Common Sense as Health Policy

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Principles for bipartisan reform

AMERICA is thought to have a market economy. Yet it is striking to consider all of the ways our health-care system prevents the market from solving our health-care problems.

Since most of the restrictions were created by Democratic legislation, it is tempting to view the liberation of health care as a Republican project.

But there is no reason that it couldn't be bipartisan. Here are several principles to guide reform.

Free the patient. About the only success Obamacare can claim has been an increase in the number of people with health insurance. But in contrast with the original promises, almost all the increase in insurance has been in Medicaid.

What's wrong with that?

Many doctors won't take Medicaid patients because Medicaid payments are so low and because Medicaid rejects more claims than either Medicare or commercial insurance. Many of our top medical centers won't take them, either. If they do take Medicaid patients, those patients are usually the last ones providers want to see.

A similar problem arises with various forms of convenient care — such as walk-in clinics and freestanding urgent-care facilities. Even when these places are willing to accept Medicaid's low reimbursements, they aren't often in the parts of the city where Medicaid patients typically live. Nor do they encourage Medicaid business.

One consequence is that Medicaid patients frequently turn to community health centers or hospital emergency rooms for their medical care. In fact, new enrollees in Medicaid visit emergency rooms 40 percent more frequently than others do.

Hospital emergency rooms are the opposite of convenient care. At Parkland Hospital, a safety-net hospital in Dallas, the average time a patient spends in the emergency room is almost six hours.

You might suppose there was a simple answer to this problem. Why not let Medicaid enrollees buy medical care the way they buy food with food stamps? They could add out-of-pocket cash to pay any portion of the bill that the government subsidy didn't cover and acquire care at market prices.

While that would be a simple and attractive answer, it could generate a harsh penalty: prison. If a doctor or nurse accepts a cash payment on top of Medicaid's rigid fee, that is a criminal act.

Massachusetts Institute of Technology health economist Amy Finkelstein, the nation's top Medicaid scholar, has a more radical proposal. Take the $600 billion we spend on Medicaid every year and give it to poor families in the form of cash.

One possibility is to put money into a health savings account (HSA), from which people could buy medical care and private insurance. After a period of time, any remaining HSA funds could be withdrawn for nonmedical spending.

Free the doctor. Doctors are the only professionals in our society who are not free to reprice and rebundle their services when technology, scientific knowledge, or the condition of the market changes. Medicare, for example, has 10,000 tasks it pays doctors to do. Commercial insurers and employers tend to pay the same way Medicare pays.

Although the list of tasks is voluminous, communicating with patients by phone, email, or Zoom was not on it before the Covid pandemic. It took an act of Congress and an executive order for doctors to get paid for activities that lawyers and accountants consider routine.

Not long ago, wealthy people paid thousands of dollars to "concierge doctors," who did talk to them by phone. But such arrangements were completely outside the normal third-party-payer system.

Today, this kind of service is called direct primary care (DPC), and it is increasingly affordable and popular. DPC is based on a model developed in Wichita, where the price is very reasonable. It costs $50 a month for an adult and $10 for a child for 24/7 access to a physician who provides all traditional primary care.

The DPC model is also attractive to employers. But current regulations prohibit employers from putting money into an account from which

employees can make monthly payments to a direct-primary-care doctor of their choice.

Clearly this needs to change.

Free the employee. Most people with health insurance are getting a subsidy from government or an employer, and the rules governing that subsidy are very confining. But why? Why should an employee have to be in a health plan chosen by an employer? Why not let the employee have a plan of her own choosing — one that she owns and can take with her if she changes jobs?

Before the Affordable Care Act (Obamacare), some employers actually funded personal and portable health insurance — chosen by the employee and owned by the employee. An Obama executive order threatened, however, to fine any employer caught doing this $100 per employee per day. That brought the practice to a grinding halt.

The Trump administration reversed course with its own executive order. Employers can now pay for health insurance chosen and purchased by their employees. But the insurance has to be “Obamacare-compliant.” That means employees essentially have to buy Obamacare insurance instead of the more attractive alternatives described below.

This also needs to change.

Free the insurance market. Obamacare was originally sold to the public as a way of protecting people with preexisting conditions, and some Democratic defenders of Obamacare continue to talk as if that were what it mainly did. In fact, Obamacare insurance is great for the healthy but lousy for the sick.

Four out of every five people in the Obamacare exchanges are paying premiums of $10 a month or less. If you have average income, the insurance is probably free. If you are sick, however, the annual out-of-pocket maximum exposure for a family this year is $18,900. That’s the amount you might have to pay in the form of deductibles and coinsurance, over and above any premium payment. Plus, if you had an

above-average income and didn't get a subsidy, know that the average family premium last year was $13,824.

The Obamacare exchange was originally billed as an improvement on the commercial insurance market. But what has emerged are plans that look very much like Medicaid with a high deductible. If a medical practice or hospital doesn't take privately managed Medicaid, it probably doesn't take Obamacare insurance, either.

If you buy insurance in the exchange, odds are good that the best institutions are not in your network. And if you go out of network, the plan pays nothing. It should come as no surprise that a lot of families are looking for alternatives. One possibility is short-term, limited-duration insurance.

The basic product has been around for many years. A typical plan lasts for only twelve months and serves as a bridge for people transitioning from a family policy to school, or from school to work, or from job to job. It resembles the kind of insurance that was popular before there was Obamacare.

What makes this product especially interesting is that it is largely unregulated. The plans can and do ask health questions, and they exclude people with expensive chronic conditions. Partly for those reasons, these plans often sell for as little as half the price of Obamacare insurance. They also typically have lower deductibles and broader provider networks.

Because President Obama saw these plans as a competitive threat to the Obamacare exchanges, he issued an executive order to limit them to three months' duration and no renewal.

By contrast, President Trump allowed these plans to operate for twelve months' duration, with an option to renew for two more years. Trump also allowed a second type of insurance to bridge the gap between three-year periods, protecting people from a premium increase if they developed a health problem that was expensive to treat. In this way,

Trump really opened the door to free-market health insurance under which people could have insurance protection indefinitely.

Following these changes, the short-term market quickly expanded from 600,000 to 3 million enrollees. But President Biden recently restricted the plans to three months' duration, with renewal for only one month.

There is no justification for Biden's denying people the opportunity to buy insurance that meets their family's financial and health-care needs. If a short-term plan fails to meet a family's needs, as critics claim may happen, the family can always turn to an exchange and buy Obamacare insurance.

Free the chronically ill. Because of unwise government regulations, no health plan wants to attract the sick. No employer. No commercial insurer. No plan in the Obamacare exchanges. That is why most people with expensive health-care problems have worse health insurance today than they likely would have had before the Affordable Care Act was passed.

The one exception is the Medicare Advantage program, through which health plans receive risk-adjusted premiums based on the health status of the enrollee. Medicare Advantage is the only place in the entire health-care system where a doctor who discovers a change in a patient's health condition (say, cancer) can forward that information to the insurer (in this case, Medicare) and obtain a higher premium payment reflecting the higher expected cost of care.

Even though created by government and highly regulated, the Medicare Advantage program comes closest to resembling what free-market health care for the chronically ill could look like. It also has lower costs and offers higher quality than traditional Medicare.

Because of sophisticated risk adjustment, some Medicare Advantage plans specialize in such chronic conditions as diabetes, heart disease, and lung disease. This sort of specialization is not allowed in the Obamacare exchanges, where plans are forced to be all things to all patients. The market for individually purchased insurance would be

radically transformed overnight if we allowed it to operate under the same rules that Medicare Advantage does.

Another opportunity for improvement is in the design of health savings accounts. HSAs have been attacked by the Left as a savings vehicle for the healthy. There is some truth in that. Take diabetes. A rational insurance design for a diabetic might make insulin and other maintenance drugs available for free to the patient. That's because drug adherence is the most important aspect of care. On the other hand, if the patient fails to adhere to a drug regime and ends up in an emergency room, he should pay that expense from his HSA, bearing the full cost of his bad decisions.

The HSA law, however, doesn't allow flexible deductibles (high for some items and zero for others). Instead, it requires an across-the-board deductible for all expenditures. President Trump took a step in the right direction with an executive order that allowed employers to freely provide maintenance drugs to employees for 13 chronic conditions without jeopardizing the employees' ability to maintain their HSAs.

More needs to be done. We need to divorce the HSA from any deductible requirement and allow the market to make decisions with regard to cost-sharing by patients. We also need to allow employers and other third-party insurers to deposit any amount they deem appropriate into the accounts of chronic patients who agree to manage more of their own care.

Establish tax fairness. A final issue that cries out for reform is the way the federal government subsidizes health insurance. Currently, people at the same income level are getting radically different tax subsidies, depending on where they get their health insurance.

In general, the subsidies in the exchanges are highly progressive, while the subsidies for employer-provided coverage are highly regressive. This means that a low-income individual in an exchange is getting many times more help from the federal government than someone making the same income and obtaining the same insurance at work. Conversely, a high-income individual in an exchange is getting only a fraction of the

government help that someone with the same income, obtaining the same insurance at work, receives.

That is unfair to the individual, and it also has potentially bad consequences for the economy as a whole. Because health insurance these days is such a large portion of employee compensation, these radically different subsidies can cause firms and entire industries to reorganize in response to them. Firms now have an incentive to make decisions based on health-subsidy costs and benefits.

As part of his 2008 presidential campaign, John McCain proposed replacing all government health-insurance subsidies with a uniform refundable tax credit, to give all the same help from the government regardless of where they bought insurance. The latest version of this idea is the Health Care Fairness for All Act, introduced in the House by Representative Pete Sessions (R., Texas) and his colleagues. Under this approach, the government would not play favorites. We would all get the same help from Uncle Sam, regardless of where we obtained our health insurance.

The reforms suggested here are not particularly conservative or liberal. They are not obviously Democratic or Republican. They are, more than anything, common sense applied to health-policy problems. They will face special-interest opposition, of course. But they should appeal to the vast majority of voters.

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