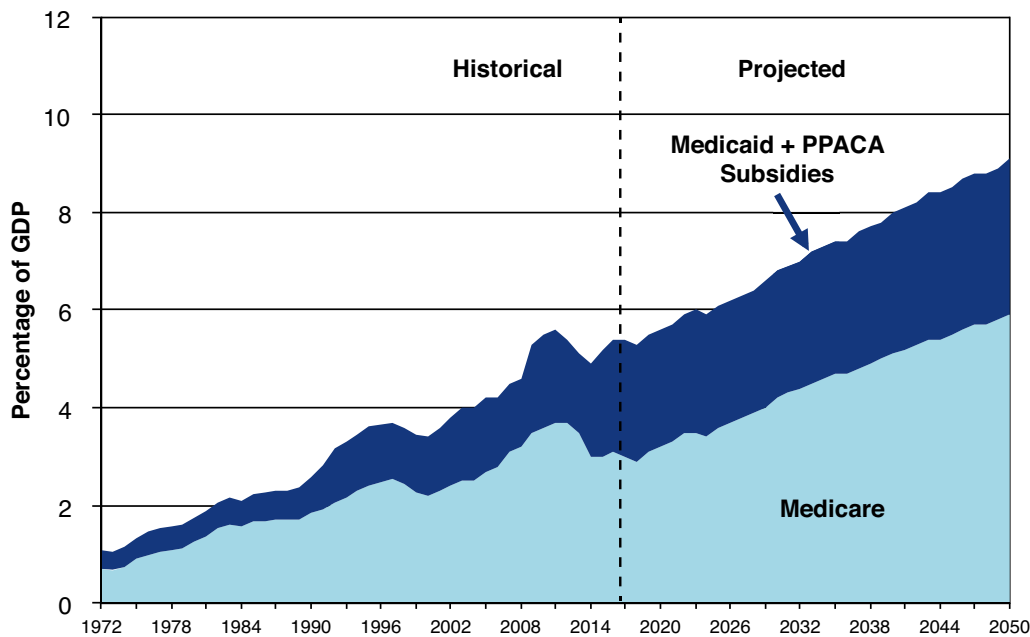
Empowered Patient-Consumer. Under the ACA, states are treated as mere functionaries in a new centrally planned and federally managed system. The law gives state officials a take-it-or-leave-it choice: they can implement and administer the new system without any deviation or adjustment, incurring the extra costs of these new programs along the way, or they can let the federal government come in and do it for them. In neither case are the states afforded any meaningful independence or flexibility.

An empowered citizen-patient-consumer approach must be true to the Constitution and reflect a genuine federalist philosophy and an understanding of the need for flexibility and for allowing states to address their particular needs and circumstances as they see fit. States should be permitted once again to define the insurance product, but consumers should also be allowed to purchase coverage from out-of-state insurers, so that the states themselves are put into competition for attractive regulatory environments. Federal rules should be as few and as flexible as possible.

4. Suppliers of Medical Services Must Have Greater Freedom to Innovate and Provide Better Services to Empowered Patient-Consumers.

Advances in information technology and in what is known about human health have the potential to revolutionize the way medical care is delivered to patients over the coming decades. Americans could get better health care, at less cost, if those delivering services to patients had the freedom to take full advantage of what these advances make possible.

For that to happen, however, US health care will need to move steadily away from the insurance-centric and government-bureaucratic models of resource allocation and control. Consumers must be given the power to actively invest in the crucial patient-physician relationship and to control a much larger slice of the health care pie. Suppliers of services must be given the freedom to meet consumer demand with products that improve

Figure 2. Rising Health Entitlement Spending

Sources: Historical tables and Congressional Budget Office, *2015 Long-Term Budget Outlook*.

the convenience, efficiency, and effectiveness of medical care in maintaining and improving the ability of patients to live fully functioning lives.

5. Reform Must Improve the Federal Fiscal Outlook by Reducing Long-Term Health Obligations. As figure 2 shows, under current law, federal health entitlement obligations threaten to overwhelm government finances in the coming years. Over the past four decades, spending on Medicare and Medicaid has soared as eligibility rules expanded enrollment, and the volume and intensity of health service use has risen inexorably. If the past is any guide, the ACA’s new entitlement spending could cost far more than the figures shown here would indicate.

Although repealing the ACA would avert much unnecessary and unaffordable costs, a credible replacement program will certainly entail expenses of its own. Some of this new cost would be offset by the savings reaped from other

components of the reform package. For example, meaningful reforms of Medicaid can help offset the cost of a replacement program. Even so, additional spending reductions will be necessary to fully offset any added budgetary burden of a patient-centered, market-oriented health reform. These should be real cuts, not budget gimmicks, and should be of sufficient magnitude to ensure that the legislation results in a net decline in federal spending, taxes, and future budget deficits.

Toward Better Health

At its core, the health care debate is about whether American health economics would work better if the government had more power or if citizens had more freedom. We believe that more centralization, more prescriptive regulation, and more misdirected subsidization will not get us to a functional, sustainable, health care system.

Instead, such a system should be centered on the empowered patient-consumer and be built understanding that the best possible balance between high quality and low cost requires empowering service providers with freedom to experiment with different products and business models, giving patient-consumers the freedom to choose among those options, letting their choices intelligently drive the evolution of new products and services, and protecting the most financially and medically vulnerable Americans from risk.

Getting there from here will be no simple matter. The government has distorted health care arrangements through misguided policies for 60 years and has exacerbated many problems in the past 5 years.

Undoing all that is wrong with health care policy will require advancing pro-market, patient-consumer-centered reforms, not just rolling things back. It will also require intelligent attention to the special requirements of transitioning to a new system. The fear of disruption has always been a barrier to health care reform. Moving in the direction of a functional market will require transitional measures that help ease concerns and prove success and viability.

Above all, it will require a clear sense of where we want to go and what we want to achieve, successfully empowering a patient-centered marketplace that intelligently drives increased efficiency of health care and individual liberty. In the following sections, we aim to describe just that plan.

Replacing the Affordable Care Act with More Effective Reforms

Key ACA Replacement Provisions

1. Retain the tax preference for employer-paid premiums, with an upper limit.
2. Provide refundable tax credits to households without access to employer coverage.
3. Allow states to regulate insurance offerings and to establish mechanisms for consumer choice of plans.
4. Provide “continuous coverage protection” for persons with preexisting conditions.
5. Allow states to adopt a default enrollment program.
6. Allow for a gradual transition from ACA subsidies.

Although it has been the law of the land for over five years, public opinion about the ACA remains predominantly negative. Polls taken month after month reveal that a majority of Americans continue to disapprove of the law.⁸ Opponents of the law continue to call for its repeal—and both repeal and replacement of the ACA remain stated goals of many in Congress, as well as all of the prominent candidates seeking the presidency in 2016.

But repealing the law without a plausible plan for replacing it would be a mistake. So too would be promises that a move toward market-based health care will come without any disruption. A replacement for the ACA should contemplate a set of policies that will help to ease the transition from the current state of affairs to a new, better-functioning approach to paying for and accessing health services.

To be credible, a replacement for the ACA must plausibly address the genuine problems that Americans faced in accessing health care and maintaining their health well before the ACA was enacted.

Brief Overview of Pre-ACA Health Care Arrangements

A contentious and lively debate raged in our politics for two decades about ways of changing US health care to address its problems. Among other things, this meant that everyone tended to highlight the weaknesses of existing arrangements, and almost no one highlighted its strengths.

It is worth seeing, therefore, that the health care arrangements in the US, as they gradually formed (in

an admittedly unplanned and somewhat haphazard manner) over the decades that followed World War II, achieved some extraordinary things. They provided access to health insurance coverage to the vast majority of Americans, including our most vulnerable populations, while allowing far more private control over decision making than is prevalent in other countries. The result was a physician corps unmatched in their level of sophistication and skill and a vast network of institutions and clinics capable of providing the highest-quality care found anywhere in the world.

A fully functioning marketplace requires active, cost-conscious consumers.

Still, what existed pre-ACA was not stable because it failed in too many ways. Critics of US health care have sometimes said that a private, market-driven health approach was tried, and it failed, thus necessitating more government regulation and control. But that is hardly a fair characterization of what existed before the ACA was enacted.

A better description is that American health care was a government-dominated hybrid approach, consisting of highly regulated and subsidized entitlement programs for the elderly and the poor, a more moderately but significantly subsidized employer-provided insurance system, and a fragmented and distorted individual insurance market for everyone else. There was much dysfunction in US health care pre-ACA, but the source of that dysfunction can be traced to government policy more than anything else.

A fully functioning marketplace requires active, cost-conscious consumers, but most Americans have been enrolled in subsidized, third-party insurance arrangements and thus have been largely unaware of the direct cost of their insurance policies or the services they receive. This is one very important reason for the rapid rise in health spending, which has created immense fiscal pressures for federal and state governments, as well as for households.

The pre-ACA approach to insurance enrollment provided secure coverage to the vast majority of Americans

(about 85 percent), but did leave a sizable number of citizens and legal residents without insurance. The problem was not among the elderly, as Medicare has become a de facto universal enrollment program for anyone who is 65 or older and not working. Rather, the problem was heavily concentrated among the working-age population and their dependents and especially among lower-income households with incomes just above the eligibility levels for Medicaid. These households frequently do not have stable employment and thus do not have access to employer coverage. And their incomes are insufficient to readily pay the premiums required for policies offered in the individual insurance market.

A related problem—one that featured prominently in the debate over the ACA—was insecure coverage for persons with expensive preexisting health conditions. The 1996 Health Insurance Portability and Accountability Act, known as HIPAA, had extended very reliable insurance protections to persons with such conditions in the employer-provided insurance market. The law prohibited employer plans from limiting coverage or charging higher premiums to new workers so long as they had stayed continuously insured. The law also attempted to provide protections for workers moving from employer plans to the individual market, but these protections were poorly designed. The result is that some Americans with expensive conditions paid very high premiums in the individual market, even if they had always been insured. And others with preexisting conditions went without coverage altogether because of the high premiums they would have to pay.

The problem of insecure insurance for those with preexisting conditions was often exaggerated in the run-up to the enactment of the ACA, but the problem was real nonetheless and contributed substantially to the enactment of the sweeping insurance regulations in the new law.

The Key Provisions of the Affordable Care Act

The ACA sought to address these problems by applying the technocratic logic of consolidated federal control. The law aims to expand insurance enrollment

through a combination of large new federal subsidies, new insurance regulations, and mandatory participation by employers and individuals. It then seeks to control costs mainly by extending federal control over the actual delivery of medical services to patients through new Medicare regulations and requirements.

The key elements of the law can be summarized as follows.

Expansion of the Medicaid Program. For the lowest-income households, the ACA expanded Medicaid eligibility to all households with incomes below 138 percent of the federal poverty line (FPL). At enactment, this provision was intended to be a nationwide requirement. However, in 2012, the Supreme Court ruled that mandating this expansion in the states violated the Constitution. The Medicaid expansion is thus now a voluntary option for the states. As of September 2015, 31 states had elected to implement it.⁹ The Congressional Budget Office (CBO) estimates that the Medicaid expansion will lead to 12 million more enrollees in the program (and in the closely connected Children's Health Insurance Program) by 2016.¹⁰

Exchanges, Insurance Regulation, and Premium Credits. Under the ACA, every state has an exchange—one built by the state or federal government—through which persons who do not have access to employer coverage can purchase coverage and receive any subsidies for which they are eligible. Private insurance plans offer standardized coverage options to consumers through the exchanges. Consumers with incomes above Medicaid eligibility (or above 100 percent of the FPL in states that did not expand Medicaid) but below 400 percent of the FPL are eligible for federally financed premium credits to offset some or all of the premiums charged by the insurance plans they have selected. The law extended substantial authority to the federal government to regulate the products offered on the exchanges. Among other things, new federal rules require insurers to offer standardized benefits (with only five variations on cost sharing) and to charge all consumers the same premium without regard to their health status. (Adjustments, within limits, are allowed for age and geographic location of the consumer.)

Mandatory Participation. Individuals who decline to enroll in a qualified health plan are subject to a new tax penalty. (Households with incomes below the levels that would require paying income taxes are exempted.) Employers with at least 50 full-time employees must offer qualified coverage to their workers or pay a per-worker fine to the federal government.

“Delivery System Reforms.” The ACA includes a series of provisions within Medicare designed to push hospital and physicians to change how they deliver care. The most prominent reform is the creation of accountable care organizations (ACOs). These are managed-care-like entities that are run by providers, not insurers. The law also authorizes the testing of a myriad of payment reforms, such as “bundling” together payments for numerous providers of services into larger lump sums for a full episode of care.

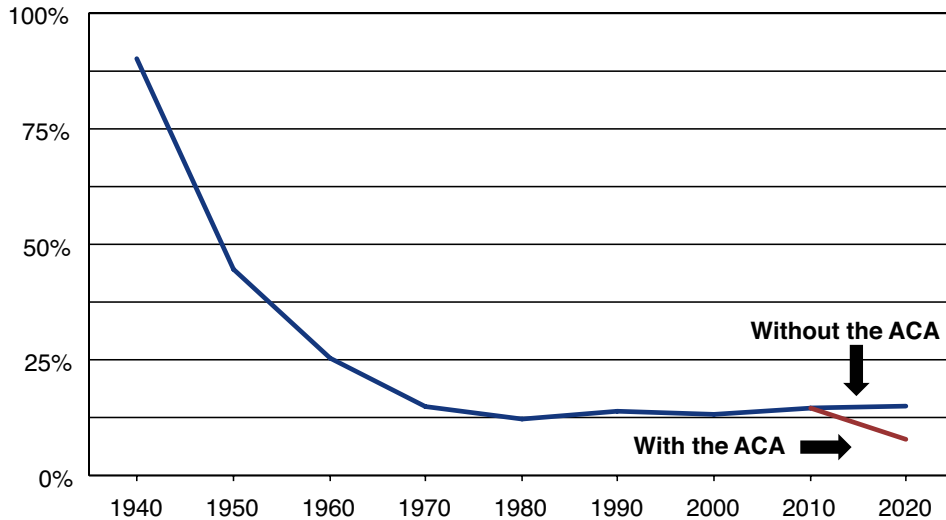
The ACA and Its Effects

The ACA's advocates have taken to describing the effects of the law as a sea change in health insurance coverage. And it is certainly the case that the ACA has expanded insurance enrollment. That is not surprising because the law set aside \$1.7 trillion over the next decade for the sole purpose of subsidizing insurance coverage for many millions of Americans.¹¹

But the ACA's coverage expansion needs to be seen in context. As shown in figure 3, the additional coverage under the ACA is really a modest improvement over the performance of the policies and insurance arrangements that existed before the ACA was enacted, which had vastly increased coverage numbers over a period of several decades after World War II. Insurance coverage levels had remain relatively stable since about 1990.

The Obama administration and other supporters of the ACA frequently argue that the ACA is not government-run health care because it was built on a market-oriented framework of consumer choice and private plan competition.

There is, of course, an element of truth to this argument. The ACA exchanges allow for some consumer choice among competing private insurance options.

Figure 3. Percent of US Population without Health Insurance

Sources: Christopher J. Conover, *The American Health Economy Illustrated Online*, Chart 6.6, 2012; and Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's March 2015 Baseline," March 2015.

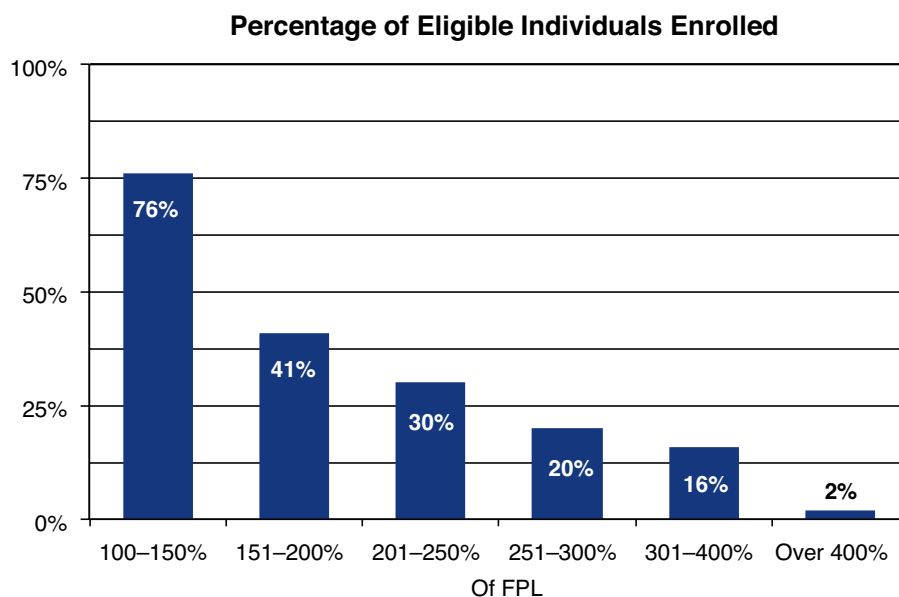
The law does not involve forcing physicians into a position of employment in a government-run insurance model, such as is the case in the United Kingdom. But as a matter of *direction*, it clearly involves a significant move toward greater federal government control. The law moves to the federal government massive amounts of power over both insurance markets and the manner by which health services are provided to patients from employers, states, hospitals, physician groups, and individuals. Among other things, the ACA:

- Establishes a uniform benefit package, as noted previously, with only five different options for cost-sharing for the same set of benefits;
- Authorizes the federal government to regulate all aspects of insurance, including allowable premium increases and marketing practices;
- Authorizes the federal government to exclude insurers from the regulated exchanges, based on criteria established entirely by the federal bureaucracy;

- Enhances the federal government's power to use Medicare payments to push physicians and hospitals to conform to the government's preferred care delivery models;
- Dramatically expands enrollment in publicly sponsored insurance; and
- Increases federal spending substantially with new subsidies for health insurance.

These provisions make it clear that the ACA is best understood as building an infrastructure of broad and deep control by the federal government over all aspects of insurance and the provision of health care services, and bringing within the government's regulatory reach many millions of Americans who were previously beyond it.

There are also other important reasons to be concerned about the ACA beyond its broad grant of authority to the federal government. The design of the insurance products available in the exchanges is highly problematic and looks likely to severely distort the

Figure 4. Enrollment in Exchange Plans by Income

Source: “Exchanges Struggle to Enroll Consumers as Income Increases,” Avalere Health, March 25, 2015.

individual market in many states. The extensive minimum coverage requirements leave insurers unable to offer consumers products that provide a service resembling insurance as it is generally understood: protection against unexpected and extreme financial risk. Instead, insurers are required to cover many routine medical expenses and therefore to offer products that pay for low-cost, predictable expenses but that confront consumers with extremely high out-of-pocket costs in an emergency and yet are not backed with personal savings vehicles that might better enable consumers to shoulder such costs.

This sort of upside-down insurance is a function of a widespread misunderstanding of the basic nature and purpose of health insurance. Insurance is a financial product intended as a protection against the risk that an unexpected health emergency will lead to an unexpected financial calamity. The insistence that only “comprehensive” insurance coverage is really insurance has things backward and encourages a great deal of economic irrationality in health policy. It is directly responsible for the kind of plan designs the ACA requires, and

the resulting insurance plans are, as a result, rightly perceived by many consumers as low-value products. They have therefore not been attractive to any but the most generously subsidized consumers in the ACA exchanges.

As a result, and as shown in figure 4, rates of enrollment in exchange coverage have been almost precisely inverse to incomes, suggesting that the more consumers must pay themselves for what the ACA is offering, the less attractive they find it—which obviously is not a good sign about the value of the coverage.

This decrease in value leaves insurers with an unattractive consumer pool and has been leading to significant premium increases each year since the ACA took effect. As some key risk-mitigation programs (which shield insurers from risk using taxpayer dollars) expire next year, such increases look likely to grow even more extreme, all of which bodes poorly for the fate of the exchanges.

And perhaps most significantly, the law embodies a misguided approach to health economics, rooted in the proposition that the answer to the challenge of reducing

costs while maximizing quality is known and need only be applied in a rational, uniform way. It therefore puts power in the hands of regulators—who presumably possess that needed knowledge—rather than in the hands of consumers and providers, who would continuously discover and hone the knowledge needed to make health care services more efficient through their interactions with one another.

What is needed instead of the ACA is a genuine market-based alternative that addresses the shortcomings of pre-ACA arrangements without handing all power and control over to the federal government. That can be done with a series of policy changes, starting with the tax treatment of health insurance.

What is needed instead of the ACA is a genuine market-based alternative that addresses the shortcomings of pre-ACA arrangements without handing all power and control over to the federal government.

The Tax Treatment of Job-Based Health Insurance

The tax treatment of health care benefits is a frequently mentioned explanation for why the existing financing system promotes comprehensive employer-sponsored health benefit plans and rising health care costs. The current system stems from Internal Revenue Service (IRS) rulings in the 1940s that made employer contributions for health insurance tax-exempt for workers and deductible for employers.

Although any effort to equalize the tax treatment of health benefits confers obvious advantages on those who purchase coverage on their own (predominantly benefiting those who are self-employed or work for small businesses), the benefits may be less obvious to the majority of Americans who obtain coverage through their employers. A goal of any reform should be to ensure that those who like the coverage they have are able to retain it (or a substantially similar plan). This has been, after all, one of the most significant failures of the

ACA—its many dictates, mandates, and requirements have basically ensured that millions of Americans lost their previous coverage. In response to heavy criticism, President Obama took action to temporarily extend the life of non-ACA-compliant plans, but over time, these plans will disappear anyway. Furthermore, the ACA itself ensures that the existing employer-sponsored health insurance system will change substantially.

This is because the ACA included the first major change to the tax treatment of employer-sponsored health benefits in decades. It created a provision in Section 4980I of the Internal Revenue Code known as the “Cadillac tax,” which will place on employers, beginning in 2018, a 40 percent excise tax on certain high-cost, employer-sponsored health benefit plans. The goal of the tax is to encourage employers to offer more cost-effective plans and engage their employees to contribute to the cost of care. The provision will also raise an estimated \$80 billion over 10 years, all of which will go toward funding other parts of the ACA.

To provide a sense of scale, the tax will be assessed in 2018 on plans with individual premiums in excess of \$10,200 and family premiums in excess of \$27,500. These thresholds are set to increase with inflation. Employers pay the same tax, regardless of the income of the worker. Given that there is an economic trade-off between wages and benefits, the Cadillac tax disproportionately harms lower-income workers with generous health benefit plans.

Thus, while the Cadillac tax imposes some level of cost discipline into employer-sponsored coverage, it does so in a poor manner. The better approach is to retain the discipline created by the Cadillac tax but without the painful side effects of a new excise tax.

One such approach is to place an upper limit on the amount of employer-paid premiums that is tax-free to workers. To simplify the transition away from the ACA, the upper limit could be initially set as a percentage of the high-value threshold at which the Cadillac tax is triggered, beginning in 2018, and indexed to inflation thereafter. Employers providing plans with premiums in excess of the threshold would create taxable income for employees, but higher-wage workers would pay more because their salaries put them in higher marginal income-tax brackets. Most Americans would never

confront the tax, and those who did would be better positioned either to pay it or to change their coverage (for example, to a lower-premium plan with more cost sharing) to avoid it.

Refundable Tax Credits for Those with No Employer Coverage

Converting the existing Cadillac tax into a cap on the amount of employer-paid premiums that is tax free to workers has the added benefit of facilitating the transition from the existing tax treatment of health care to a system featuring either a standard tax deduction for health care (similar to what President George W. Bush proposed in 2007) or a universal, advanceable, and refundable tax credit for health premiums (similar to that proposed by Senators Richard Burr [R-NC] and Orrin Hatch [R-UT] and Representative Fred Upton [R-MI] in the Patient Choice, Affordability, Responsibility, and Empowerment Act of 2015). These broader reforms are necessary to address not only the existing inequity in the tax treatment of health benefits—where those obtaining health coverage through employers receive a tax break while those obtaining coverage on their own do not—but also to enhance portability in our health care system and control health spending in the long run.

We believe that a good approach for expanding access to affordable private health insurance in a post-ACA world is a system of tax credits set initially as fixed-dollar amounts based on age. (Older people would get larger subsidies, reflecting their tendency to use health services more.) These should be sufficiently generous to ensure that anyone receiving them can afford the health care that they need but not necessarily all the comprehensive care that they might want.

There are many different levels of tax credits that could accomplish the goals of this proposal. For purposes of estimating this plan, we assume that the credits are set at the levels set in the Empowering Patients First Act (HR 2300), sponsored by House Budget Committee Chairman Tom Price (R-GA), with future amounts tied to consumer inflation.¹² Congress should consider whether these tax credits would be means-tested, as

in the ACA. Means testing would reduce the revenue impact of the subsidies that we estimate; at the same time, it would make the credits harder to administer and less attractive to some voters and would raise effective marginal tax rates.

An attractive alternative is to match the magnitude of the tax credits more closely to the varying costs of care and insurance that real purchasers will face in the less-regulated markets created in a post-ACA world. This second option would make the tax credit amounts more open-ended initially and responsive to premiums that may vary by age and geography. Structuring the tax credits as a uniform fixed percentage of premium costs would provide all purchasers with the same subsidized discount rate in choosing insurance plans. This initial floating cost-based subsidy structure then could be adjusted in later years to set a ceiling on maximum tax benefits (to curb overspending) and add additional subsidies for more economically or medically vulnerable populations.

To qualify for the tax credit, individuals would need to purchase qualified health insurance—defined as any insurance that covers “medical care” (such as major medical, qualified coverage in the state of purchase). The only federal requirement would be that insurance plans purchased with the credit must provide coverage for medical care above an out-of-pocket limit of consumer spending.

Providing “Continuous Coverage Protection”

The ACA places a myriad of rules and mandates on health insurance marketplaces across the country. It federalized much of what had, before passage of the law, been fundamentally a state concern.

But perhaps the most noteworthy (and politically significant) of these rules is the law’s ban on preexisting condition exclusions, which works in tandem with its prohibition on the use of health status in setting insurance premiums. Together, these provisions work to ensure that any American with a preexisting condition cannot be denied health insurance coverage. But the provisions also incentivize individuals to enroll in insurance coverage only when they medically need it.

The ACA tries to counteract this behavior by mandating that individuals secure creditable insurance coverage and creating a yearly open enrollment period. Those who do not are subject to a penalty imposed through the Internal Revenue Code.¹³

The ACA imposes a blanket solution to what really was a targeted problem. Estimates before the passage of the law in 2010 placed the number of Americans who were denied coverage due to a preexisting condition at somewhere between two and four million.¹⁴ The better answer is to help ensure that those who need coverage get access to it, while not raising costs and increasing regulatory burdens and mandates on the rest of the population.

Any protections for people with preexisting conditions should therefore involve rewarding continuous coverage rather than punishing lack of insurance. To do this, the federal government must provide a targeted regulatory response that extends the reach of a long-standing provision of federal law to ensure that people with preexisting conditions have access to coverage wherever they seek it.

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, outlawed the imposition of exclusions on preexisting conditions by employer-sponsored plans on workers in continuous group insurance coverage. This protection means that a worker who is continuously covered by a job-based plan for 12 months may move from one job to another without fear of losing insurance protection or of having to wait longer than other new hires before gaining coverage for a preexisting condition. Although the law was originally intended to confer portability rights to workers moving from employer-based coverage to individually owned coverage, the reality did not meet the promise in many cases.

This was the case, in part, because HIPAA still requires a worker to exhaust his right to temporary continuous coverage under his former employer's plan before becoming entitled to enter the individual market without preexisting condition exclusions. Unfortunately, many were not aware of this requirement, and moreover the temporary continuation coverage (provided through a federal program known as COBRA) is often prohibitively expensive because the worker is

required to pay both his and his employer's share of the total premium due. Before the ACA, the law also permitted insurers to vary the premium charged to an individual transitioning to the individual market or between plans in the individual market based on his health status.

A transition away from the ACA would repeal the individual mandate and simply extend the protections of HIPAA cleanly through to the individual market, while creating expanded protections for those who have remained continuously covered by insurance. To begin, this would mean eliminating the requirement that COBRA continuation coverage be exhausted before protections attach. Furthermore, individuals who have maintained continuous insurance coverage (measured as three or fewer months without coverage over the preceding three-year period) would be guaranteed access to coverage and protected against higher premiums because of a preexisting condition. Insurers would also be prevented from charging higher premiums to customers with continuous coverage who subsequently develop serious health conditions and from imposing coverage restrictions tied to changes in a person's health status. States would be free to regulate insurance offerings differently for those without continuous insurance enrollment. The requirement of continuous coverage to avoid restrictions on the coverage of preexisting conditions serves as an effective alternative to a requirement to purchase health insurance because individuals will have a strong economic incentive to remain covered.

A credible replacement for the ACA should also include some mechanism to help those with preexisting conditions who have not secured continuous coverage. In this situation, the federal government should consider assisting states with the financing of high-risk pools, as the traditional challenge with these pools is that states argue that they lack the resources to appropriately finance them. This results in the collapse of the high-risk pool and returns us to a system where those who are uninsurable because of health risks remain so. A system of adequately financed pools, with an initial capped allocation of \$10 billion per year, could avoid this problem.¹⁵

High-risk pools are not themselves without challenges. Most notably, the high-risk pool must be properly cabined off such that it does not eventually morph into a pool for a broader range of patients, some of who may not be “high-risk.” The definition of high-risk must be sufficiently precise so as to prevent expansion of the pool to cover a larger number (and perhaps more expensive group) of patients. Put another way, there must be a mechanism in place to prevent the high-risk pool from turning into the all-risk pool. One way to address this challenge is to cap the federal contribution to state high risk-pools to remove the political and policy pressure to expand them. Still another alternative is to establish parameters on which sorts of health risks and above-average premium offers will be covered by federal subsidies to state high-risk pools. This alternative would allow states to better target who should be eligible to participate in the high-risk pools, rather than using other techniques to economize and limit enrollment in them.

Role of the ACA Health Insurance Exchanges

One of the most controversial provisions of the ACA also happens to be one that presents a significant opportunity in a post-ACA world. The law’s health insurance exchanges were conceived as a way of expanding private coverage, administering the tax and cost-sharing subsidies created by the ACA, and regulating the benefits that plans must furnish. And therein lies the problem: the law created health insurance exchanges to be all things to all people, which they should not be. The notion of combining (and at times conflating) marketplace with regulator was a flawed one, and an effective replacement plan for the ACA must ensure that any remaining health insurance exchanges do not assume both of these roles.

Adding to the confusion is the fact that although states were incentivized and encouraged by the Obama administration to create their own exchanges, the ACA also established a federal marketplace that would be the default source of subsidized coverage for citizens of states that did not set up their own exchanges.

As of July 2015, 13 states plus the District of Columbia have state-run marketplaces, and another 3 states have a state-run marketplace using the federal website. The rest have hybrid arrangements that vary and include setups where the state runs the marketplaces but uses federal technology; the federal government facilitates the marketplace but the state conducts plan management; and the states and the federal government partner, with the state conducting plan management and consumer assistance.

Regardless of the arrangements, the health insurance exchanges can be functional and effective marketplaces if they behave strictly as information-rich marketplaces—as venues where individuals can select between various plans based on price, benefits, and other features. They need not be regulatory arms of the federal or state government, nor the exclusive source of federal subsidy dollars. But policy changes are clearly needed.

It would be impractical to require states to roll back exchanges they have already created. But a reform plan to replace the ACA should adhere to three very important principles regarding these exchanges:

1. They should be marketplaces and not regulators.
2. They should not be forced to administer federal tax law, nor should federal tax credits or other cost-sharing benefits be limited to plans purchased through exchanges.
3. The law should permit nongovernment-sponsored or administered exchanges to freely compete with state-based exchanges and should in no way preference the state-based exchanges. In a post-ACA system, the state-based exchanges should be seen as sources of competition and innovation, rather than the monopoly provider of subsidized health coverage.

Adhering to these three principles will allow existing (and any newly created) exchanges to enhance choices for consumers rather than to limit them.

Deregulating Mechanisms Aiding Consumer Choice

Regulatory reforms are needed to free exchanges from serving as ready mechanisms for further federal control over US health care. First, the authority and responsibility for regulating insurance should be returned from the federal government to states. Part and parcel of this shift in responsibility is repeal of the ACA's essential health benefits requirement, which allows the federal government to set standard requirements for many plans issued in the country. This requirement drives up costs, limits choices, and requires consumers to purchase coverage for benefits that they neither want nor need. Returning regulatory authority to states will expand the flexibility of insurers to design exchange-based policies that are more attractive to consumers and increase the range of different plans that consumers can choose from. A federal reform to allow consumers to shop for and purchase health insurance across state lines would effectively complement this policy.

It is important that consumers have access to more, and better-quality, information regarding the health plan options available in their states.

Such flexibility will also spur the growth of consumer-directed health plans, which, while popular in employer-based plans, have seen their growth in adoption threatened by the ACA's inflexible mandates and coverage requirements. These regulatory changes will help to drive down health insurance premiums and costs.

States that already have exchanges should be permitted to retain that architecture but be freed from the ACA's essential health benefits mandates and other regulatory requirements currently placed on the exchanges. Nor should they be required to enforce federal tax law or be the sole source of subsidized coverage for those who qualify. State-established exchanges should compete with other alternatives (whether web-based or

otherwise) on a level playing field. What is objectionable about state-based exchanges under the ACA is the effective monopoly they have been given over individuals who have access to tax subsidies and who want to purchase coverage. A more competitive marketplace, where the state-established exchange is but one player, will benefit consumers and help to drive down health insurance premiums.

States without exchanges that wish to establish them should be permitted to do so, but the distribution of federal tax credits for coverage in those states should not be premised on the creation of an exchange. Nor should those exchanges necessarily be operated and run by state governments per se—rather, states should be permitted to set up private or public-private partnership exchanges, with the only requirements being that they can assure the flow of tax subsidies to eligible individuals and that the state-backed marketplace will not have monopoly power over the market in that state.

It is important that consumers have access to more, and better-quality, information regarding the health plan options available in their states. Rather than the ACA's system of metal tiers, actuarial value requirements, and the like, a less prescriptive approach such as the one taken by the Federal Employees' Health Benefits Program (FEHBP) is preferable. The FEHBP focuses on furnishing more information directly to consumers about the choices available rather than regulating a certain level or amount of health benefits.

Under this reform plan, states will once again assume the responsibility for ensuring that a competitive marketplace exists among plans and for ensuring that individuals eligible for federal tax credits get access to those benefits in the selection of health insurance plans. Thus, there will not be a need for a federal fallback exchange in states that choose not to build one themselves.

That does not mean, however, that the intellectual property associated with the federal exchange will go to waste. We propose placing this technology into an open-source environment so that qualified users (including states) wishing to establish a health insurance marketplace of their own—using existing federally procured technology—can do so. The American taxpayer owns

the intellectual property behind Healthcare.gov, and therefore it should be made available to anyone who wants to use it.

A State Option for Default Insurance

Even with a widely available tax credit for insurance, some portion of the population would likely still go uninsured. (This is often the case with other programs like Medicaid, in which large numbers of eligible individuals fail to sign up.) There are a couple of reasons for this phenomenon: some people are hard to reach via public information campaigns, and others tend not to make significant changes to their life arrangements without a clear need and direct, personal intervention.

It is possible, however, to boost insurance coverage among the hard-to-reach population without resorting to coercive mandates or requirements. Under the framework proposed here, this could be done through what might be called “default insurance.” States would be responsible for designating several insurance plans as default options to which persons who are eligible for a refundable tax credit would be assigned (on a random basis) if they failed to sign up for coverage on their own.

The key to making this concept work is that the premiums for default insurance would need to be set to the value of the tax credit so that persons who were assigned to such plans would not be charged any additional premium. And to keep the premiums equal to the credits, the insurance plans must be given the authority to set their upfront deductibles accordingly so that the cost of the coverage does not exceed the federal credit.

This approach would of course mean that persons assigned to default plans would likely get catastrophic insurance coverage, with a larger-than-normal deductible. Nonetheless, they would have insurance to protect them against high medical expenses, which is the primary need and benefit of health coverage. Most importantly, those assigned to a default plan would retain the continuous coverage designation and thus be protected against getting risk rated later based on their health status.

The insurance plans offered for default coverage could also be made available to persons eligible for the tax credit who want to sign up for a plan that involves no additional premium from them. These plans may turn out to be among the most attractive options in the marketplace.

Default insurance, in combination with a federal tax credit for persons without access to employer coverage, would ensure that the reform framework proposed here would be, for all intents and purposes, a plan for ensuring all Americans have ready access to at least catastrophic insurance coverage. Every American household would either be in an employer plan or get the refundable credit, and those who for whatever reason failed to use their credit to buy coverage would be placed into an insurance plan providing catastrophic insurance protection.¹⁶ Thus, there would be no reason for anyone in the United States to have a significant break in their insurance protection.

Transitioning from the ACA to the Replacement Program

The ACA’s supporters in Congress have paid a heavy political price for needlessly disrupting pre-ACA insurance arrangements and doctor-patient relationships. Those proposing ACA alternatives should avoid making the same mistake. They should both refrain from promising that all disruption can be avoided and also refrain from causing avoidable disruption. A replacement will need to include a transition—a bridge from the ACA to a working health-financing system and, in particular, to the replacement plan’s alternative tax credits and Medicaid coverage.

The transition from the ACA to the program proposed here would be a move from a more prescribed and regulated approach to a less prescribed and regulated approach and, therefore, would increase rather than reduce the range of options available to most Americans. This would make such a transition dramatically different from, and far easier than, the transition to the ACA from pre-ACA arrangements. By adding options, rather than subtracting them, it can make it possible to enable even those people who are

most entangled in the ACA's new mechanisms to gradually make their way into the new and more functional market-based alternative.

The challenges of transition are greatest in the case of the two populations that receive direct benefits under the ACA—those covered under the Medicaid expansion in their states and those who receive premium subsidies for the purchase of coverage through the exchanges. These individuals are most directly and materially entangled in the ACA's architecture, and smoothing for them the transition to a better system would require special attention.

The best way to transition those in the Medicaid program is through a grandfathering exemption. No one enrolled in Medicaid would be pushed out of the program. People could stay enrolled as long as they remained eligible under the old ACA rules. But all new applicants would go into the reformed Medicaid program, and all participants in the old program could voluntarily elect to switch into the reformed Medicaid program.

A great many Medicaid beneficiaries are likely to choose to make that transition, as they would be given new choices and the ability to enroll in the same types of mainstream insurance plans available to the middle class, often with significantly greater access to care than they now have in Medicaid. The states would also have an incentive to make choosing the new Medicaid alternative more appealing, smoother, and easier, since the new program would be significantly less costly. Given these incentives, and the fact that turnover in Medicaid has always been very high, the full transition to the new Medicaid alternative could occur fairly rapidly, yet could be experienced by people in the current program as a choice, not a disruption.

The transition to the new health insurance tax credits for those currently receiving subsidized coverage in

the ACA's exchanges could follow the same general principle. Current enrollees (say, through the beginning of the year in which the alternative is enacted) in plans bought through the ACA exchanges could stay in those plans and continue to receive premium credits based on the ACA rules, though those credits would only rise with the Consumer Price Index (CPI) each year. New applicants would instead receive the new tax credit and select from insurance plans in the new, more functional market.

The limited population of existing subsidized ACA enrollees could choose at any time to transition to new coverage using the new tax credits instead of their ACA plans. The new system would be able to offer them lower-cost plans (including catastrophic coverage that could be purchased for a premium equal to the value of the tax credit and, therefore, involve no out-of-pocket premium costs at all), and the credits would help offset their costs if they chose more comprehensive options. Some individuals would find themselves better off remaining in their ACA-purchased coverage for a time and could do so, but the new system would grow more attractive each year as it brought down costs while the relative value of the ACA subsidies declined.

Providing for an adequate transition will not undermine the ultimate effectiveness of an ACA replacement plan. The goal is a functioning marketplace in which consumers decide how to allocate resources, all Americans have access to stable insurance, high-quality care and medical innovation are rewarded, and federal support for insurance enrollment is affordable for taxpayers. These are goals that are important for the long-term strength and vitality of the country and goals that are more likely to be reached if an ACA replacement plan wisely includes short-term transition provisions to defuse opposition.

Reforming Medicaid to Allow More State Control and Consumer Choice

Summary of Medicaid Reforms

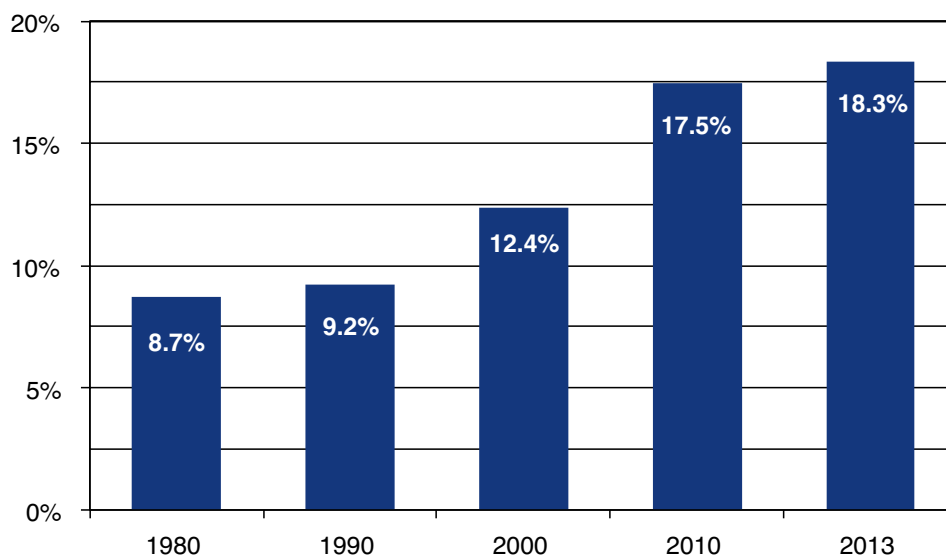
1. Pursue separate reform strategies for Medicaid's two distinct parts.
2. Finance Medicaid with fixed federal funding per Medicaid enrollee.
3. Integrate acute care Medicaid into market-driven health insurance reform.
4. Empower the disabled and frail elderly (and their families and caregivers).

The Medicaid program today bears little resemblance to the program Congress thought it was creating a half-century ago. Medicaid's creators thought they were providing federal structure and uniformity, as well as some funding, for the many state programs long in existence that were already providing "indigent care." The congressional authors of the legislation were not aware that what they were setting in motion was a program that would become the largest entitlement—by enrollment—in the United States. Today, Medicaid costs federal and state taxpayers some \$500 billion annually and serves about 66 million people.¹⁷

Medicaid's fundamental problem is rooted in its original legislative design. As a shared federal-state program, it is financed partly by the federal government and partly by the states, resulting in split political accountability. State officials often blame the federal government for imposing costly mandates in Medicaid, even as federal officials and agencies increasingly blame the states for using the program as a means of tapping federal taxpayers to solve their budgetary problems.

The method by which Medicaid's costs are assigned to the federal and state governments—a state-specific federal "match rate"—is a primary source of the program's perverse incentives. On average, the federal matching rate is now 62 to 64 percent of state Medicaid costs (depending on the year), meaning the federal government covers about \$0.62 of every \$1.00 in state-initiated Medicaid spending. Because there is no upper limit on federal Medicaid funding, states can reduce their budgetary costs if they are able to move programs traditionally financed with state-only funds under the Medicaid programmatic umbrella, thus drawing partial federal support. Not surprisingly, this has been a common practice among the states for many years.

Further, the Medicaid matching formula undermines the incentive for spending discipline at the state level. The shared financing of Medicaid means that states can initiate new spending in Medicaid and have it partially financed by federal taxpayers; the flip side is that state-initiated Medicaid spending cuts must also be shared with federal taxpayers. So, for instance, in a state where the federal government is financing 60 percent

Figure 5. Medicaid Enrollment as a Percentage of the US Population

Sources: US Census Bureau and CMS Actuary.

of Medicaid spending, the governor and state legislators face the unattractive prospect of keeping only \$1.00 in savings for every \$2.50 in Medicaid spending cuts they can identify and implement. The other \$1.50 in savings is returned to the federal treasury. This formula discourages cost cutting by politicians.

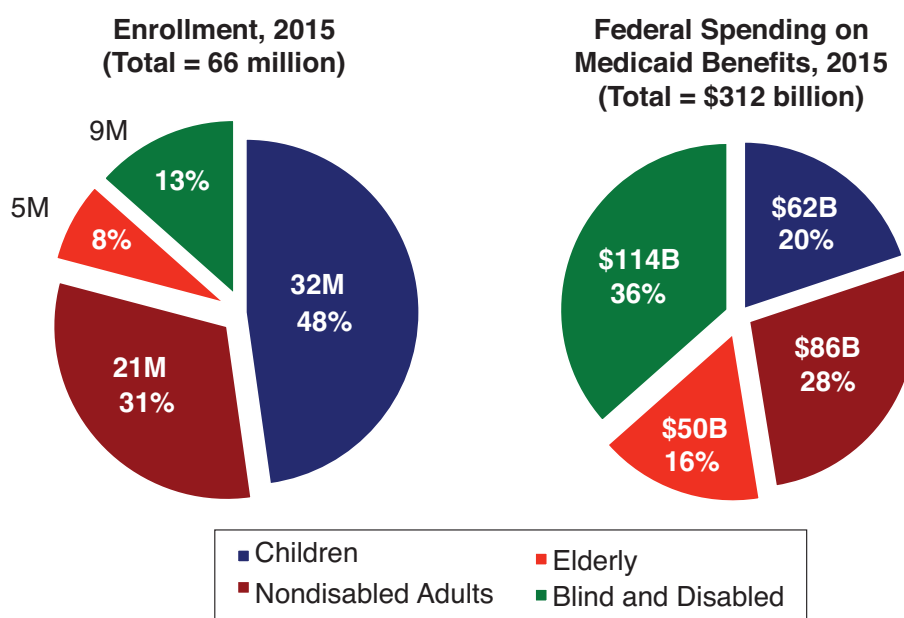
The federal matching system for Medicaid also distorts political accountability. Because of its large financial role in the program, the federal government has felt more than free to impose extensive regulatory control over the states. Indeed, the web of federal regulation of Medicaid is so pervasive that states often protest they do not have sufficient discretion to really manage the program. Thus neither federal policymakers nor state officials are obligated to take full responsibility for effectively managing program resources.

Medicaid's open-ended federal matching formula is an important reason for Medicaid's steady enrollment growth since the program was enacted. As originally conceived, Medicaid was to provide health insurance to the same families needing welfare support under the old Aid to Families with Dependent Children, replaced by Temporary Assistance to Needy Families in 1996. Over

the years, Congress has expanded the program steadily to many people, especially single women and their dependent children. In addition, as rules for determining what constitutes a disability have been eased, Medicaid has become a source of financing for many health and social services for this population. The end result, as shown in figure 5, is a program that has roughly doubled in size as a percentage of the US population.

Medicaid's Heterogeneous Population and Services

One of the challenges in reforming Medicaid is that the program is designed to subsidize different types of health coverage for several very different populations. Medicaid subsidizes health coverage for the disabled, for the Medicare-eligible elderly (dual eligibles), for children (including through the related Children's Health Insurance Program, or CHIP), for pregnant women and newborns, for parents and caretakers of low-income children, and for low-income able-bodied childless adults.

Figure 6. Medicaid Enrollment and Spending

Source: Congressional Budget Office, "Detail of Spending and Enrollment for Medicaid—CBO's March 2015 Baseline," March 2015.

As shown in figure 6, Medicaid is dominated by children and nondisabled adults, including pregnant women. These groups make up almost four-fifths of all persons enrolled in Medicaid. The elderly and the disabled comprise just 21 percent of Medicaid participants.

However, the distribution of expenditures is an altogether different story. In FY 2015, more than half of Medicaid spending is expected to go toward services for the elderly or the disabled, and less than half will go toward services used by children and nondisabled adults. The higher concentration of spending on the elderly and disabled is due to the much more expensive and intensive services needed for these populations.

Reforming Medicaid, therefore, requires consideration of the very different service needs of these populations.

Medicaid's Poor Health Outcomes

The large amounts spent on Medicaid might be viewed as appropriate if the program were delivering sound

results for its enrollees. Unfortunately, there is ample evidence that Medicaid provides inferior access to care for its participants, especially for nondisabled adults and their dependent children, with real consequences for their health.

- A landmark study published in 2013 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.¹⁸ 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, although those enrolled in Medicaid did show some improvement in their mental health.
- Other studies have found similar results. A University of Virginia study published in the *Annals*

of Surgery examined outcomes for 893,658 individuals undergoing major surgical operations from 2003 to 2007.¹⁹ 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. The death rates for Medicare, uninsured, and Medicaid patients were, respectively, 54 percent, 74 percent, and 97 percent higher 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. Ironically, Medicaid had these worse outcomes even as it spent more per patient than private insurance. According to the authors, Medicaid patients cost, on average, 26 percent more than those enrolled in private insurance.

- A University of Pennsylvania study published in *Cancer* found that, for 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 percent for those with private insurance.²⁰ The rate of surgical complications was highest for Medicaid, at 26.7 percent, compared with 24.5 percent for the uninsured and 21.2 percent for the privately insured.
- 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. Medicaid patients did outperform the uninsured on late-stage colon cancer (11 percent less likely to have late-stage cancer).²¹

Low Reimbursement Rates Result in Poor Access to Care

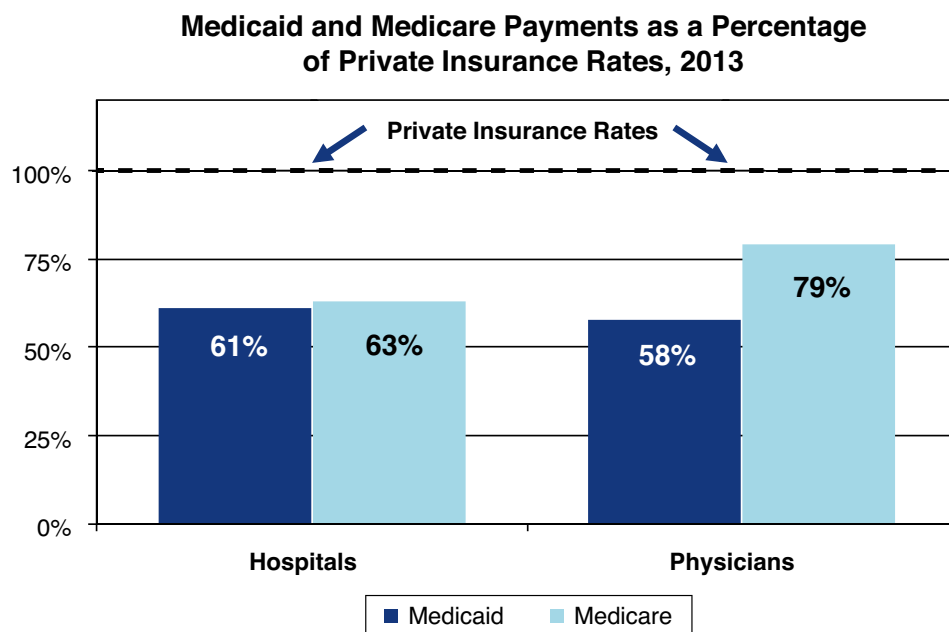
Why do patients fare so poorly on Medicaid? The key reason is that Medicaid pays physicians and other providers of medical services far below market rates to care for program enrollees.

As shown in figure 7, Medicaid pays physicians, on average, about 58 percent of what private insurers pay for the same services and only about 73 percent of what Medicare pays. Medicaid's payments for hospitals are also very low relative to private insurance payments, at about 61 cents on the dollar.

In 2012, Sandra Decker of the National Center for Health Statistics at the Centers for Disease Control published research in *Health Affairs* describing a strong correlation between low Medicaid reimbursement rates and low physician acceptance of Medicaid-enrolled patients. A 10 percentage point increase in the ratio between Medicaid and Medicare fees correlated to a 4 percentage point increase in doctors' acceptance rates.²²

States with the poorest physician acceptance of Medicaid—New Jersey, California, Florida, Connecticut, Tennessee, and New York—are also among the states with the lowest physician reimbursement rates for Medicaid.

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 1.²³ Among clinics that did accept both Medicaid/CHIP and privately insured children, the average wait time for an

Figure 7. Medicaid versus Medicare and Private Insurance

Source: John D. Shatto and M. Kent Clemens, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," Office of the Actuary, Centers for Medicare and Medicaid Services, July 22, 2015.

appointment was 42 days for Medicaid and 20 days for the privately insured.

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.

Low reimbursement rates are a predictable byproduct of Medicaid's dysfunctional fiscal structure. 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 copays, 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 review process by

the federal 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.

Restructuring Medicaid Financing

Medicaid reform must begin with a restructured relationship between the federal government and the states.

One approach would be to convert the federal contribution to the states into a fixed federal block grant that would not be altered based on additional state spending. Medicaid funding could also be divided into two funding streams, one for the disabled and elderly and the other for everyone else. This would allow states to pursue separate reforms for these very different populations, who have very different needs in terms of medical and social services.

The idea of a block grant is to provide budgetary certainty to the federal government and the states and to provide strong incentives to the states to manage the federal funding prudently. Under a block grant, cost overruns at the state level would be financed entirely by state taxpayers, not the federal government. Conversely, the federal contribution to a state would not decrease if the state found ways to reform the program and save money.

All of the savings from rooting out waste and efficiency would accrue to state taxpayers.

The key issue in converting to a block grant is establishing the basis by which the federal government will make payments to the states. One option would be to examine historical Medicaid spending levels by the federal government in the various states over a particular number of preceding years. The first year of the block grant could then be calculated as the average of federal Medicaid spending in the state per year during that time, inflated to the year in question by the national Medicaid spending growth rate.

*Medicaid pays physicians, on average,
about 58 percent of what private insurers
pay for the same services and only about
73 percent of what Medicare pays.*

Once the first year is settled, the question becomes how to inflate the federal Medicaid block grant amounts in future years. The indexing options include using the CPI, which historically is well below medical inflation, the growth rate of the national economy as measured by gross domestic product, or perhaps a measure of national or regional health spending growth. The decision on indexing is highly consequential because alternative approaches can result in large differences in federal spending over time. If the block grant is pursued in part to help ease the nation's severe, long-term budgetary challenges, then indexing the block grant amounts to something below the historical rate of growth for Medicaid can produce significant savings estimates, especially over the long term.

Opponents of the block grant concept argue that it will necessarily result in a reduction in services for vulnerable populations. But that is far from certain; the current program, with open-ended federal matching payments, provides strong incentives to the states to move as much spending as possible under the Medicaid umbrella, and little incentive to carefully scrutinize expenditures. With a block grant, the states would have strong incentives to eliminate waste without undermining coverage for those who truly need it.

In 1996, similar arguments were made about the block granting of welfare funding, with predictions that it would lead to significant hardship for the program's enrollees. What happened instead is that the states reviewed who was on the cash assistance program and quickly found that many of them were capable of entering the workforce and improving their household incomes from wages instead of government assistance. By 2000, the cash welfare rolls had fallen by about half even as the population in the bottom fifth of the income distribution experienced substantial gains in their real incomes.²⁴

Health coverage is more complicated than cash welfare, but there is every reason to expect that substantial inefficiency exists in Medicaid and that a block grant would provide the incentive to find and eliminate it.

Still, concerns about the effect that a block grant might have on health services for the vulnerable has led to proposals that mitigate against some of the financial risks a block grant would entail. The most prominent example of such a proposal is what is known as "per capita caps."

Under per capita caps, the federal government would establish for each state a per-person payment for each of the main eligibility categories in the Medicaid program: the elderly, the blind and disabled, nondisabled adults, and children. The federal government would then make payments to the states based on the number of Medicaid enrollees in each of these categories. The per capita payment would be based on historical spending rates for the various categories of beneficiaries in each state and, again, would be indexed to a predetermined growth rate.²⁵

Per capita caps in Medicaid would have the same advantages as a block grant in that the states would

have strong incentives to use the federal funding wisely. The amount of the federal payment per person would be the same regardless of how much the state spends on each enrollee. The only difference with the block grant is that the states would not be at risk for increased enrollment in the program because the per capita payments would be made for all enrollees in the program, including those who might not have been expected to sign up and thus were excluded from the block grant formula. This could be important in times of slow economic growth or during a recession, when Medicaid enrollment typically surges.

Perhaps most important, per capita caps have enjoyed bipartisan support in the past. In 1995 and 1996, the Clinton administration proposed Medicaid per capita caps as part of a larger balanced budget plan. That proposal was explicitly endorsed by 46 Senate Democrats in a letter to the president in December 1995.²⁶

The key to Medicaid reform is moving away from the matching rate formula for financing the program. That is accomplished with the per capita allotment approach to federal funding in a way that allows for more enrollment flexibility and perhaps more bipartisan support. For these reasons, policymakers should make implementation of per capita federal payments to the states the centerpiece of a Medicaid reform plan.

Integrating Medicaid with Health Insurance Reform

With more flexible federal funding streams for the two distinct parts of Medicaid (the disabled and elderly and nondisabled adults and children), states would be free to pursue reforms of their choosing.

However, federal law should provide a basic template for the programs that represents a default structure of reform. States would implement programs based on this structure and would be free to adjust it as they saw fit from the basic federal template. A template would provide some guidance to the states about what kinds of reforms are likely to work best because of their compatibility with the rest of the reforms we have proposed. Moreover, the history of Medicaid indicates that many states lack the resources to design and

build a reform program entirely from scratch and that a starting template is likely to spur effective action rather than inhibit it.

The objective of this template for the nondisabled and their children should be full and seamless integration with the health insurance reforms contained in the replacement plan for the ACA outlined in the previous chapter.

What is needed throughout the health sector is a better-functioning marketplace for insurance and health care services. By necessity, a marketplace will need to have special accommodations for lower-income households to ensure they have affordable access to care. But that does not mean they must be enrolled in a program that is completely set apart from what is available to everyone else.

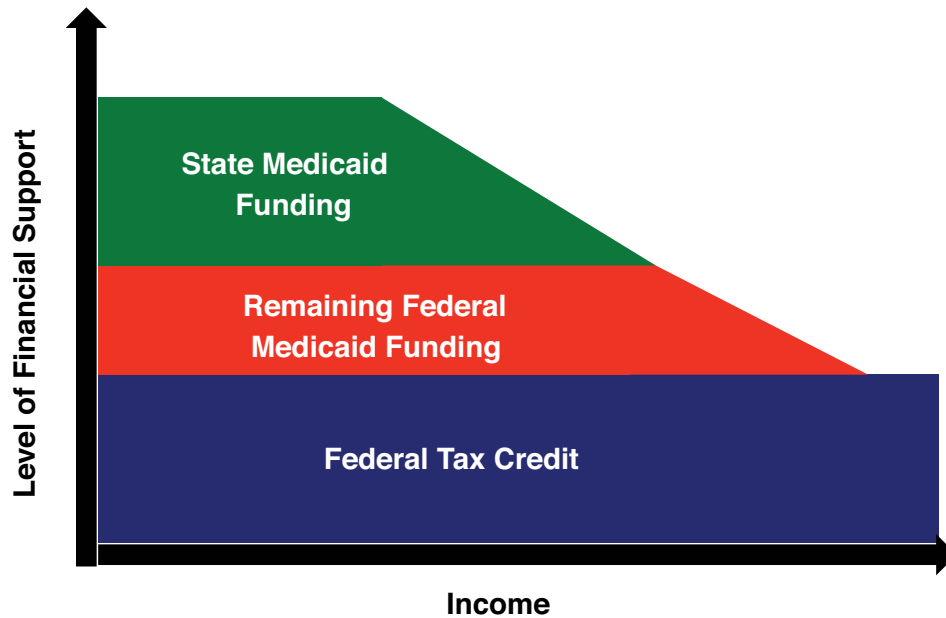
Separate insurance arrangements for those on Medicaid and for those more strongly attached to the workforce creates discontinuity in coverage for those who move into higher-paying jobs and thus lose their Medicaid eligibility. It would be far better for Medicaid beneficiaries if they received health insurance subsidies that allowed them to keep the same coverage when they got better-paying jobs. The subsidies would be withdrawn gradually as their ability to pay for premiums on their own increased. But they would not be forced to abruptly switch insurance plans, and potentially also doctors, simply because they moved up the wage scale.

A plan to integrate Medicaid into the larger reform of health insurance would include the following key reforms:

Integration of Medicaid with the Federal Tax Credit.

The federal tax credit proposed in this ACA replacement plan could serve as the foundation of federal support for the Medicaid population as well. This would allow Medicaid enrollees (again, the nondisabled and their children) to enroll in the same health insurance plans made available to other state residents. Importantly, the Medicaid participants would stay enrolled in these plans even if they went off Medicaid as their incomes rose with better-paying jobs.

Of course, the tax credit would be worth less than Medicaid coverage, and low-income families are not likely to have enough resources to pay large premiums

Figure 8. Integrating Medicaid with Federal Tax Credits

Source: Authors.

for coverage themselves. Thus, the federal tax credit would need to be supplemented with a reformed Medicaid program that would be converted into a supplemental payment to participants offsetting an additional portion of their premium.

The states would have wide discretion over amounts of additional premium assistance provided through Medicaid and how that assistance would be phased down as incomes rise. Figure 8 illustrates the how the combination of Medicaid and the federal tax credit would be combined to provide support for insurance enrollment.

The amount of Medicaid support beyond the federal tax credit would be set based on a combination of household income and some measure of the premium necessary for an average cost plan. The very lowest-income households would receive premium assistance covering most of the cost of a standard plan. The state could then design a schedule by which the subsidy was reduced gradually as incomes rose. (The state could choose to phase out the subsidies differently than provided for in the ACA.) In this system, the Medicaid

participants and the population receiving subsidies under the ACA would be grouped together in the same program.

The combined federal tax credit and Medicaid assistance would be delivered to enrollees in the form of defined contribution payments. This would ensure the program participants, like those receiving just the federal tax credit, would be cost conscious in their choices of insurance plans and the mechanisms by which they access care.

This approach to financing coverage would give the states substantial budgetary control. If a state found that the total cost of the program would exceed its available funding, it could accelerate the phaseout of the subsidies by income, reduce the defined contribution payments for all participants by a fixed percentage, or change the definition of a standard coverage plan.

Using the federal tax credit as the foundation for financial support for Medicaid participants would require adjusting the per capita payment amounts to the states for the Medicaid portion of the premium assistance. In effect, a portion of the federal financial

support would go directly to the program participants in the form of the refundable tax credit, and therefore the aggregate amount of federal funding for these credits should be deducted from the federal Medicaid payment to the states. The federal government would then provide a residual amount in flexible federal per capita payments, and the states would supplement that funding with whatever Medicaid funding is required from them as part of their shared responsibility for the program.

State-Regulated Insurance Offerings. States would set the terms of the insurance offerings made available to subsidy-eligible program participants, just as it would under the ACA replacement program proposed in the previous chapter.

State-Determined Mechanism for Choosing Plans. States could also choose to have a separate insurance enrollment program for its Medicaid population, or they could choose to integrate Medicaid recipients into whatever arrangement is established for the tax-credit-eligible state residents.

The ACA's Medicaid Expansion and Reform of the Program

The ACA included a provision for expanding Medicaid coverage to all persons with incomes below 138 percent of the FPL, which, in 2015, is \$33,465 in annual income for a family of four. Initially, the intent was to force the states to adopt the expansion, which would mainly extend coverage to many millions of childless adults. But the Supreme Court ruled that the law's penalty on states for noncompliance—loss of full federal Medicaid funding—violated the Constitution's federalist principles.

As a result, states have the option to expand the program, but there is no penalty for declining to do so. So far, 31 states and the District of Columbia have taken the option to expand, while 19 states have not. States that have expanded their programs are now receiving substantial additional federal funding for their Medicaid programs compared to the states that have declined to expand.

The wide federal funding gap between expansion and nonexpansion states poses a problem for national reform of the program. Moving toward per capita payments to the states should be based not only on historical spending in the states but also on a fair standard for basing enrollment in the program across all states.

The most sensible approach is to provide a transition over a period of years to a new standard, which would be below the expansion included in the ACA but above the levels observed today in nonexpansion states.

We recommend a five-year transition to this new Medicaid eligibility standard, which would be roughly halfway between the ACA expansion level and the eligibility levels prevalent in the nonexpansion states. As noted previously, a transition away from the ACA should also include protection for everyone who signed up for Medicaid under the ACA's rules. They should be allowed to stay on the program indefinitely until they cycle off naturally.

Reforming Medicaid's Long-Term Care Program

We do not recommend a universal template for state reform of the part of Medicaid assisting the disabled and elderly. However, many states have been pursuing reforms over the past decade to give disabled and elderly participants in Medicaid more control over the resources devoted to supporting their daily activities and medical needs, and, with per capita federal payments, states could more aggressively pursue these reforms without federal interference, as well as try new approaches.

An important and promising theme of many state efforts is more direct patient and family control over the allocation of resources to actual service delivery providers. These efforts, often called Money Follows the Person (MFP), attempt to transition disabled and elderly Medicaid participants out of nursing homes and into their own homes or group homes by directing resources to service providers promoting independent living.²⁷ In addition to MFP, most states have made

extensive use of home and community-based waiver programs, which allow the states to contract directly with service providers on behalf of elderly and disabled citizens in an attempt to keep them out of nursing homes altogether.

These movements have been very important developments within Medicaid administration, even if their reach is still too limited and the degree of true consumer direction too circumscribed. With per capita federal payments, states will have the freedom to move much more aggressively on reforms of this kind because they will not have to seek federal permission first, thus increasing the potential for large cost reductions and better service to program participants.

Conclusion

The policy debate about Medicaid often revolves around its fiscal problems—and rightly so. But while well-structured reforms of Medicaid should reduce America's long-term fiscal liabilities, that should not be their primary purpose. Instead, reform should ensure that those enrolled in Medicaid today have good health care and, for the nondisabled, strong incentives to improve their incomes and support themselves.

The opportunity to reform Medicaid is an opportunity to stimulate important innovation in the delivery of personalized, high-quality care. It is an opportunity to reward those who make responsible decisions and to transform the lives of tens of millions of low-income Americans.

A Market-Based Reform of the Medicare Program

Summary of Medicare Reforms

1. Adopt the premium support reform model.
2. Improve the competition between Medicare Advantage and fee-for-service.
3. Promote consumer decision making.
4. Modernize Medicare's benefits.
5. Reform Medigap and other supplemental coverage.
6. Reform Medicare's payment policies, and eliminate unnecessary bureaucratic controls.
7. Provide greater administrative flexibility in local markets.
8. Gradually raise the eligibility age to 67.

Medicare is the key to health security for more than 50 million seniors and disabled people, but it is at the heart of the fiscal challenges facing the country. The Congressional Budget Office (CBO) projects that the program will spend \$626 billion in 2015, making it the third-largest category of federal spending after Social Security and defense.²⁸ Because of perverse financial incentives and burdensome regulations that encourage wasteful spending and fail to promote efficiency, neither the beneficiary nor the taxpayer gets full value for the money spent on Medicare.

The recent slowdown in health spending—including a sharp reduction in the growth of Medicare spending—does not signal that we have bent the health cost curve down or that Medicare's fiscal future is sound. Much of the slowdown is due to the deep recession that ended in 2009 and the subsequent weak recovery.

Some observers credit the ACA with bending the health cost curve down.²⁹ Although the administration has vigorously promoted accountable care organizations, value-based purchasing programs, and bundled-payment pilot projects as ways to reduce Medicare spending without reducing patient access to care, these initiatives have been slow to start, and the early returns have not been promising.³⁰

Instead, the ACA relies on cuts in Medicare payments that lower rates without changing the flawed payment mechanisms that promote excessive use of services. CBO estimates that if those cuts are taken, they account for \$715 billion in spending reductions used by the ACA to offset the cost of the new subsidies for insurance purchased on the exchanges.³¹ But those cuts in payments to hospitals and other providers soon would impose financial losses on many providers, according to CMS actuaries.³² Even if such cuts are implemented, they do nothing

to make Medicare a better-functioning program for the future.

There are already signs that health care costs and Medicare spending have resumed their rapid growth. CMS actuaries recently reported that national health spending will grow an average 5.8 percent per year over the next decade, up from about 4 percent in recent years.³³ Medicare spending is also expected to rise sharply, growing at 7 percent annually over the decade. Moreover, the Medicare trustees predict in their most recent report that the Medicare Trust Fund will run out of money in 2030.³⁴

Medicare is the largest individual payer in the health system, and its policies shape how health care is delivered in this country. A carefully designed series of reforms can set Medicare on a more sustainable fiscal path while providing more sensible coverage to its enrollees. If we hope to move to an efficient consumer-oriented health care system, we must reform Medicare.

Medicare's Core Problems

Over the next two decades, the baby boom generation will shift from working and paying the taxes that support Medicare to retiring and receiving benefits. That massive demographic wave, coupled with the continuing trend toward greater use of increasingly expensive—and increasingly effective—medical services, will put unprecedented strain on the country's ability to finance the program. None of this comes as a surprise, yet Medicare is ill-prepared to meet the challenge.

Medicare suffers from structural problems that were designed into the program at its inception and have never been seriously addressed by policymakers. Some program changes—including adding private plan choices (under Medicare Advantage and its predecessors) as an alternative to traditional Medicare and the competitive prescription drug benefit (under Part D)—have introduced consumer-oriented options, but more often than not legislative and regulatory changes have avoided altering the basic design of the program.

Medicare suffers from numerous systemic shortcomings that prevent the program from providing the coverage people need efficiently and effectively.

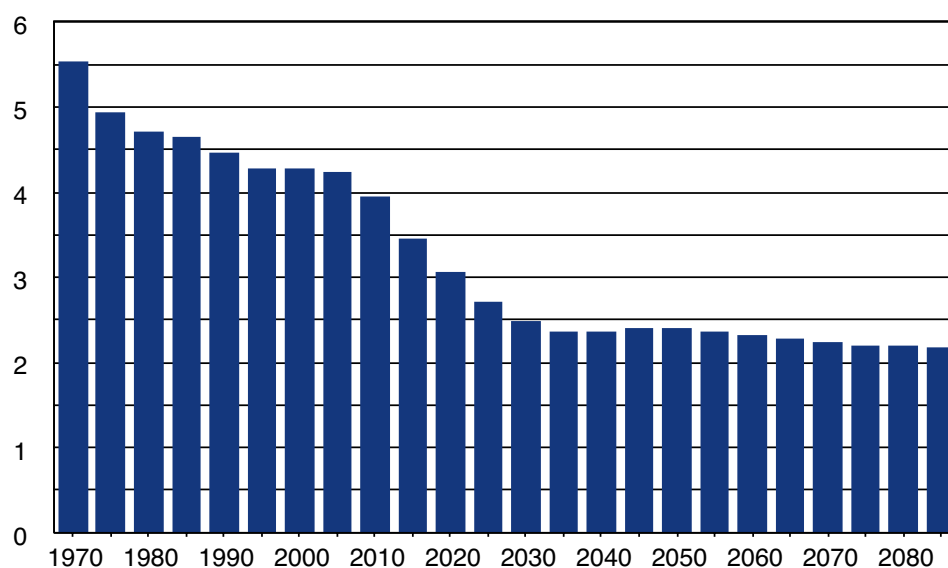
Medicare Primarily Benefits the Elderly, but Is Primarily Paid for by the Young. Workers and their families are increasingly bearing the rising cost of Medicare. The program has three primary sources of financing: the Medicare payroll tax (which provided \$227 billion to the program in 2014), general revenue (\$249 billion), and premiums paid by beneficiaries (\$80 billion).³⁵ Lesser amounts come from taxes on Medicare benefits, transfers from states, and other sources. More than three-quarters of Medicare's annual spending is paid for by workers through the payroll tax and income taxes that contribute to general revenues.

The consequences of the upward trend in Medicare spending for workers and for the program are serious. In 2030, when the last of the baby boomers retire, there will be nearly 82 million people on Medicare, up from about 55 million today. But fewer working people will be funding the benefits of this much larger retiree population. The result is a rapid decline in the ratio of the working-age population to Medicare beneficiaries, as shown in figure 9. In 1980, there were 4.7 Americans of working age for every Medicare beneficiary. By 2030, the ratio will have fallen to 2.5, and it will be just 2.4 by 2050.

Improvements in our ability to diagnose and treat disease also drive up program spending. As new medical technologies and services are developed and adopted, both the use of services by Medicare beneficiaries and the cost of those services are likely to increase. More beneficiaries will use more services that are more effective in treating disease, which will lead to longer lives. But as this older population ages, they will likely require even more services.

Providing an increasingly expensive service to a rapidly growing population while drawing on a fast-declining pool of taxpayers is a recipe for fiscal doom. Not only will Medicare spending outpace the revenue collected to support the program, but it will also reduce the funds available to pay for other government programs and activities. As baby boomers age, pressure will grow to control the cost of Medicare without reducing benefits.

FFS Provides Strong Incentives for High Use of Intensive Services. Traditional Medicare pays health

Figure 9. The Ratio of Working-Age Population to Medicare Enrollees

Sources: 2015 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds and 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 2015.

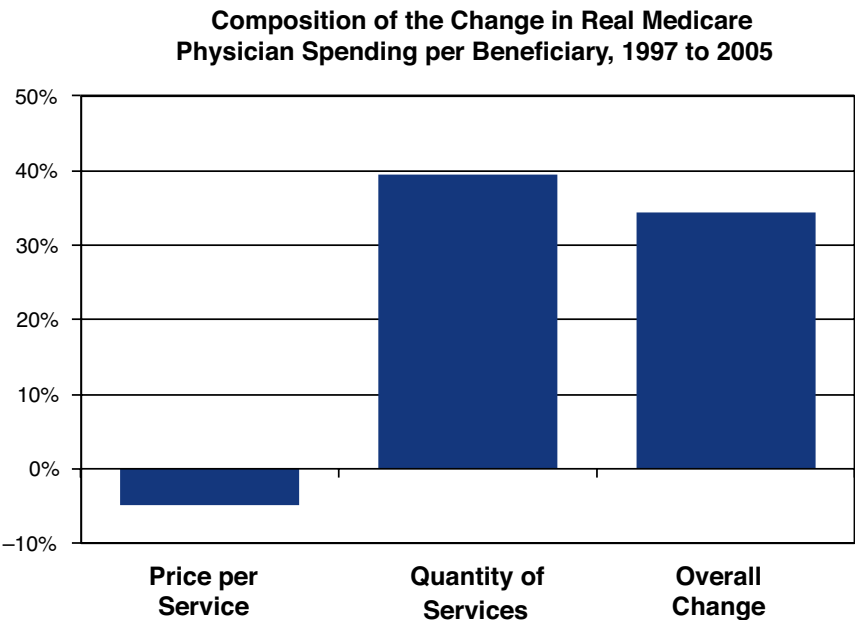
care providers on a fee-for-service (FFS) basis. As the term suggests, health care professionals and facilities are paid for each service they provide—the more services provided, the more fees will be paid. Accordingly, reimbursement under a FFS model generates a strong incentive for a high volume of tests, procedures, inpatient stays, and outpatient visits, including those that have questionable potential to improve health.³⁶

The strong incentive within FFS for physicians and others to provide ever-increasing amounts of services to the patients is reflected in figure 10. Over the period of 1997 to 2005, CBO found that Medicare's overall cost of physician care per beneficiary went up by 35 percent in real terms (after controlling for price inflation). But this increase in cost was not due to a real increase in the prices Medicare paid for services. In fact, over that eight-year period, Medicare's payment rates for physician services declined in real terms by nearly 5 percent. This decline in real prices was overwhelmed by the large 40 percent increase in the volume of services provided by physicians to Medicare beneficiaries over that same period of time.

The incentive to generate income by performing more tests and procedures is exacerbated by having most of the costs typically paid by Medicare, masking the true cost to consumers. The economic incentives are particularly strong for services with high fixed costs, typically those making extensive use of medical equipment, such as imaging services. Under Medicare payment methods, more complex services are paid at higher rates. Consequently, we have seen an increase in both the volume and complexity of services. In addition, Medicare typically does not pay for less traditional services that can be important for the management of serious illnesses, especially chronic disease, such as patient education and coordination of care with other providers. This reinforces a delivery model that relies heavily on in-person contact between patients and physicians.

Medicare Beneficiaries Are Insulated from the Cost of Care. Medicare requires beneficiaries to pay part of the cost of their care through deductibles, copayments, and other cost-sharing requirements. Those requirements are intended to reduce the program's spending

Figure 10. Volume in the Medicare Physician Setting



Source: Congressional Budget Office, “Factors Underlying the Growth in Medicare Spending on Physician Services,” Background Paper, June 2007.

while making beneficiaries more cost conscious. In 2015, Medicare requires a \$1,248 deductible for each inpatient hospital stay, a \$147 deductible for physician and other outpatient services, and a 20 percent coinsurance payment for each physician office visit and service.

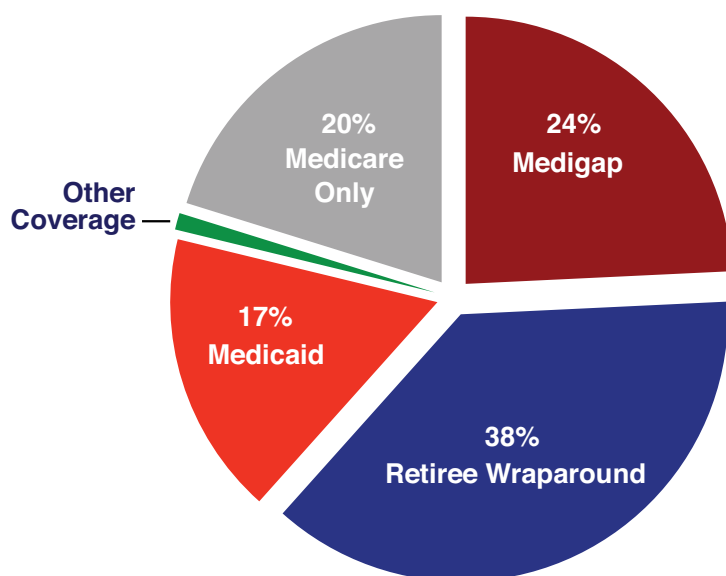
However, as shown in figure 11, the majority of enrollees in traditional Medicare—80 percent in 2011—have supplemental coverage through Medigap, retiree plans, or Medicaid.³⁷ These secondary insurance plans fill in most of the costs not covered by Medicare. Moreover, Medicare limits the amount that providers can charge above the government’s payment rate. Consequently, most FFS enrollees directly pay out of pocket only a small part of the full cost of their health care.

Supplemental coverage insulates the patient from the cost of their care, making patients less careful purchasers of health care than they otherwise would be. This problem is compounded by the general lack of price information that exists throughout the health sector, making it extremely difficult for consumers to weigh the costs of their medical alternatives.

Competition Is Limited in Medicare. Beneficiaries have the choice of traditional Medicare or a private competing plan offered under Medicare Advantage (MA). MA plans offer a better deal than traditional Medicare for many beneficiaries. They cover the basic Medicare benefit and often provide additional benefits (such as vision or hearing coverage). Faced with premiums for Medicare Part B and Part D as well as the added cost of a Medigap plan, many lower-income beneficiaries choose MA. In 2014, 15.7 million beneficiaries, or 30 percent of the Medicare population, enrolled in MA plans—up from 10.5 million in 2009.³⁸

MA plans receive a fixed monthly payment for each enrollee (known as a capitation payment) to provide Medicare benefits. Because the capitation payment does not change regardless of the volume of services delivered to the patient, MA plans have strong incentives to reduce unnecessary use and to provide care more efficiently.

The plans submit premium bids that are used to determine the amount of the capitation payment.

Figure 11. Additional Coverage Arrangements for Medicare FFS Beneficiaries

Source: Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, June 2015, Chart 3-2.

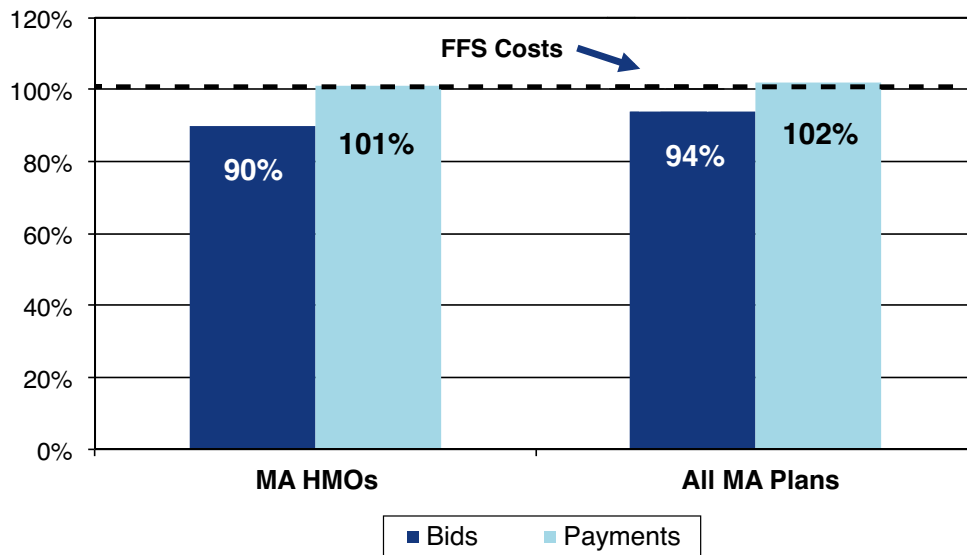
However, this bidding process remains flawed because FFS is excluded from it. Congress has left FFS out of the bidding to ensure FFS enrollees pay no more than the current law Part B premium. With FFS excluded from the bids, it would not be possible to have a full competitive bidding model among just the MA plans without driving down MA enrollment. Congress has created a hybrid payment model based in part on bids from the MA plans and in part on reference to a benchmark in the local market, which is generally well above FFS costs. The use of benchmarks tends to bias bids upward, resulting in higher cost to Medicare than necessary. A less complex alternative would eliminate the benchmark and require bids from both MA plans and FFS Medicare in each market area, with the bids representing the projected cost of providing benefits to a representative enrollee.³⁹

Indeed, it is clear from current MA bids that a level playing field of competition between FFS and MA would lower overall Medicare costs substantially. As shown in figure 12, MA plans submitted premium bids in 2015 that were, on average, 6 percent below the cost of providing coverage through FFS. MA HMOs were

able to submit even lower bids—10 percent below the cost of FFS. Under current rules, actual payments to the MA plans were just above FFS costs because of the influence of the law's system of MA payment benchmarks. Nonetheless, it is clear from these data that MA plans have the capacity to provide Medicare-covered benefits at substantially less cost than FFS, and this cost differential could be translated into savings both for the beneficiaries and the government.

Medicare Part D has not been saddled with the same complicated bidding process as MA (because there is no government-run FFS option), and that has helped Part D hold down cost. Premiums and subsidies are based on the national average of plan bids, which reflect each plan's expected benefit payments and administrative costs. No cap limits the allowable growth in federal subsidy amounts from year to year. Instead, the cost of Part D depends solely on the strength of plan competition and the responsiveness of consumers to changes in their costs.

Part D's cost experience has been far better than initially anticipated.⁴⁰ At the start of the program, the CBO estimated that the prescription drug program

Figure 12. Medicare Advantage HMOs versus FFS: Bids and Payments, 2015

Source: Medicare Payment Advisory Commission, *Healthcare Spending and the Medicare Program: A Data Book*, June 2015, Chart 9-6.

would cost \$509 billion between 2006 and 2011 and \$768 billion by 2013.⁴¹ In contrast, the Medicare trustees report that federal outlays for Part D totaled \$336.4 billion through 2011.⁴² By 2013, the program will have spent \$485 billion—37 percent less than the CBO estimate.

Part of this difference is undoubtedly the result of faulty assumptions in the original estimate. Enrollment in Part D has been lower than expected, and the slower introduction of new drugs, coupled with the movement of branded drugs to off-patent status, has contributed to the slower cost growth.⁴³ But we also saw considerable price sensitivity on the part of seniors and aggressive discounting by pharmaceutical manufacturers as plans finetuned their formularies and steered patients toward lower-cost drugs.

Medicare Price Controls Are Ineffective and Distort Treatment Decisions. Medicare's prices—the payment rates for services provided by health care providers—are set administratively and are the main tool used by FFS Medicare to slow the growth of program spending. Legislation that lowers the annual update (which

controls the increase in payment rates) yields program savings as scored by CBO.

Medicare's price controls at best yield short-term slowdowns in program spending. Because traditional Medicare operates on a fee-for-service basis, savings from reducing the annual update are offset by increases in the volume and complexity of services provided. Future savings may be reduced or eliminated if Congress decides to reverse payment reductions enacted previously.

The best known example of the failure to maintain Medicare payment cuts is the sustainable growth rate (SGR) formula used to limit the growth of Medicare physician payments. Because the SGR formula was cumulative, every override added to a future payment reduction. By 2015, the physician payment update was to have been reduced by 21 percent, causing CMS to delay implementing the cut to give Congress a chance to pass a permanent alternative (known as the "doc fix") that avoids extreme payment reductions in the future.⁴⁴ Between 2002 (the first year that the SGR called for a reduction in the payment update) and 2014 (the last year the SGR was in force), Congress passed

17 separate pieces of legislation to override the SGR payment cut for periods ranging from one month to two years.⁴⁵

The ACA imposes its own version of formulaic reductions in payment updates, and they are likely to be as unrealistic as the SGR was. An annual adjustment on payment updates based on economy-wide productivity gains was imposed by the ACA for most of the services covered by FFS Medicare. CMS actuaries point out that measured productivity gains for the health sector have been much lower than economy-wide productivity gains, and it is unlikely that Medicare providers will be able to match them.⁴⁶ The actuaries estimate that 15 percent of hospitals would lose money on their Medicare business by 2019, largely as a result of the productivity adjustments. By 2040, half of all hospitals in the country would have negative profit margins across all lines of business, raising concerns about access and quality of care for Medicare beneficiaries.

The way in which CMS sets individual prices for services is just as important as the rate at which they increase from year to year. Each type of service, from inpatient hospital care to home health to physician services, has its own complex price-setting system. As a result, Medicare's prices do not adjust quickly to changes in either the supply of or the demand for a specific service. If Medicare over- or underpays for a specific service relative to clinical alternatives, that discrepancy is likely to persist for years. Systematic underpayments eventually reduce the availability and use of the affected services in favor of better-compensated alternatives. Systematic overpayments for some services may encourage their use instead of more cost-effective alternatives.

Medicare's physician payment system illustrates the complexity of the program's price-setting mechanisms.⁴⁷ The Medicare physician fee schedule sets the reimbursement rates for about 7,000 procedures and services, ranging from normal office visits to hip replacement surgery. The resource-based relative value system (RBRVS) assigns a score to each procedure accounting for the amount of work required to provide a service, expenses related to maintaining a practice, and liability insurance costs. Payment rates are adjusted for geographic differences, with lower-cost localities receiving lower payments.

The RBRVS is founded on the simple, but incorrect, view that higher payments are justified for services that require greater inputs—ignoring the consumer side of the market. When medical practice changes and a complex and difficult treatment is replaced by one that is as effective with fewer complications for the patient, Medicare's prices for the physician's services do not change because the RBRVS does not reflect market conditions. Without price controls, those prices would adjust automatically, helping to reallocate resources to their best use.

Medicare's administered prices often exceed market prices for the same services. Stanford professor Daniel Kessler points out that this “lead[s] providers to furnish more of these ‘profitable’ services than beneficiaries need. . . . In addition to causing wasteful spending, unnecessary procedures increase the risk of medical errors.”⁴⁸

Medicare's administered prices often exceed market prices for the same services.

The Medicare Benefit Is a Relic of the 1960s. Traditional Medicare's complex benefit structure is unlike any modern health insurance plan. Everyone who is eligible for Medicare is enrolled in Part A (which covers hospital and other services), but they must choose to enroll in Part B (which covers physician and other outpatient services). Prescription drug coverage under Part D was not available until 2005, decades after such coverage became common among private health plans.

Part A and Part B have different cost-sharing rules that are unlike the cost-sharing requirements typical in employer-sponsored plans. Those cost-sharing requirements and limitations on coverage expose enrollees in traditional Medicare to significant financial risk. For example, Part A requires a substantial payment—\$1,248 in 2015—from a beneficiary who is admitted to a hospital on an inpatient basis. That beneficiary may be required to pay this “hospital deductible” more than once during the year, depending on the circumstances of subsequent admissions. Unlike all private plans,

Medicare also does not comply with the ACA's out-of-pocket maximum requirement, which limits how much beneficiaries must pay in deductibles, copayments, and other out-of-pocket expenses during the year.

Because traditional Medicare's benefit is confusing and financially risky, the majority of enrollees obtain additional coverage through Medigap, retiree plans, or Medicaid to fill in the gaps, but they also promote greater use of covered services, adding to program cost. These problems also encourage individuals to enroll in Medicare Advantage, which offers up-to-date health plans that are often more generous than the traditional program.

Medicare Regulations Discourage Innovation and Interfere with Sound Patient Care. Medicare is a highly regulated program that imposes numerous, sometimes conflicting, requirements on health care providers. The combination of payment rates that do not keep up with the cost of providing services and increasing regulation is prompting physician practices to join local hospital systems that have the infrastructure and financing needed to operate successfully.

Provider consolidation in local markets reduces competition, which results in higher prices charged to patients with private insurance. Consolidation can bring with it some efficiencies. For example, the cost per patient of installing and maintaining an electronic medical records system can be reduced with more providers (and more patients) using the same system. But consolidation does not reduce the challenge of making fundamental improvements in care delivery seen in large health systems such as Kaiser Permanente or Geisinger Health System. Consolidation alone creates larger delivery systems, not more efficient ones.

The top-down approach taken by Medicare impedes the development of new ways to deliver care and treat patients. For example, most patients with end-stage renal disease (ESRD) are unnecessarily limited to FFS Medicare and are not permitted to join an MA plan. That leaves kidney patients, who often have other comorbidities, to fend for themselves in the disorganized FFS program that finances individual services rather than addressing all the health needs of the patient in a coordinated way.

Some kidney patients have another option: Medicare special needs plans (SNPs) that specifically accept people with ESRD. The idea behind SNPs is that a specialized MA plan will be able to more closely manage these patients, reducing morbidity associated with chronic ailments and potentially reducing Medicare cost. There were 115 SNPs for patients with chronic conditions in 2012, but very few of them accepted ESRD patients.⁴⁹ However, payment cuts enacted in the ACA are reducing the already-limited number of plans available to patients with special needs.

The ACA established the CMS Innovation Center with a \$10 billion budget to test new payment and delivery system models. Such a massive investment in research can yield useful insights and improvements in the way Medicare operates. However, the CMS approach is overly prescriptive, which limits the potential for developing innovative approaches that can adapt to local conditions while producing better care at lower cost.

A case in point is the Pioneer ACO Model, an Innovation Center initiative designed to support organizations that can provide more coordinated care to beneficiaries at a lower cost than FFS Medicare.⁵⁰ By providing bonuses to groups of providers that coordinate patient care and reduce unnecessary services, ACOs attempt to reproduce the incentives of MA plans (which receive a fixed per capita payment) in FFS Medicare. Unlike MA, neither the beneficiary nor the ACO knows who has been assigned to the ACO when services are being provided.

The ACO program's initial results have been disappointing but not unexpected.⁵¹ Even well-respected organizations, such as Sharp HealthCare in San Diego, had difficulty when they became Pioneer ACOs. (The model was designed for groups already experienced in coordinating patient care.) Thirteen of the original 32 Pioneer ACOs have dropped out of the program, citing problems with complex rules and inadequate financial incentives.⁵² The 243 ACOs operating under the Medicare Shared Savings Program reported Medicare savings totaling \$372 million—less than 0.1 percent of the half-trillion dollars Medicare spends each year on care for the elderly and disabled.⁵³

Rather than allowing a thousand flowers to bloom, the Innovation Center follows the federal procurement

process that starts with the agency identifying the research project and specifying in detail the requirements for participating organizations. Considering the large sums of money involved, there may be no other alternative, but this approach limits the scope of innovation and restricts how potentially good ideas can be adapted to meet local health sector conditions.

The ACA also gave HHS authority to implement any payment or delivery model that is expected to reduce program cost without reducing quality of care, or increase quality without increasing cost, on a nationwide basis. That vests extraordinary power in the agency to impose its vision on Medicare and ultimately on the health sector.

Medicare Does Not Coordinate Well with Medicaid for Dual-Eligible Enrollees. There are about 10 million people who are jointly enrolled in Medicare and Medicaid (hence, they are called “dual eligibles”) who typically have higher health care costs than individuals enrolled in Medicare alone.⁵⁴ Dual eligibles have substantially higher health care costs than persons enrolled solely in Medicare, in many cases relying on Medicaid to provide long-term care services and supports and other benefits not covered by Medicare.⁵⁵

Because the two programs operate under different rules, the federal and state governments running the programs and the health care providers who serve the patients face conflicting financial incentives that increases the cost of care. In addition, because the programs are not coordinated, the care of dual eligibles—particularly those with chronic conditions and functional limitations—is often fragmented and poorly managed, which increases cost and reduces patient outcomes.

These problems are particularly acute for dual eligibles who enroll in FFS Medicare. Special-needs plans under the MA program are a better option, but they are not widely available. As of July 2015, 13 states are participating in the Financial Alignment Initiative aimed at improving care and controlling cost for dual eligibles, but low enrollment is jeopardizing the program.⁵⁶ Greater flexibility is needed for Medicare to effectively pool its resources with state Medicaid programs, which could save money and improve the effectiveness of care.

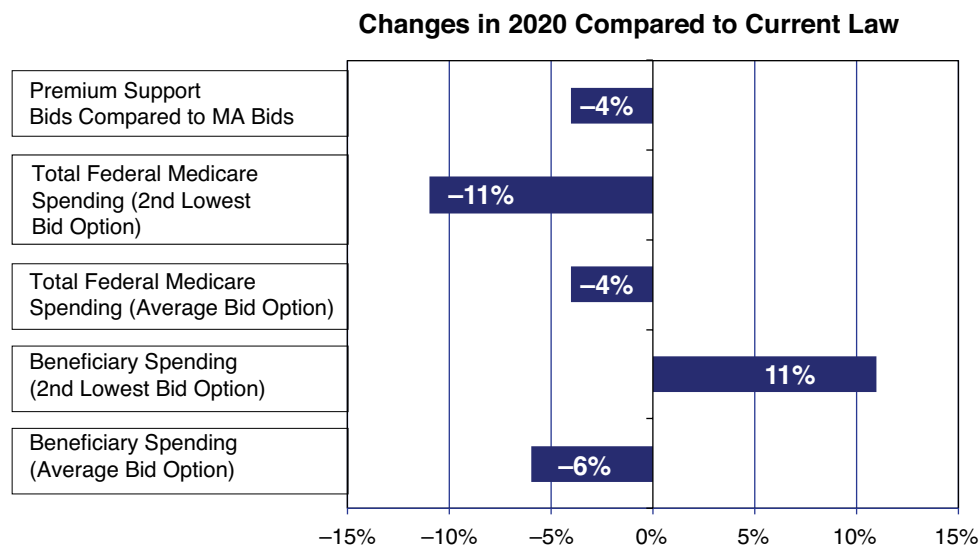
Medicare Reform Agenda

Medicare is extremely popular with seniors despite its many defects. Reform proposals are typically met with fear and suspicion that any change will undercut benefits and undermine the stability of the program. A balanced approach restructures Medicare’s subsidy to slow the rapid growth of program spending while giving beneficiaries better plan options and greater certainty that Medicare will be there when they need it. The following outlines the major components of market-based Medicare reform.

Adopt Premium Support. Converting the uncapped entitlement and distorted fee-for-service structure of the traditional program to a premium support model is the centerpiece of a consumer-focused market-oriented reform of Medicare. Premium support relies on the concepts of competition, choice, and a defined contribution subsidy. Premium support would fundamentally change the incentives that drive up Medicare cost, making both patients and providers more aware of cost and promoting health care value rather than volume.

CBO believes that moving to a premium support model could substantially reduce costs both for the federal government and the beneficiaries.

Under premium support, all beneficiaries would receive a uniform subsidy to purchase insurance from competing health plans, including FFS Medicare. The subsidy amount would be based on the low bids, with each plan offering at least a core set of benefits. Subsidies could be adjusted according to the financial circumstances and health conditions of beneficiaries, but they would not be increased for more expensive plans. Beneficiaries choosing more expensive plans would pay any extra premium themselves. This gives seniors an incentive to select lower-cost plans and provides plans with an incentive to provide appropriate services in a cost-effective manner. More efficient health care

Figure 13. Congressional Budget Office on Premium Support

Source: Congressional Budget Office, "A Premium Support System for Medicare: Analysis of Illustrative Options," September 2013.

delivery is rewarded, rather than penalized, as is the case under the current system.

A recent study by Harvard professors Zirui Song, David Cutler, and Michael Chernew shows that under a competitive bidding system, Medicare Advantage plans could provide the same level of benefits as traditional Medicare but be as much as 13 percent cheaper.⁵⁷ This is a strong argument for premium support, but it tells only part of the story. With competitively determined pricing, health care providers would have a stronger incentive to adopt more cost-effective practices, which could lower FFS costs, making traditional Medicare more competitive with private plans.

CBO estimates that moving to a premium support model could substantially reduce costs both for the federal government and the beneficiaries. As shown in figure 13, if the government's contribution toward Medicare coverage were based on the weighted average of bids, total federal Medicare spending would decline by 4 percent in 2020 compared to current law, and the beneficiaries would pay 6 percent less in premiums and other costs for their care.⁵⁸

Improve the Competition between Medicare Advantage and FFS. Under current policy, if beneficiaries make no overt choices, then they are presumed to select FFS. Like many other markets, Medicare displays "status quo" selection bias. That is, once a beneficiary is in a plan, he or she tends to stay there, even when switching would make sense. So the current system, with FFS as default coverage, is biased toward more FFS enrollment.

A possible remedy would be to change Medicare's default rules. For newly eligible beneficiaries who do not overtly select coverage, the Medicare program could randomly assign them among MA plan options instead of automatically placing them into FFS. To minimize undue financial hardship and unexpected surprises, those default options might be limited to the two lowest-cost Medicare plan options (under one version of competitive bidding) or to those plans with bids equal to or less than the average enrollment-weighted bid in a particular county (under another version of competitive bidding). This change would not apply to current enrollees in FFS.

The current MA bidding system is also flawed and needs improvement. All beneficiaries, including those in MA plans, must pay the Medicare Part B premium, which is generally withheld from the amounts otherwise due to the beneficiaries in their Social Security checks. MA plans are permitted to provide premium rebates to the beneficiaries as a way of attracting enrollment, but current policy requires those rebates to come in the form of adjusting the Part B premium withheld from Social Security checks. This is a very nontransparent way of encouraging direct price competition between FFS and MA because a beneficiary choosing a plan offering a rebate would not see the change in any amount they owe to the MA plan. The adjustment would come in the form of an adjustment to their net Social Security benefit, which is indirect and less visible. The result is that very few MA plans compete with FFS in this way; instead, they charge no premium above the Part B premium and then give away whatever else they can in the form of expanded benefits, including adjustments in deductibles and other copayments.

This limitation of the current, flawed price competition between MA and FFS can also be seen from the perspective of what the beneficiaries must pay to remain in FFS. Under current law, the premium for FFS is always the uniform, national Part B premium, regardless of the relative cost of FFS to the available MA plans in the region.

The competition between MA and FFS could be improved, even before full adoption of premium support, by allowing MA plans to offer plans that would allow beneficiaries to pay even less than the Part B premium. For example, beneficiaries could continue to be charged the full Part B premium by the Social Security Administration, but the lower-cost plans could send a rebate check to their enrollees. This would encourage MA plans to bid even lower, and the beneficiaries would see the savings clearly rather than having it hidden in the computation of their monthly Social Security check.

MA plans should also be required to offer to the beneficiaries a plan with an actuarial value equivalent to the statutory benefit. Added benefits would be offered in supplemental coverage for an added premium. (Separating bids and premiums for standard Medicare benefits from supplemental coverage was originally

recommended by the National Bipartisan Commission on the Future of Medicare.)

Promote Consumer Decision Making. One of the key reasons for the inefficiency of the health care market is the lack of information that consumers can use in selecting their health plan, their doctor, and their course of treatment. CMS offers several online decision-support tools to help beneficiaries sort through their plan options, with separate “plan finders” for traditional Medicare and MA plans, Part D plans, and more limited information on Medigap options. The current tools produce information that is both overly complicated and incomplete.

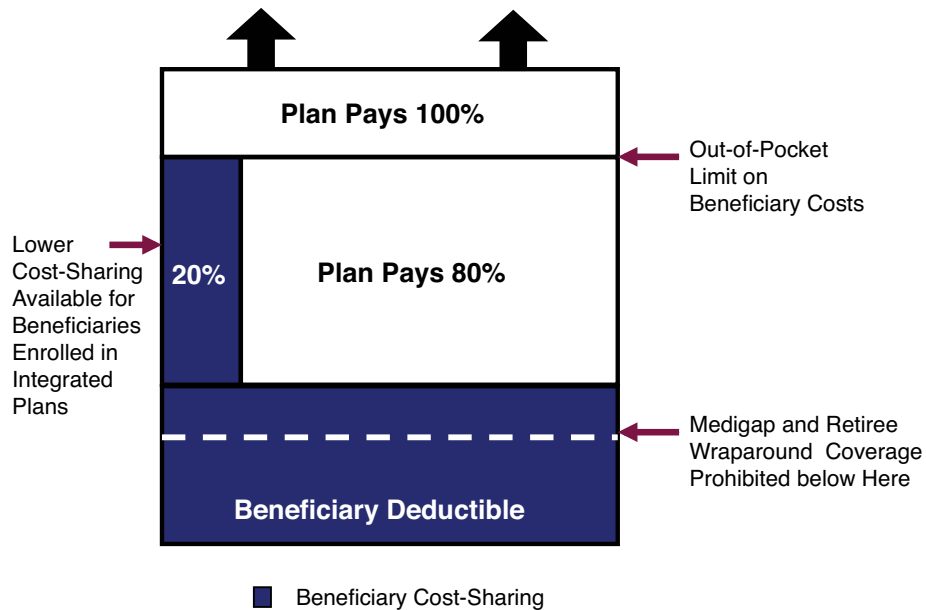
The complication stems from traditional Medicare’s being a collection of mix-and-match parts, not a comprehensive health plan. But consumers need basic information that is difficult to find: what will it cost to enroll in traditional Medicare with Part D and a Medigap plan, compared to a comprehensive MA plan? What are the important differences in coverage between the options? Having selected a plan, what will typical services (such as a routine office visit or a routine surgery) cost the patient after the Medicare payment?

These problems are well known. A reformed Medicare program must commit itself to developing consumer-friendly information on the cost of alternative plan options, provider performance measures (including patient satisfaction scores), and the out-of-pocket costs that patients are likely to bear for specific treatments.

Reduce Fraud and Abuse. Medicare fraud and abuse is a serious problem that can cost taxpayers billions of dollars while putting beneficiaries’ health and welfare at risk. New efforts are needed to shift beyond a “pay and chase” approach to preventing fraud before it happens. In addition, the federal government should collaborate with the private sector, law enforcement, and states to harness best practices in the fight against fraudulent and wasteful depletion of Medicare’s resources.

Modernize Medicare’s Benefits. Medicare has a complex benefit design unlike any other health insurance, with separate rules governing the program’s coverage

Figure 14. Modernizing Medicare's Benefits



Source: Authors.

for inpatient care under Part A and physician and other outpatient services under Part B. This leads to confusion and higher cost for enrollees in traditional Medicare. MA plans, in contrast, are designed as modern health plans with comprehensive coverage for inpatient and outpatient services, often including a prescription drug benefit as part of the package.

Although a private plan is a better choice for many beneficiaries, traditional Medicare will continue to attract enrollees for the foreseeable future, making it imperative that we modernize that program. Several modifications of traditional Medicare's benefits would simplify the program and extend necessary financial protections to enrollees (a simplified illustration is shown in figure 14). They include:

- **Combine Part A and Part B into a single program with a single premium that covers both parts.** The Part B premium would be redefined to help finance the operations of the combined program. Beneficiaries could be offered the choice of retaining the current generous benefit package for a higher monthly premium or accepting

less generous benefits at the current premium. Initially, the Part D prescription drug program would remain separate, but later inclusion in the combined program is possible.

- **Simplify cost-sharing in traditional Medicare and provide catastrophic protection.** Under the combined program, beneficiaries would be liable for a single deductible (rather than multiple deductibles that depend on which services are used) and a uniform 20 percent coinsurance on all services, similar to mainstream insurance. Medicare would also add catastrophic protection, which limits the total cost-sharing that a beneficiary must pay in a year. One option to reduce the federal cost of this new benefit and to provide greater protection for those most in need is to vary the cost-sharing limit by income.

Reform Medigap and Other Supplemental Coverage. Supplemental coverage through Medigap, retiree plans, and Medicaid reduces or eliminates the amount beneficiaries pay in out-of-pocket costs. By blunting

consumers' sensitivity to cost, these plans promote the use of services that may contribute little or nothing to the patient's health. Several reforms address this issue.⁵⁹

Require a minimum out-of-pocket payment in FFS Medicare that cannot be covered through a third party. In general, Medigap plans and employer-sponsored retiree coverage should not be allowed to pay the entire amount of Medicare's FFS cost sharing. One approach would require that beneficiaries be personally responsible to pay part of those costs directly through the deductible. For example, if the deductible for the combined Part A and Part B benefit was set at \$800 a year, the first \$300 could be required to be paid directly by the beneficiary. The minimum direct payment could be adjusted according to the beneficiary's income to avoid placing an unaffordable burden on low-income individuals.

The Medicare Access and CHIP Reauthorization Act, passed in April 2015, limits Medigap coverage to costs above the Part B deductible amount, to begin in 2020.⁶⁰ That limit could be extended to private supplemental insurance offered by employers to retirees. However, many types of supplemental plans do not provide full first-dollar coverage but still pay for most of the cost sharing that would otherwise be paid directly by the beneficiary, which also induces additional use of services. An alternative approach is to require supplemental plans to defray those higher program costs, which would result in less cost shifting from Medicare beneficiaries to the taxpayer.

The minimum out-of-pocket payment requirement would apply only to beneficiaries in FFS Medicare with third-party insurance, including Medigap. It would not apply to amounts paid by the beneficiary out of a health savings account, which is equivalent to a cash payment for out-of-pocket costs.

Better coordinate FEHBP for retirees with Medicare. The federal government provides qualified workers with continued health coverage, through the FEHBP, when they are retired. In effect, this coverage becomes a retiree wraparound plan for these workers, covering whatever Medicare does not. As a consequence, the vast majority of retired federal workers are enrolled in Medicare

FFS, with FEHBP covering all of Medicare's cost sharing. This is a particularly bad arrangement for federal taxpayers. They are paying for an unmanaged FFS program through Medicare and then also for the supplemental insurance that makes Medicare's cost-sharing requirements meaningless.⁶¹ Retiree coverage for federal workers should be coordinated more closely with Medicare by requiring enrollment in either a low-cost MA or integrated care plan or by limiting the amount of cost-sharing covered by the wraparound plan.

Give beneficiaries with supplemental coverage a new FFS option. Allow secondary insurance to provide more favorable cost sharing for beneficiaries who get their care from an approved integrated system (a successor program to the current ACO arrangement). This would give beneficiaries financial incentives to forgo unmanaged FFS and would create within Medicare something like an "in-network" and "out-of-network" structure, much like what many private employers have in place today.

Replace the ACO program with a model based on letting beneficiaries choose more efficient providers. The ACO "shared savings" program should be explicitly replaced with a program aimed at fostering competition among integrated delivery networks through beneficiary choice. Instead of the automatic enrollment system now in place, in which beneficiaries may not even know they are being treated in an ACO, beneficiaries should be given the option to enroll in integrated plan of their choosing. As an incentive to do so, they would be allowed to share in the savings from network's cost cutting. The amount of savings they would get (in the form of reduced Medicare premiums) would depend on how much the network reduces overall costs below what would otherwise occur in an unmanaged FFS structure. Networks that are particularly effective at cutting costs would offer reduced premiums and attract market share.

Reform Medicare Payment Policies and Eliminate Unnecessary Bureaucratic Controls. Medicare has been moving toward a bundled payment approach to FFS since the adoption of prospective payment for

hospital inpatient services in the early 1980s. More recently, CMS has been experimenting with new payment and delivery models, including bundled payment for the various services involved in diagnosing and treating a particular illness or injury, pay-for-performance, and competitive bidding. Similarly, private insurers have also been testing better ways of paying for and delivering care.

CMS should continue to test new approaches while adopting a more flexible approach to such projects. Plans and providers participating in these demonstration projects should be encouraged to adapt these models to local conditions. The program should be more open to new business models that can deliver care more efficiently.

Two new entities created by the ACA should be eliminated. The first, the Independent Payment Advisory Board (IPAB), is charged with holding the overall growth of Medicare spending below a target specified by the law. The IPAB—a 15-member board appointed by the president—would be charged with eliminating excess growth in the program through changes in how Medicare pays for services.

CMS should continue to test new approaches while adopting a more flexible approach to projects.

The law prevents the IPAB from pursuing consumer-driven reforms. The ACA specifies that the IPAB's proposals are to be instituted as the default if Congress does not override them, regardless of conditions in the health care market or circumstances affecting Medicare beneficiaries. The law does say that the IPAB is prohibited from rationing care; increasing revenues; or changing benefits, eligibility, or Medicare cost sharing (including premiums for Part A and Part B). But that is a pipe dream. Cuts in provider payment rates, which are permitted, can impact access to care for Medicare beneficiaries and could have spillover effects on everyone else (through price increases to non-Medicare patients or specific services no longer being offered).

The predictable result of IPAB-initiated changes would be a widening of the gap between what Medicare and private insurers pay for services.

The Medicare trustees expect that action by the IPAB could be triggered as early as 2017.⁶² The fact that no members of the board have been named yet is no comfort. The HHS secretary will exercise the IPAB's powers in the event that the board has not been constituted. To prevent the IPAB from ever getting off the ground, the ACA provisions creating it should be repealed.

The second new entity is the Center for Medicare and Medicaid Innovation (CMMI). CMMI was given a \$10 billion budget by the ACA to test out new ways of paying for services in Medicare and Medicaid. New payment approaches can be implemented nationwide if the Medicare actuary finds that they are successful at cutting costs without harming quality. Long-term cost projections of this kind are unlikely to be an effective hurdle because measuring quality is nearly impossible, including for the actuary. Moreover, policies can always be manipulated to achieve cost savings on paper with unrealistic steps that can later be revised.

The CMMI has far too much power to implement what it believes to be technocratic improvements that will inevitably have unintended negative consequences. There is no evidence that the federal bureaucracy has the skill or capacity to redesign how health care is organized in the US, and so the CMMI should also be stopped before it acquires too much power and momentum.

Give Medicare Greater Flexibility in Local Markets. Medicare operates as a national program, but health care is delivered locally. Traditional FFS Medicare should be restructured so that it can adjust its policies to local conditions. Subdividing the program into regional plans within the overall Medicare framework would make it easier to develop and implement innovations that can reduce costs or improve value. Such regional plans could operate with more independence from the central bureaucracy and thus be more capable of responding in a timely fashion to developments in the local market.

In the context of premium support, a regional structure allows FFS Medicare to adapt in a more measured

and appropriate way to the shift from financing with no limits to a budget determined by competitive bidding among plans. If bids from competing plans reduce the budget for FFS Medicare, that program would have to adjust provider payments, coverage rules, premiums, and cost-sharing requirements and find other ways to limit cost or increase program revenue. Because the subsidy level depends on private plan bids and FFS costs in each market, such adjustments should reflect the varying cost conditions in each market.

Gradually Raise the Medicare Eligibility Age. The Medicare program has maintained an eligibility age of 65 for its nondisabled enrollees since the program was enacted in 1965. During that time, average lifespans have increased considerably. In 1965, the average male could expect to live to nearly 78 years old if he reached age 65. Today, he should live to age 83. The improvement in longevity at age 65 has been similar for women, from an average age at death of just over 81 in 1965 to nearly 86 today.⁶³

The 1983 Social Security amendments raised the normal retirement age for that program to 67 over a transition period of two decades. That change left in place the option for persons to continue to receive Social Security benefits at age 62, albeit with lower monthly payments. The failure to raise the Medicare age means that the program will be paying for an ever-increasing portion of lifetime health care costs, even as the tax base for the program grows much less rapidly than the eligible population.

The increase in the eligibility could proceed in two steps. First, there could be a gradual increase to reach age 67. Second, there could be periodic additional adjustments to keep the age of eligibility consistent with overall life expectancy for those who have lived to age 60 or 65.

Raising the eligibility age to keep up with improvement in lifespans does not fundamentally change the structure of the program. But it makes the program more consistent with demographic reality. Moreover, persons age 65 and 66 who would no longer be eligible for Medicare would get an age-adjusted federal tax credit for the purchase of coverage in the private market, so there would be no reason for a gap in coverage for this population.

The Reason to Reform Medicare Now

Experts have raised concerns about Medicare's long-term financing from almost the beginning of the program. Over the past 50 years, Medicare has periodically neared crises that forced Congress to adopt short-term fixes—mainly reductions in provider payment rates—but we have rarely seen structural changes in the program. In effect, Medicare remains the program it was in 1965 with a few important additions (such as Medicare Advantage and the Part D prescription drug benefit). If we have gone this long without fundamental reforms, why risk proposing them now?

The reason, of course, is to strengthen the program to ensure it remains sustainable for current and future generations. As Americans live longer lives and have fewer children, it will not be possible to sustain indefinitely the current policy of fully subsidized Medicare benefits for everyone over the age of 65. According to the Medicare trustees, the program faces insolvency by 2030 without necessary reforms. But we should not fool ourselves: Medicare draws on general tax revenue to fund Part B and Part D, which places a growing burden on workers and their families.

With the aging of the baby boom generation, Medicare enrollment will increase dramatically over the next two decades and so will program costs. Over the next two decades, Medicare enrollment will increase by 32 million people—a 60 percent increase.⁶⁴ Program spending will also grow dramatically, and that will draw resources away from other policy priorities. As Medicare costs rise, fewer dollars will be available to fund education, roads and other public infrastructure, defense, and other programs of vital interest to middle-class Americans.

There is time to act. The program's financial crisis will be delayed by several years by the entry of millions of relatively young people who are just turning 65. The combination of a large number of new enrollees having lower health care costs and the inevitable deaths of many older enrollees with greater health needs will slow the growth of Medicare spending over the next few years. Between 2015 and 2018, Medicare spending is expected to increase an average of \$43 billion annually.⁶⁵ Between 2021 and 2024, the average increase doubles.

This relative calm before the financial storm gives policymakers an opportunity to enact thoughtful reforms than can be phased in gradually. That also allows for midcourse corrections and refinements that would not be possible in the heat of an acute financial crisis.

In any event, policymakers may not have the luxury of procrastination. Medicare actuaries have made it clear that the ACA's reductions in payment updates to reflect economy-wide productivity increases are unsustainable. By 2019, these productivity adjustments will mean that 15 percent more hospitals will lose money on their Medicare patients—and 5 percent more will have negative margins over their entire patient load.⁶⁶ The financial situation for hospitals, skilled nursing facilities, and home health agencies only worsen in later years.

That will pressure the next administration to reduce or eliminate those automatic payment cuts. Policymakers could enact short-term fixes, as Congress did with Medicare's sustainable growth rate formula. But that only delays the problem, making it even harder to patch in later years. A substantial market-based reform would garner health industry support if the alternative is to repeat the mistakes of the last decade that delayed reform of Medicare physician payment.

Integrate Medicare Reform with Broader Changes to the Health Sector

Rather than allowing Medicare's competitive elements to be taken apart piece by piece, policymakers should acknowledge the public's concerns and offer a complete package of health system reforms. Consistently over the past five years, about 40 percent of Americans have an unfavorable opinion of the ACA, and another 20 percent are unsure.⁶⁷ The lack of support suggests that the public wants something better.

That something better must include a reformed Medicare program capable of meeting the needs of

seniors today and tomorrow without imposing unaffordable burdens on taxpayers. However, there is a substantial risk in proposing structural Medicare reform. In a recent survey, 77 percent of those polled said Medicare is a very important program, just below Social Security.⁶⁸ More than half said they are concerned about Medicare's ability to maintain the current level of benefits for future enrollees, and two-thirds agreed that some sort of reforms are needed. But the public hopes those changes can be minor, with only 26 percent supporting a change to a fixed government contribution for the cost of coverage.

The trade-off is familiar: propose real solutions to Medicare's financing problems and lose public support, or discuss cosmetic changes and retain the public's backing at the polls. The challenge is to change the terms of the debate by helping the public understand the consequences of continuing to ignore Medicare's problems and the benefits of undertaking prudent market-based reforms before it is too late.

Conclusion

Failure to adopt reforms will result in growing program costs and worsening access to health care services for seniors. When the inevitable crisis occurs, there will be calls for a massive tax hike to put off the problem a few more years. A responsible policy would reform the program to make it sustainable for the long term.

The reforms discussed in this chapter would place Medicare on a sound financial basis, promote a more efficient health care delivery system, and give beneficiaries better choices of health plans—all essential steps in preserving Medicare for future generations. Beyond that, more help can be provided to beneficiaries with low incomes or greater health needs by setting income-related premiums and cost-sharing requirements and adjusting subsidies for health risks. Steps also can be taken to better coordinate Medicare and Medicaid to reduce cost and improve care for dual eligibles.

Lifelong Use of Health Savings Accounts

Summary of HSA Reforms

1. Provide a one-time federal tax credit matching enrollee contributions to HSAs.
2. Eliminate the minimum deductible requirement for a universal HSA contribution allowance of \$2,000/\$4,000.
3. Increase the maximum contribution limits for persons with high-deductible health plans by \$2,000/\$4,000.
4. Allow HSAs to use nontraditional payment methods (non-FFS).
5. Include HSAs in Medicaid reform.
6. Integrate HSAs into Medicare.
7. Allow withdrawals tax-free at age 75+ (above a minimum balance).
8. Allow tax-free HSA rollovers to designated HSAs at death.

The dominant theme of this volume is the critical need for a patient-centered, market-based reform of US health care. That is what is behind all of the recommendations, including the proposal to incorporate a premium-support approach within Medicare and to replace the ACA's heavily regulated structure with a more flexible combination of tax credits and meaningful, patient-centered, consumer choice.

Much of the focus of these reforms is to ensure a fully functioning marketplace for the purchase of private health insurance. That is, of course, very important. It is crucial that value-focused, cost-conscious consumers have real and meaningful choices among competing insurance offerings based on prices and the quality of the services provided to patients. This will allow consumers to make informed judgments about how they can receive the best value for their

money and actively invest in their own health and well-being.

A successful functioning marketplace for health insurance will have productive and important implications for the marketplace of health services. In the United States, health insurance is often directly linked with the manner by which patients access care. In managed care or integrated care insurance plans, like HMOs, the insurer takes direct responsibility, to some degree, for putting in place processes and protocols for delivering care to patients. To optimize the success of these programs and management efforts, however, the patient-consumer must be empowered, driving improved and active patient-physician relationships and improved efficacy of care.

We fully expect that these integrated care plans will do very well under the proposals recommended in this

Table 1. HSAs under Current Law

HDHP Minimum Deductible (2015)	<ul style="list-style-type: none">• \$1,300 for single coverage• \$2,600 for family coverage
HDHP Maximum Out-of-Pocket Limit (2015)	<ul style="list-style-type: none">• \$6,450 for single coverage• \$12,900 for family coverage
HSA Contribution Limits (2015)	<ul style="list-style-type: none">• \$3,350 for singles• \$6,650 for families• Additional \$1,000 “catch-up” contributions (age 55 and older)
Distributions	<ul style="list-style-type: none">• Tax-free for qualified medical expenses• Other distributions are included in taxable income• Additional 20 percent penalty for nonmedical withdrawals before age 65

Source: HSABank, “IRS Guidelines and Eligible Expenses.”

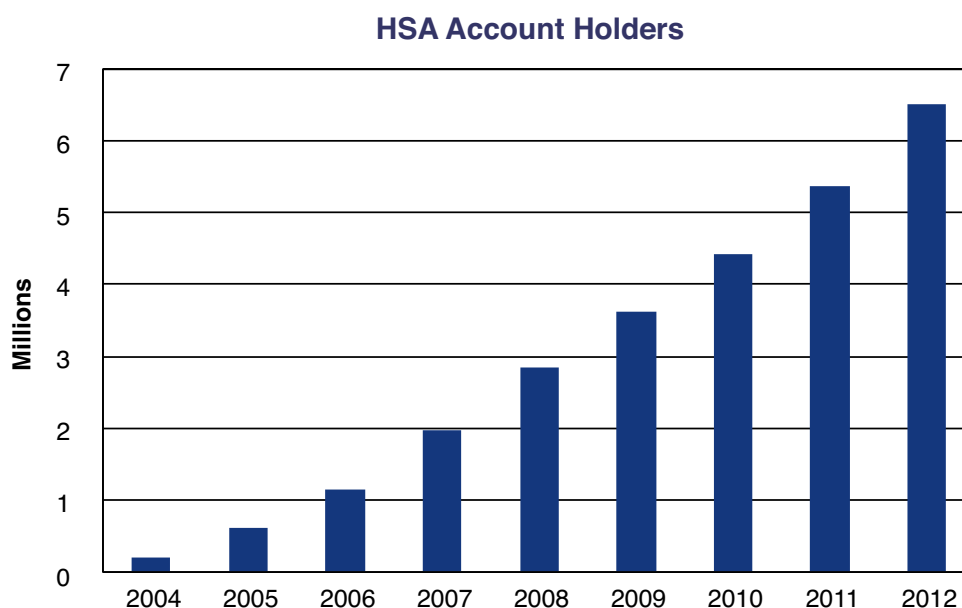
volume because they can reduce costs by minimizing unnecessary care. When a primary care physician truly acts as a patient advocate through the full continuum of care, that physician can successfully steer patients toward services that eliminate or defer the need for costly interventions. In such a relationship, these plans will be able to offer health insurance coverage with lower premiums than many of their competitors, which will be very attractive to consumers.

But the core principle here is a belief not in integrated care per se but in the power of meaningful consumer choice. Large numbers of active, cost-conscious consumers is the surest way to guarantee a steady source and demand for innovation, cost reduction, and better ways of keeping patients healthy.

The key policy reform needed to promote a patient-centered, consumer-directed health system is the use of defined contribution payments by the government for supporting insurance enrollment. Defined contributions work well because they ensure value focused, cost-conscious consumption. Selections of more expensive options require consumers to pay more out of their own pockets. And, conversely, economizing allows consumers to reduce their expenses.

We recommend, in different ways, moving to defined contribution support within Medicare and Medicaid and for those without access to employer-sponsored insurance. For employer-sponsored insurance, we recommend the capping of the tax exclusion for employer-paid premiums, which will provide an incentive for employers sponsoring expensive plans to limit their contributions toward coverage and thus replicate the incentive of a fully defined contribution approach.

A very closely related concept to defined contribution support is the promotion of HSAs. HSAs are individual consumer-owned and controlled accounts, tied exclusively today to qualified high-deductible health plans (HDHPs). The combination of an account for the direct purchase of care alongside the qualified high-deductible insurance plan provides a sensible, intelligent, balance of what insurance is really for—financial protection for the enrollee—with real incentives for the judicious use of resources by the patient-consumer when accessing health services. In fact, the combination is so sensible that the idea has taken off, with many millions of new HSA holders since the current concept was put in place by legislation enacted in 2003.

Figure 15. Health Spending Account Enrollment Growth

Source: Lorens A. Helmchen et al., "Health Savings Accounts: Growth Concentrated among High-Income Households and Large Employers," *Health Affairs*, September 2015.

Even so, only a small fraction of the overall population has been able to access the significant patient-consumer advantage of an HSA, largely because of the newness of the concept and the lack of seamless integration with other potentially valuable health plan design components.

Removing the impediments to an even more robust enrollment in HSAs is the surest route to ensuring a functioning consumer-centered marketplace for insurance and health services in the United States, and thus high-quality health care at an affordable price with high value for the patient-consumer.

Current Law on HSAs

HSAs are tax-preferred vehicles for saving for medical expenses. As shown in table 1, account holders can contribute to their personal HSA when they are enrolled in a qualified health plan with a minimum deductible amount (\$1,300 for single people and

\$2,600 for family coverage in 2015). Employers and individuals are allowed to make tax-free contributions to HSAs, up to a combined maximum. In 2015, the maximum contribution is \$3,350 for single people and \$6,650 for persons enrolled in family coverage. In addition, people age 55 and older may make an additional \$1,000 "catch-up" contribution each year above the amount otherwise allowed. All earnings in HSAs are also not taxed.

People may withdraw funds out of their HSAs tax free at any time for qualified medical expenses. HSAs are thus a very attractive vehicle for health savings, as both contributions and distributions avoid income taxation. However, withdrawals for nonmedical purposes are included in taxable income and, if the account holder is under age 65, the withdrawal is subject to an additional 20 percent tax penalty.

Since these provisions were enacted in 2003, HSA enrollment has increased rapidly, as shown in figure 15. Over the period of 2005 to 2012, enrollment grew by about one million people per year, reaching 6.52

million account holders in 2012. Aggregate balances in HSAs now top \$2 billion, and nearly 25 percent of workers at large firms had access to employer-sponsored HSA plans.⁶⁹

HSA Reforms

Although HSAs have been growing steadily since their inception, their role in shaping the overall direction of the health sector is still minimal because of the far greater numbers of Americans enrolled in government- and employer-sponsored insurance plans with far lower deductibles than are allowable in combination with HSAs.

Removing the impediments to an even more robust enrollment in HSAs is the surest route to ensuring a functioning consumer-centered marketplace for insurance and health services.

HSAs can and should feature much more prominently in the workings of US health care in the future. The following reforms would go far toward making HSAs a more commonplace option for Americans of all ages and economic circumstances and allowing individuals and families to rely much more on HSAs throughout their lives, including into retirement.

Provide a One-Time Federal Tax Credit for HSA Enrollees. To rapidly increase enrollment in HSAs, a tax credit of up to \$1,000 should be provided to all persons who have established an account and have contributed to it by the end of 2017. The credit would provide a matching contribution of \$1 for every \$2 contributed to an account in calendar year 2017, up to the maximum credit of \$1,000. This initiative will ensure that tens of millions of Americans who today do not have an HSA will take the steps necessary to learn about what they are and establish one.

Liberalize the Rules for HSA Contributions. HSAs successfully serve as a vehicle for savings for future, unknown contingencies and for paying for health and medical services not covered by insurance. Currently, however, only persons enrolled in a qualified HDHP are eligible to make tax-preferred annual contributions. We recommend allowing all Americans to establish and contribute up to \$2,000 per year (individuals) and \$4,000 per year for families (both indexed to the CPI), independent of their participation in a qualified HDHP or any insurance program.

Participants in a qualified HDHP would continue to be eligible to make contributions up to the allowable amounts under current law, in addition to the base \$2,000/\$4,000 contribution allowed for all Americans.

This policy makes HSAs and contributions available to all and expands this valuable savings opportunity to those who elect to participate in qualified HDHPs as active, engaged consumers, who seek to save more for their future health care needs. This policy also makes HSA eligibility universal, empowering all Americans working and nonworking, young and old and irrespective of the level of insurance coverage they maintain.

Allow HSAs to Be Used for Nontraditional Payment Methods (Non-FFS). HSAs have often been thought of as a balancing option to integrated care plans. Instead of an insurer managing access to care, patient-consumers with HSAs are in charge of making the decisions to get care, or not, and then also they are responsible for paying for that care out of their account balances. In general, the presumption is that these payments will be based on a fee-for-service model—that is, payments will be made to providers out of HSAs only as services are rendered.

But there is no reason that HSAs could not be used more creatively when financing care below the HDHP deductible amounts. For instance, enrollees might use HSAs to purchase a predetermined level of access to care from an integrated health plan, or from a specific physician or other provider, for a monthly fee. An HSA enrollee could make payments directly to his or her primary care physician under a direct pay arrangement, independent of insurance or any network requirement. The fee could cover a certain number

of physician visits, phone consultations, online health support, and other services to help enrollees meet their routine health and wellness management needs. Today, HSA withdrawals must be directly tied to a service for the amount of the withdrawal, which hinders the development of models that would work better for the enrollees and for the integrated delivery plans and other direct-pay physician relationships that require payment methods other than FFS.

Include HSAs in Medicaid Reform. Indiana has pioneered the use of HSA-like accounts in Medicaid, through a waiver program negotiated with the federal Department of Health and Human Services.⁷⁰ Participants get a high-deductible insurance plan and a HSA-like account (called a POWER account). The state pays for the insurance and deposits funds in the account for use by the Medicaid enrollee. Participants in the program with incomes above the federal poverty line are also required to make their own contributions to the account. Independent evaluations of the program have shown that it has reduced costs and that the participants in the program highly value the accounts they now own.⁷¹

There is no reason why HSAs could not be featured prominently in every state Medicaid program. Under the reform plan presented in this volume, Medicaid would be converted into defined contribution support, with the program participants deciding what kind of insurance plan they would like to secure with the available funds. One of those options should be an HDHP-HSA combination, similar to what is being offered in Indiana. Enrollees electing this option would be able to keep their accounts as their earnings rise and they exit Medicaid and could very likely keep their HDHP too.

Medicaid contributions to the HSA could also be contingent on the enrollee's active participation in a qualified health and wellness program, managed by his or her physician.

Integrate HSAs into Medicare. Today, Medicare allows for a medical savings account (MSA) option within the Medicare Advantage program, but it is underutilized for a number of reasons. Among other things, it is run separately from any HSAs that Medicare beneficiaries

may have from their working years. Moreover, Medicare precludes beneficiary contributions to an MSA or HSA while enrolled in Medicare.⁷² So, for all intents and purposes, HSAs are currently assumed to be something useful for those under the age of 65 but not relevant for those in Medicare. Additionally retirees can also make penalty-free withdrawals from their HSAs when they reach age 65 for nonmedical uses, which also lessens the incentive to retain HSA funds as a cushion for health care expenses into retirement.

HSAs could be made a much more prominent and viable part of the Medicare program through two important steps. First, the Medicare MSA program should be modified to explicitly build on the HSA model. Beneficiaries with preexisting HSAs should be allowed to keep those accounts and use them to pay for Medicare-covered services, in combination with high-deductible Medicare Advantage offerings. The Medicare program would pay for the insurance premium and deposit whatever is left into the beneficiary's HSA. The total amount payable to a beneficiary electing this option would be adjusted for their age and health status, relative to an average Medicare beneficiary.

Second, HSA holders should be allowed to continue to make tax-free contributions even after they become eligible for Medicare. The purpose of HSAs is to provide additional financial security for the account holders. It makes little sense to restrict the ability of seniors to save for their future health care needs in the years that they are most likely to see a surge in expenses, inclusive of long-term care.

Allow Withdrawals Tax-Free at Age 75+ above a Minimum Balance. Current HSA law provides an incentive for account holders to begin depleting their reserves when they reach age 65. (They can make withdrawals for nonmedical expenses without facing the 20 percent penalty, although they pay income taxes on withdrawals for nonmedical purposes.) HSAs, however, could be an important source of protection against the high cost of nursing home and other long-term care needs in retirement if account holders had an incentive to grow their balances and maintain them for this purpose.

One way to do that would be to set a minimum HSA balance, roughly equal to two years' worth of nursing home care (or about \$75,000), and allow anyone age 75 and older with balances that exceed that amount to make withdrawals (up to a certain limit, perhaps \$75,000) that are tax and penalty-free. This would reward people who, over a lifetime, saved and provided for their own health care needs with the ability to spend a portion of their savings on their other priorities. Setting the minimum balance would allow these HSAs to also be used to pay for a significant amount of nursing home care, which should lessen reliance on the Medicaid program.

Allow HSAs to Be Rolled Over Tax-Free to Other Family Members with Designated HSAs at Death.

Under current law, when an HSA holder dies, the HSA balance automatically goes to a spouse and is kept as an HSA. However, if there is no spouse, then the HSA balance is distributed through either an estate or other designated persons and is fully taxed at that point.

The law should be amended to allow HSA holders to designate family members who are not spouses as recipients of their HSA balances at death. The balances would retain the HSA designation for the new owners and could be added to the balances of any HSAs they already own.

Additional Reforms

Summary of Additional Reforms

1. Phase out existing federal funding of graduate medical education, and replace a small portion of it with annual appropriations and performance-based grants.
2. Reform federal funding of graduate medical education.
3. Reform the Federal Employees Health Benefits Program.
4. Integrate veterans into mainstream coverage and care, and refocus VA health care.
5. Improve the transparency of useful cost and quality data.

The preceding sections provide a policy roadmap for reforming the most significant components of US health care. But some other changes are also needed and would reinforce the reforms already proposed.

Reform Federal Funding of Graduate Medical Education

Federal government financial support of graduate medical education (GME) remains driven by habit rather than by results. It should be reduced substantially and retargeted to provide better incentives to address long-standing imbalances in the physician workforce. To the extent that new funds are appropriated, they must be justified by evidence of the outcomes that they will produce in the future, rather than the institutional interests that they have served in the past.

Federal funding for GME amounted to nearly \$16 billion per year, according to a recent review by the

Institute of Medicine. Based on fiscal year 2012 estimates, the largest share—about \$9.7 billion—came from the Medicare program. Medicaid (including both the federal and state shares) contributed another \$3.9 billion. The Veterans Health Administration added another \$1.4 billion.⁷²

The nature of Medicare funding for GME is particularly unusual and continues to be problematic. Since the program's inception in 1965, it has provided Direct Medical Education (DME) support to recipient hospitals as a statutory entitlement. A much larger share of Medicare's contribution to GME (more than 70 percent) began in the 1980s, in the form of Indirect Medical Education (IME) payments, with the beginning of the program's prospective payment system for hospital reimbursement.

The federal government does not provide such funding to undergraduate medical education or other health care professions (or other professions) in any similar way. IME payments actually reward hospitals

simply because they spend more in providing inpatient health care services, whether or not such spending produces better value and improved outcomes.

Critics find that DME funds do little to offset the actual costs of training physicians. The latter still essentially pay the full cost of their training as residents. DME money simply improves the overall bottom line of recipient hospitals.⁷⁴ Moreover, increasing Medicare funding for GME is not essential for increasing the supply of physicians. In fact, the Institute of Medicine (IOM) found that between 2002 and 2012, overall enrollment in US medical schools rose by nearly 28 percent, and 17.5 percent more physicians were in residency than 10 years earlier despite a cap on the number of Medicare-funded slots imposed by the Balanced Budget Act of 1997.

Removing the impediments to an even more robust enrollment in HSAs is the surest route to ensuring a functioning consumer-centered marketplace for insurance and health services.

The 2014 IOM study also concluded that simply increasing the number of physicians would not resolve long-standing imbalances in their distribution by specialties or geography and provide better care to underserved populations and areas. Indeed, because Medicare GME dollars are directed by historical allocations of DME costs and training slots, plus inpatient volume, they fail to distinguish between high- and low-performing residency programs and tend to prolong rather than correct current inequities in the distribution of those funds.

The IOM study outlined the initial direction of GME reform—such as ending separate funding streams for IME and DME payments—but it failed to urge a faster pace to provide a clear break with GME’s muddled past. The existing entitlement for Medicare-based GME funds should be phased out completely within five years (declining by 20 percent each year). A much smaller fraction of those funds (most likely no more

than 25 percent, phased in upward over the same five years) should be reallocated in the form of direct appropriations that are targeted more competitively and strategically, to achieve higher-priority policy goals.

More innovative approaches to medical workforce reform should be encouraged, but with at-risk accountability for evidence-based results. By reopening competition for all types of medical-training sponsors and institutions to demonstrate how effectively they can meet the changing needs of the future, a more modest amount of federal support of GME would need to justify its ongoing role by the results it produces, with more effective performance-based incentives to reach clearly articulated policy goals.

Reform the Federal Employees Health Benefits Program

Federal employees are enrolled in a health insurance program with some commendable features. The program has genuine consumer choice of coverage options and direct price competition among competing insurers, and workers have at least some incentive to be economizing in their selections.

But the federal government’s contribution toward coverage on behalf of workers and retirees still allows for higher payments for more expensive options. Under current law, the government makes a contribution equal to 75 percent of the premium charged by the plan selected, up to a maximum of 72 percent of the average premium for all plans, weighted by enrollment.⁷⁵ The practical effect of this formula is to undermine the incentive for insurers to offer very low-premium plans because workers will get a higher federal contribution if they select plans closer to the average cost of all plans.

The program would function better, with more cost discipline, if the government made a true defined contribution payment on behalf of workers and retirees that did not vary based on what plan was selected by the program participant. This would ensure that all federal workers and retirees were fully cost conscious in their selections, and it would provide a stronger incentive for the competing plans to seek out ways to offer lower-premium options.

Integrate Veterans into Mainstream Coverage and Care, and Refocus VA Health Care

The reforms proposed in this volume would open up new possibilities for improving health for millions of Americans. That should include veterans.

Today, too many veterans are forced to seek care from a low-performing veterans' health program, run by the federal government. The Department of Veterans Affairs (VA) has the capacity to deliver essential medical services to veterans that are not available elsewhere. But much of what is provided through the VA health program could be delivered by physicians in private practice and nongovernmental hospitals and clinics.

Veterans should be fully integrated into the mainstream medical care and insurance coverage options recommended in this volume so that they can decide for themselves about where to get the care they need. Among other things, veterans who do not have access to employer coverage should be given the same tax credit as other people and allowed to use that tax credit to purchase an insurance plan that best meets their needs.

At the same time, the VA should focus its efforts on delivering world-class services for conditions related to combat and war injuries, as no other system of health care will be able to match the agency's knowledge and expertise in this area. Over time, this approach would allow veterans to have the best of both worlds by being more fully integrated into mainstream medical care delivery while retaining eligibility for the specialized care that only the VA can offer.

Better Data for a Functioning Marketplace

Increasing choice and competition in health insurance is necessary, but not sufficient, to improve the health care options available to consumers. Patients also need better choices regarding who delivers their health care and better information about how well they do it. The primary problems with our health care delivery system do not involve the quality or cost of health care services in isolation as much as their overall combined value (the relative balancing of cost and quality for a given episode of treatment). In the United States, patients

receive a lot of beneficial medical services, but those may carry high costs, vary unpredictably in quality, and too often fail to reflect good value.

Health care frequently is dispensed and received within a complex, fragmented delivery system that lacks sufficient transparency to allow its participants to make sense of what really matters and what is going on. We often just do not know enough about what works and who performs better, if not best, in treating patients. The various networks of physician groups and hospital systems still lack sufficient data, effective measures, and workable standards to assess the value of health care treatment options and help patients choose where they seek care. Even when such information exists, it is not widely available or usable at the consumer level.

More innovative approaches to medical workforce reform should be encouraged, but with at-risk accountability for evidence-based results.

How do we move from the rhetoric of consumer choice and provider competition to the reality of market-based payments that reward higher-value health care services? The objective of providing greater information transparency in health care is saluted by almost everyone but achieved by too few parties. Both federal and state government officials can improve the development and dissemination of more accessible and actionable health care information, but they should not be the sole arbiters of what this information means and how it is used.

Aggregation of as much health care data as can be accurately and securely derived from multiple sources is an essential, but still preliminary, step in developing a more transparent and value-conscious health care system. Such data—whether from administrative processing of claims, medical charts, prescription drug transactions, clinical lab findings, patient registries, or electronic health records—need to be collected just once but aggregated into accessible formats that can and should be used much more often.

- **Federal Efforts.** Some early efforts at the federal level may help make more provider-identifiable Medicare data available to qualified intermediaries. However, ACA provisions to do so still suffer from a “Washington knows best” mind-set that sees private sources of health care data primarily as contributors to the federal government’s ultimate determinations of cost, quality, and value. Instead, the government and private parties should be equal partners in assessing whatever a richer, more comprehensive stream of data might tell patients, providers, and payers about how well different parts of the health care system are performing.

The early stages of ACA implementation in this area remain biased toward setting national strategies and limiting the scope and scale of data shared with private-sector analysts. The ACA’s template for enhancing and expanding health information relies on measurement and dissemination through government-mediated, centralized channels, rather than a more pluralistic market-based competition to discover, refine, and deliver it. It focuses too much on comparative effectiveness of medical treatments at broader population levels in theory and too little on the comparative efficiency and effectiveness of health care providers in treating individual patients in practice.

- **States.** States generally run two of the largest health care programs in their region: a state Medicaid program and health insurance plans for state government workers. Many states also are involved in guiding, if not directly operating, state-level all-payer claims databases (APCD). Those databases are usually created by state mandate and generally rely on data derived from various medical claims, along with eligibility and provider files, from private and public payers. Although some states have created various types of hospital report cards on cost and quality or web portals with price and quality information ranging from health insurance options to select medical treatments, the assumed scope, scale, and predictive power of their current APCDs can easily be overestimated.

Nevertheless, more energetic and imaginative

states can use APCDs to improve understanding of the overall health of their citizens, such as rates of disease and diagnoses and even underlying causes of morbidity. One perennial limiting factor is that this information is an important source of power; hence, some parties are not eager to pool and share it. States looking to improve the information base for their patients, payers, and providers should pursue greater federal grant support to enhance the clinical content of state-level administrative claims data (such as by requiring that key “present on admission” indicators be included in hospital claims records and linking hospital-based claims data to other laboratory services data sources).

Instead of focusing too much on facilitating elusive, long-term evaluations of the clinical effectiveness of particular treatments, they might start with more tangible measurement and reporting of the relative costs of routine and frequent health care services, the actual out-of-pocket costs that consumers are likely to face in their own insurance plan, and how patients evaluate their care experience with different health providers.

Health care professionals tend to emphasize quality information. Payers care more about cost information. We need to determine both the relative value of health care treatment options and the relative performance of health care providers. But in those instances when clear measures of quality (particularly health outcomes) remain unavailable or elusive, information about the relative costs of different options actually becomes more important. In other words, if we at least know that a particular course of treatment costs more or less when received from a particular health care provider, it should lead to more insistence on knowing why this is and whether it is related to the quality of the care received and the health outcomes achieved. All other things being equal or unknown (until proven otherwise), cheaper may be just as good or better!

Working within the constraints of existing data sources, improved measurement and reporting at the state level and expanded access to federal health program data, could help achieve reasonable minimum-volume

thresholds needed for measurement validity. Establishing baseline standards that provide sufficient consistency but do not stifle further innovation could facilitate payer-provider collaboration on practical, consensus approaches that will help move us beyond the end of the beginning of performance measurement. Such a “best available” measurement approach has driven measurement and performance improvement in other sectors of the economy. This approach would be vastly preferable to remaining in the dark about performance variation until more exacting levels of statistical precision can be met.

Even as some aspects of the ACA (such as outcome-based performance measurement, wider access to Medicare claims data, and electronic health records) could potentially improve the supply side of health care information, the law’s complex cross-subsidies, administered prices, and insurance rating restrictions

are more likely to suppress necessary information about the full costs of health care services. Nevertheless, better-designed provider-level measurement can make the cost-containment tools of differential reimbursement, high-performance tiered networks, value-based benefit design, clinical reengineering, and the responsible choices these methods offer more visible and effective. All of those tools need a more transparent and credible evidence base to make the judgments they signal sufficiently acceptable and appealing to patients, providers, and other purchasers. Such measurement can also begin to construct a model of state health care regulation that relies more on providing useful information to consumers instead of simply mandating or limiting their choices. This change in mind-set on regulatory reform and transparency would be a powerful agent to foster greater choice and competition in health care.

Conclusion

The health of Americans is influenced by many factors that are well beyond the boundaries of health insurance financing and even the normal services provided by medical professionals. These key factors include education, nutrition, family, culture, early childhood development, income adequacy, physical environment, and prolonged exposure to stress.

Nonetheless, the manner by which medical services are delivered and financed is crucial for the health of millions of American families. The set of health care

reform policies presented in this volume will improve the value of those services for every segment of the US population. The guiding principle is patient-centered care, which ensures those providing services to patients are committed to finding ever more effective ways of keeping people healthy or restoring them to their full health so that as many people as possible can engage in pursuits that strengthen their families and give them fulfillment in life.

Notes

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About the Authors

Joseph Antos is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at AEI.

James C. Capretta is a senior fellow at the Ethics and Public Policy Center and a visiting fellow at AEI.

Lanhee J. Chen is the David and Diane Steffy Research Fellow at the Hoover Institution and director of domestic policy studies in the public policy program at Stanford University. He is also an adviser to the Rubio for President campaign.

Scott Gottlieb is a resident fellow at AEI.

Yuval Levin is the Hertog fellow at the Ethics and Public Policy Center and editor of *National Affairs*.

Thomas P. Miller is a resident fellow at AEI.

Ramesh Ponnuru is a visiting fellow at AEI and a senior editor at *National Review*.

Avik Roy is a senior fellow at the Manhattan Institute and the opinion editor at *Forbes*. He is also an adviser to the Rubio for President campaign.

Gail R. Wilensky is a senior fellow at Project Hope.

David Wilson is CEO and senior consultant at Wilson Partners.