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The most serious problems can be solved with modest, easy-to-implement reforms that don't require new taxes or new spending.

Is There a Republican Alternative to the Democrats' New Health Reforms?

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There is much to criticize in the Inflation Reduction Act (IRA) the Democrats have pushed through Congress.

The plan to extend the subsidies Congress created last year for higher income buyers in the (Obamacare) exchanges will send good money after bad. It is regressive, expensive, inflationary, and will have very little impact on the number of people with health insurance. The proposal to impose price controls on prescription drugs for Medicare beneficiaries will lead to fewer new drugs, fewer cures, more avoidable deaths, and higher drug prices for the private sector.

To make matters worse, these health reform ideas are packaged inside a bill that will destroy almost 1 million jobs, according to University of Chicago economist Casey Mulligan.

Still, public opinion polls show high approval for both proposals. Why is that?

It's certainly not because the average citizen has paid a lot of attention to how the Democrats' plan actually works. More likely, the proposals are popular because voters realize there are problems that need solving. But, if the Democrats' solutions are so bad, surely the Republicans can come up with something better.

Here are some suggestions.

Alternatives to More Obamacare Subsidies

Currently, the deductible in the (Obamacare) exchanges can be as high as $8,700 for an individual and $17,400 for a family. If you combine the average premium that people without subsidies paid last year with the average deductible they faced, a family of four potentially had to pay $25,000 for their health insurance plan before receiving any benefits. This is like forcing people to buy a Volkswagen Jetta every year before their insurance kicks in. For families living paycheck-to-paycheck, this is like not having health insurance at all.

One way to evaluate the worth of a product is to see if it can survive the market test. That is, are buyers willing to spend their own money to cover the cost of the product being offered? A Kaiser Foundation study estimates there are almost 11 million people who have elected to remain uninsured even though they qualify for subsidies in the exchanges. Meanwhile, the

unsubsidized part of the market has been in a death spiral – losing almost half of its enrollment (45%) between 2016 and 2019.

All told, we have a clear indication that what Obamacare is offering is not what people want. And that should not be surprising. Obamacare-type insurance is not what people chose to buy before Obamacare became law.

The Democrats answer to this problem is to double down. The American Rescue Plan, enacted in March 2021, increased Obamacare subsidies for those already receiving them and created new subsidies for the previously unsubsidized part of the market for two years. Furthermore, most of the new subsides are going to high-income families, who don't need financial help. The new spending proposal will extend those subsidies for three more years.

There are better alternatives and they are relatively simple.

Let people buy health insurance that meets their financial and medical needs.

Young families with moderate incomes and routine health needs will almost never willingly choose a plan like Obamacare, with its high deductibles. They want to know that they can take a sick child to the doctor's office or to the emergency room without having to worry about whether they can afford it. That's why they will almost always choose first-dollar coverage over last-dollar coverage.

So why not allow people to have the kind of insurance that meets their needs? Let families have a partial tax credit for the kind of insurance they want and send the remainder of the credit to a safety net fund that will cover those rare and unusual circumstances when the medical bills are really high.

Because Obamacare-regulated insurance is so unattractive, millions of people are finding health insurance outside that system. At last count, more than one million people were enrolled in "sharing" plans, which often unite families with similar religious beliefs. More than 3 million have short-term, limited-duration insurance – that traditionally bridged the gap from school to work or from job to job, but now is available for longer periods in many states. An estimated 3 million are in association health plans, which are available to people in the same line of work or trade.

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All told, for every two people with Obamacare insurance there is another person with unregulated, individually-owned insurance – in most cases getting no tax relief, while people in the Obamacare exchanges are getting a tax subsidy that averages about 80 percent of their premiums.

A fairer system would let everyone choose insurance that meets their personal financial and medical needs and give everyone some tax relief, regardless of the insurance plan they choose.

A frequent objection to this idea is that when people buy insurance that meets their own needs, they may neglect needs that we think are socially important – such as substance abuse or mental health care. The answer is: let government use some of its health care dollars to fund a safety net to meet needs that are inadequately insured for in the private marketplace.

In an ideal system, private markets are left

free to solve all the problems they can solve – because markets in general work so much better than government bureaucracy. The remaining role for government is to use safety net dollars to take care of those needs the private sector leaves unmet.

At a minimum, people who find their needs unmet in an unfettered insurance marketplace can always turn to the exchange plans – which by law must cover every applicant for just about every illness, regardless of health condition.

End Obamacare's narrow networks, which are denying patients access to the best doctors and the best care.

According to its supporters, a primary benefit of Obamacare is protecting people who enter the individual market with a preexisting condition. Yet the Affordable Care Act triggered a race to the bottom by giving health plans perverse incentives to attract the healthy and avoid the sick. The most successful Obamacare insurers are Medicaid contractors. The plans that have survived in the exchanges look like Medicaid managed care with a high deductible.

In an ideal health care system, health plans would compete to attract patients with medical problems.

As a result, in Dallas, Texas, no individual insurance plan includes the University of Texas Southwestern Medical Center – one of the country's premier medical institutions. In the entire state of Texas, cancer patients don't have access to MD Anderson Cancer Center in Houston – one of the country's premier cancer treatment centers. This pattern is repeated across the nation.

How could the individual market be different?

In an ideal health care system, health plans would compete to attract patients with medical problems. That's because risk-adjusted premium subsidies would make it profitable to enroll the chronically ill. Something like this is already being successfully done in the Medicare Advantage program.

Let workers have access to personal, portable health insurance.

There would be far fewer problems in the individual market if people did not lose their health plan when they are laid off, retire early, or become too sick to work. In an ideal world, most people would own their own health insurance and take it with them as they travel from job to job and in and out of the labor market. Because of a Trump administration executive order, we are closer to the ideal. Employers can now give tax-free funds to employees to buy health insurance that they will own.

This is a major change from the Obama regulations, which threatened to fine employers as much as $100 per employee per day – or $36,500 per year – for giving their employees the opportunity to own their own insurance.

Congress needs to codify this change and expand the range of plans that qualify to include short-term insurance, sharing plans, etc.

Protect virtual medicine, so that patients can get care in their own homes.

The benefits of telemedicine have been long known. But as we entered the year 2020 it was illegal (by act of Congress) for doctors to charge Medicare for a patient consultation by means of phone, email or Skype. Even non-Medicare

patients and their doctors were prohibited from using Zoom or Facebook or similar devices – because of privacy regulations.

Two things made radical change possible: Covid-19 and the Trump administration's commitment to deregulation.

Unfortunately, Trump's executive orders can easily be reversed by a future president. And, in almost every case, when the Covid emergency goes away, the newly acquired freedoms also go away. Congress needs to codify these changes to ensure their permanence.

Give families access to 24/7 virtual care.

Atlas MD in Wichita offers round-the-clock care by means of phone, email, Skype, Zoom and Facebook at nights and on weekends if needed. The cost: $50 a month for mother and $10 for a child. This model, called "direct primary care," not only offers patients the entire range of primary care services, it helps patients make appointments with specialists and helps them get discount prices on MRI scans and other medical tests. It even provides generic drugs for less than Medicaid pays in some instances.

This type of care needs to be an option throughout the health care system – in individual plans, in the Obamacare exchanges, in employer plans, and in Medicare.

Alternatives to Drug Price Controls

In the Inflation Reduction Act (IRA), Congressional Democrats are capping the annual out-of-pocket costs for all Medicare Part D enrollees at $2,000 and to impose price controls on some new drugs to boot. University of Chicago economist Tom Philipson estimates that because of the price controls there will be 135 fewer new drugs in the next two decades – causing a loss of 331.5 million life-years in the U.S. That is a reduction in life spans about 31 times as large as from Covid-19 to date!

The Congressional Budget Office (CBO) also predicts there will be fewer new drugs, and it predicts that some drug prices will now be higher. That's because, in anticipation of future controls on price increases, drug companies will charge a higher "launch price" when their drug is first introduced.

Fortunately, there is a better way.

Give enrollees access to drug plans that meet their financial and medical needs.

In a proper insurance arrangement, people self-insure for small expenses they can easily afford from their own resources and where cost control and waste avoidance are best done by the alert buyers, rather than by a third-party bureaucracy located miles away in some distant city. At the same time, people should rely on third-party insurers for very large expenses that would have a devastating impact on their finances and are difficult for individuals to manage and monitor on their own.

The Inflation Reduction Act (IRA) could result in 135 fewer new drugs in the next two decades - and a huge loss in life span.

Medicare drug coverage does the reverse. After a deductible (that can be as low as zero, depending on the plan), Medicare enrollees pay 25 cents of the next dollar of cost. And they pay 25 cents of the dollar after that. This keeps on going until the patient's out-of-pocket expenses reach a "catastrophic" limit of $7,050. Above that amount the patient is responsible for 5 percent of any additional costs.

A study of 28 expensive specialty drugs found

that even among Medicare enrollees covered by Part D drug insurance, the out-of-pocket spending by patients on those drugs ranged from $2,622 to $16,551. And those are annual costs! More than half (61 percent) of these drugs would require an average out-of-pocket cost of $5,444 in the catastrophic phase alone.

Medicare could be redesigned to cover all catastrophic costs, leaving patients with the responsibility to pay for smaller expenses. This would give seniors complete protection against potentially bankrupting drug costs, while leaving them free to economize on low-cost drug purchases – without spending any more taxpayer money.

At a minimum, seniors should be given a choice to stay in the current system or pay, say, $4 to $5 in extra monthly premium for drug insurance to limit their catastrophic exposure.

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Give enrollees access to drug plans that profit when patients stay healthy.

Medicare is the only place in our health care system where plans that sell drug coverage are completely separate from plans that cover medical expenses. So, if a diabetic neglects to purchase insulin or a cancer patient neglects to pay for cancer drugs, the drug plan they are in will profit from those decisions. But the health plan that covers the patient's medical procedures will likely incur costs that are much greater than any savings generated by failure to purchase those drugs.

The biggest problem in chronic care is noncompliance. The diabetic who neglects to take insulin and other drugs, for example, can end up in an emergency room, requiring expensive hospital care. That's why the typical Medicare Advantage plan and many employer plans make insulin (and many other chronic medications) free for enrollees. Yet no Part D insurer is doing that.

Currently only about half of all eligible enrollees are in a Medicare Advantage plan. However, more than 12 million of those who aren't are in something called an Accountable Care Organization (ACO). Doctors in ACO plans have incentives to encourage drug compliance, but their patients are in separate Part D Plans with deductibles and copayments for drug purchases that make compliance costly.

The Trump administration enacted several measures that encourage ACO patients to switch and become MA enrollees. More needs to be done.

Encourage a competitive market to meet the needs of the chronically ill.

In any system in which health plans are forced to community rate (charge the same premium, regardless of health status) the plans will have strong incentives to attract the healthy and avoid the sick. As noted, that is what is happening in the (Obamacare) exchanges where health plans discourage the sick with high deductibles and narrow provider networks and use the savings to attract the healthy with lower premiums.

Bad as things are in Obamacare, the effects are ameliorated by some risk adjustment – giving extra compensation to plans with disproportionately sicker enrollment populations. In Medicare Part D, however, the risk adjustment

is even less adequate, because the risk adjusters only have access to pharmaceutical information, not underlying medical information.

This gives Part D plans a perverse incentive to overcharge the users of expensive drugs and use the surplus funds to lower premiums for healthy enrollees, who tend to choose plans based on price alone. The entire rebate system (discussed below) is a prime example of how this works.

As noted, in the Medicare Advantage program things are different. MA plans can specialize in the treatment of such conditions as diabetes, heart care, cancer care, etc. They advertise and seek to enroll patients with these chronic conditions because it is in their financial self-interest to do so. Like a normal market, MA plans that fall behind their competitors in meeting patient needs risk losing customers to rival plans and incurring losses instead of profits.

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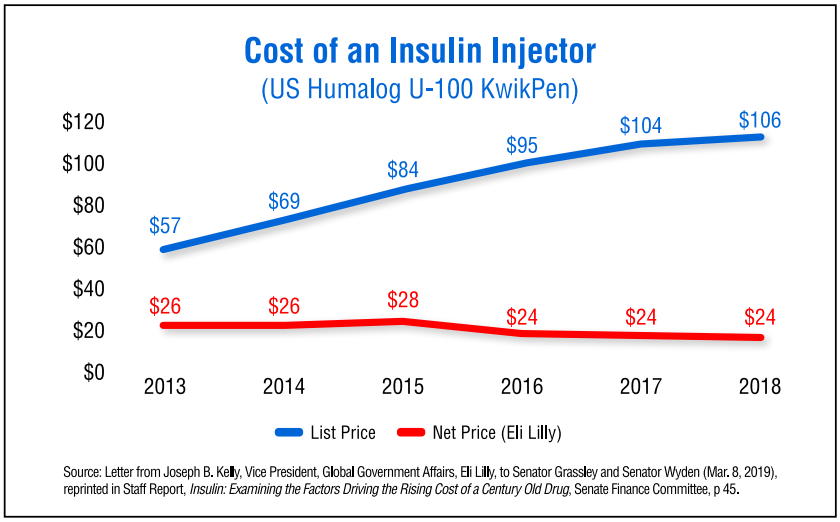
Let patients who buy the drugs get the full benefit of price discounts.

One of the most frustrating aspects of the market for Medicare-covered drugs is the practice of basing the patient's (25%) copayment on the list price of a drug, even though the insurer pays a much lower net price, courtesy of a rebate from the drug company. In some cases, the patient's copayment is higher than the cost of the same drug purchased from GoodRX or Mark Cuban's Cost Plus Drugs (at 15% over the manufacturer's cost). These discount outlets are able to offer low-priced drugs because they operate outside of the Medicare Part D system and its distorted incentives.

To add insult to injury, if the patient buys the drug from GoodRX or Mark Cuban, the Part D insurer doesn't pay any part of the bill and the purchase doesn't count toward the patient's deductible.

Why is this happening? It's tempting to search for a scapegoat.

Take the market for insulin. Critics of drug manufacturers claim that the price is so high because only three companies produce insulin for the U.S. market, and that smacks of monopoly. But as the accompanying graphic shows, the manufacturer's price in recent years hasn't even kept up with inflation.



Source: Letter from Joseph B. Kelly, Vice President, Global Government Affairs, Eli Lilly, to Senator Grassley and Senator Wyden (Mar. 8, 2019), reprinted in Staff Report, *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, Senate Finance Committee, p 45.

Other critics (including some in the drug industry) blame pharmaceutical benefit managers (PBMs). These are "middlemen" who contract with insurers to lower drug costs. Are they ripping

everyone off by paying rock-bottom prices to the drug companies, overcharging the patients, and pocketing the difference? To the contrary, a General Accounting Office (GAO) study finds that 99.6% of profits PBMs make from the rebate system are returned to patients in the form of lower premiums.

This really is a competitive market, even though the competitors face perverse incentives when they compete. It's the reason that premiums are more than one-third lower than they otherwise would have been. The perverse outcomes we are discussing here arise because of (1) the lack of adequate risk adjustment (described above) and (2) the antitrust law.

In the 1990s, drug companies could give upfront discounts to large institutional buyers, and these discounts could be passed along directly to patients. But pharmacists, who thought they were disadvantaged, brought a lawsuit under the Robinson-Patman law. As part of the settlement, drug manufacturers' upfront discounts were replaced by after-the-sale rebates.

Interestingly, one of the largest insurers in the country (Kaiser) is able to circumvent the antitrust law because it buys drugs for its own members. Kaiser negotiates upfront discounts with drug companies and passes those costs on to the patients.

Most economists think the Robinson-Patman law ought to be repealed in its entirety. Barring that, Congress should create a carve-out for drugs. And we need risk adjustments in the Part D program, to make them more like the risk adjustment in Medicare Advantage plans.

Let patients, rather than the government, get the full benefit of "negotiated" prices.

As noted, the IRA bill does not eliminate any of the perverse incentives in the current system. It keeps them all in place. Although it uses the term "negotiation," the mechanism for achieving lower drug prices is really price controls.

As we have seen, highly reputable analysts say this will discourage the production of new drugs and encourage producers to charge higher launch prices for the drugs they do produce. To the extent that these things happen, Medicare beneficiaries will be worse off. That's the down side. But to the extent lower prices are actually achieved (the upside), almost all the benefits will be realized by people who aren't in Medicare.

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Say a senior is in the 25% copayment range. Then, the senior will get only 25% of the benefit of any price reduction, while 75% goes to Medicare. If the senior is in the 5% copayment range, 95% of the benefit of a price reduction will go to Medicare.

However, these gains for Medicare (an estimated $288 billion over ten years) will not accumulate in the Medicare Trust Fund. Instead, the IRA bill uses the money to pay for other programs – including special-interest energy subsidies. Of the total, $64 billion is targeted for a three-year extension of Obamacare subsidies (discussed above), and in the very likely event that those subsidies are extended for a full ten years, $248 billion will go for Obamacare.

Under the pretense of doing something for the elderly and the disabled, the IRA bill is actually designed to take money from both groups and spend it on people who are mostly young and healthy.

When negotiations are real (and not coercive), evidence suggests that private insurers are just as effective as the government at negotiating price reductions. And if the perverse incentives are eliminated, 100% of those discounts would be passed on to the patient/buyers.

Make it easier to produce the generic version of brand name drugs.

One survey of the 12 top-grossing drugs in the U.S. found that filing multiple patents for these drugs slowed the ability of competitors to produce generic drugs. On average, drug companies were able to keep patent protection for these drugs for 38 years, nearly double the 20-year monopoly intended under U.S. patent law.

Another report found that some patent abuse schemes cost American consumers and the U.S. health care system billions of dollars each year. Reforms to curb patent abuse would still reward innovators, but also permit timely competition.

Let seniors have Health Savings Accounts.

Roughly 30 million Americans have a Health Savings Account (HSA), by which they manage some of their own heath care dollars. Seniors are not among them, due to a law that limits contributions to HSAs to people under the age of 65. This is unfortunate.

There are good reasons to believe that people can manage their own drug expenditures (especially generic drugs) better than third-party payers. Health economist Devon Herrick has shown that people can substantially lower their drug costs (in some cases by more than 90 percent) by techniques such as buying in quantity, splitting pills, etc. And it's legal for people to order drugs from a Canadian pharmacy for personal use.

Also, if seniors were allowed to use HSAs to contract with direct primary care (DPC) doctors – including phone and video access at nights and weekends – they would discover that some of these practices make generic drugs available for less than what Medicaid pays.

Give enrollees the benefits of deregulation.

The single most important deregulation in modern times was the Trump administration's executive order relaxing restrictions on vaccine production – something that was done before anyone knew that Covid was about to strike. When the pandemic did hit, a vaccine was produced six months earlier than would have been the case. University of Chicago economists estimate this regulatory change saved an estimated 182,000 lives.

A more radical reform would restrict the FDA's approval authority to a determination of safety, not efficacy. Since the outcomes of drug therapies vary a lot from patient to patient, drug effectiveness is almost always determined at the doctor-patient level. A safety-only standard would greatly lower the cost of new drugs and move them to the market much faster without putting patients at risk.

A more modest reform would speed up the process of moving drugs to over-the-counter status. Yet doing so could save patients the cost of unnecessary doctor visits. Other countries save money by allowing pharmacists more authority to prescribe. Contraceptives are an example.

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