The Greatest Health Plan Ever

Wherever we look around the world today we almost always find that normal market processes have been systematically suppressed in health care. As a rule, no one ever sees a real price for any medical service. No patient. No doctor. No employer. No employee. Further, we have not replaced the price system with an alternative that would allow people to make rational choices.

The Sessions/ Cassidy proposal removes the federal government as a source of some of our most important health policy problems.

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As a consequence, in virtually every health care system in the world, people face perverse incentives. When they act on those incentives they do things that make costs higher, quality lower, and access to care more difficult than otherwise would have been the case.

In the United States, federal policies are a key source of many of these problems.

Coming to the rescue is a remarkable health plan, introduced by Rep Pete Sessions (R-TX), who, as Chairman of the Rules Committee, is thought to be the second most powerful member of the House of Representatives, and Sen. Bill Cassidy (R-LA), who is probably the most knowledgeable person on health policy in the Senate.

Half of the 12 bold ideas in the Sessions/ Cassidy proposal have never appeared in any previous bill or proposal.

The two gentlemen immodestly call their proposal, "The World's Greatest Healthcare Plan" (hereinafter, WGHP). Given what they are attempting to do, that appellation may not be unreasonably boastful. Of 12 bold ideas in the legislation, fully half have never appeared in any previous bill or in any previous proposal – Republican or Democrat. Here are the goals:

- Based on a thorough review of the major ways in which federal policies create perverse incentives, the bill corrects those perversions and removes the federal government as a source of some of our most important health policy problems.
- Along the way, the legislation makes good on what many regard as the three broken promises of the Affordable Care Act (ACA): universal coverage, cost control and real protection for people with pre-existing conditions.
- At the same time, the bill paves the way for a medical marketplace in which empowered patients can make more of their own choices, while enjoying protection against the cost of catastrophic illness – both the financial cost and the cost

of rationing by waiting.

Before showing how this is done, let's jump to the major provisions of the legislation:

- It repeals all the ACA mandates and replaces current tax and spending subsidies with a universal tax credit that that varies by age and geography, but is the same regardless of income.
- It ensures that the social safety net will always be adequately funded, regardless of the number of people with private insurance.
- It allows Medicaid to compete with private insurance, since the size of the tax credit for private insurance is roughly equal to the federal contribution to a well-managed Medicaid plan.
- It allows employers to buy individually owned insurance for their employees – insurance which they can take with them from job to job.
- It replaces all tax-favored medical accounts with a Roth Health Savings Account.
- It gives employers and employees new tools to control costs, allowing them to convert insurance benefits of marginal value dollar-for-dollar into take-home pay.
- It denationalizes and deregulates the exchanges and subjects competing health plans to a type of "free market risk adjustment."

A summary of the major provisions of the legislation, with links to short white papers explaining each of them, and 25 problems in the ACA that the legislation is designed to correct can be found on the Goodman Institute website (goodmaninstitute.org).

Now, let's see how the proposal affects fundamental choices people have to make.

Insurance or Uninsurance?

Before the enactment of the ACA, we were spending far more on free care for the average uninsured patient than we were spending on subsidies for individually-purchased insurance. That meant millions of people had an incentive to be uninsured. They were getting a better deal from implicit insurance through the social safety net than they were getting from tax advantaged private insurance.

That situation has now changed for people who are getting highly subsidized insurance in the (ObamaCare) exchanges. But one reason the enrollment numbers have been so disappointing is that many obstacles stand in the way.

ObamaCare forces people to have one-size-fits-all insurance that is often inconsistent with their health and financial needs.

People are being confronted with one-size-fits-all insurance that is often inconsistent with their health needs and their financial needs. Enrollment can be an administrative headache in exchanges that still do not function the way they were originally envisioned. Enrollees must guess their income a year in advance and pay higher taxes if they guess wrong. Several million low-income families fall into an ObamaCare "no man's land," where they are ineligible for Medicaid as well as subsidized insurance in the exchange.

The employer mandates favor part-time, temporary and contract work over full time employment and favor small companies over larger ones. They also are encouraging employers to offer "unaffordable" options to low-wage employees; and when these offers are rejected, the employees and their families are

ineligible for subsidized exchange insurance.

At the same time, the financial incentive to remain uninsured for many is stronger than before. By (1) eliminating individual underwriting, (2) imposing guaranteed issue and community rating regulations, (3) allowing risk pools and other public and private plans to dump their sickest, most costly patients into the exchanges, and (4) imposing weak or non-existent penalties on potential enrollees who game the system, the ACA has actually created greater incentives for some to willingly choose to be uninsured. The cost of insurance has become much higher and the cost of getting insurance after people get sick has become much lower for a great many people.

How does the WGHP solve these problems? Because the tax credit is independent of income, no one has to guess their future income. Because the credit is the same for everyone, the exchanges do not have to verify income with the IRS. Because the credit is available regardless of eligibility for Medicaid or an employer plan, the exchanges do not have to verify those things either. A company such as EHealth could easily enroll people with off-the-shelf technology, the way they have been enrolling people for years. And because all of the anti-job provisions of the ACA (including the high marginal tax rates created by the phase out of the ObamaCare tax credits) will be gone, families will have more income with which to pay premiums.

Under the WGHP, there is no reason for anyone to be uninsured. But if people choose that option, some portion of their unclaimed tax credits will be sent to safety net institutions in the communities where they live. Money will follow people. If everyone in a community opts to be insured, the tax credits will help pay for private insurance, and safety institutions will get no federal help. If everyone elects to be uninsured, money will go to local safety net institutions as a backstop in case patients cannot pay all of their medical bills. The uninsured consume only about half as much health care as the insured. Plus, they pay about half of the costs out of their own pockets. So, for every $1 of tax credits that go unclaimed, 25 cents will be sent to local safety net institutions.

If everyone in a community opts to be insured, the tax credits will help pay for private insurance and safety net institutions will get no federal help.

The subsidy for private insurance will always be larger than the federal contribution to the safety net.

Public or Private?

Before the ACA, we spent far more on enrollees in such public programs as Medicaid and CHIP than we spent on subsidies for individually-purchased insurance. Thus, millions of people had an incentive to choose public insurance rather than private insurance, and whenever there was an expansion of public insurance eligibility, private coverage dropped – even if the public insurance wasn't as good. The ACA actually reverses that problem for many families – spending more on exchange enrollees than it spends on people with comparable income on Medicaid.

By contrast, the WGHP is designed to ultimately equalize all forms of government help. Medicaid is block granted to the states for four distinct population groups (elderly, disabled, single adults and families with children). Eventually, the per capita allotment in each group will be equalized

nationwide. The nationwide average tax credit is roughly equal to the federal contribution to a well-managed Medicaid plan. If the state chips in its share of Medicaid spending, a family should be able to leave Medicaid, claim the tax credit and obtain privately administered, Medicaid-like insurance for a few dollars a month, at most.

If a state wants to do so, it could let its Medicaid program compete with private insurance – a public option that some on the left have long advocated.

Individual or Group?

Under the current system, almost everybody with a below average income gets a larger tax subsidy in the exchange than they get with employer-provided insurance. For those with above average incomes, the subsidies are generally much larger at work. This is clearly unfair. Families at roughly the same income level are getting subsidies that can differ by as much as $10,000 or more, depending on where they get their insurance. It is also causing the entire structure of some industries to change.

Worse than all of that, however, is the fact that federal policies are trying to force employers to be in the health insurance business -- even if they are no good at it. And the insurance which employers are being forced to provide is non-portable. A change of jobs almost inevitably means a change of doctors and thus no continuity of care. Surprisingly, if an employer buys individually owned insurance with pre-tax dollars the (ObamaCare) fine is a whopping $100 per employee per day, or $36,500 a year – higher than any other penalty!

Under the WGHP, there will be a level playing field for the individual and group markets. Employers will provide insurance if they have something to offer that their employees cannot easily get on their own. If not, they will pay higher wages. Importantly, all laws and regulations that are today preventing employees from having personal and portable health insurance will be repealed.

There will be a level playing field for the individual and group markets.

Third-Party or Self Insurance?

Historically, employer-provided insurance was liberally subsidized through the tax law while self-insurance through a saving account was not. That is why people had too much of the former and too little of the latter. This in turn led to third-party payer domination of the entire medical marketplace. The introduction of Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) has helped change things for the better. But the law is still too restrictive and the Obama administration is threatening to regulate HSAs out of the individual market completely.

Under the WGHP, there will be a completely flexible savings account and it will be possible to combine the account with third party insurance in creative ways – including special accounts for the management of chronic illness.

With a Roth HSA, contributions are made with after tax dollars. With a fixed sum tax credit, any additional premium (over and above the amount of the credit) will be paid with after tax dollars. This puts third-party insurance and individual self-insurance on a level playing field under the tax law. Since withdrawals from the Roth HSA are tax free, non-health goods and services will trade against health care in an unbiased way. And since the Roth accounts grow tax free, future

health and non-health consumption will also trade against each other in a neutral way.

Health Care versus Other Goods and Services.

Under the current system, when an employer pays an employee a dollar in wages, that dollar is subject to federal, state and local income taxes, in addition to the (FICA) payroll tax. Yet if the employer spends that same dollar on health insurance, the dollar gets spent tax free. Suppose the employee is facing a 15 percent payroll tax and a 15 percent federal income tax. If the employer pays a dollar of wages, the employee gets only 70 cents in take-home pay. That can make additional health insurance attractive, even if it is worth only 71 cents.

Moreover, the higher the marginal tax rate, the more wasteful health insurance can be and still be preferable to wages. High-paid Silicon Valley employees facing California's state income tax, for example, are actually paying less than half the cost of their insurance – after the tax breaks are taken into account. These folks are likely to prefer a dollar of insurance to a dollar of wages, even if the insurance is worth less than 50 cents on the dollar!

No wonder our system is so wasteful.

Under the WGHP, the employer (or union) will have a choice. They can continue under the current tax regime, or they can have a dollar-for-dollar tax credit up to $2,500 for an adult or $8,000 for a family of four.

The credit approach pushes the tax benefits up front – presumably funding the core insurance we want everyone to have. All additional insurance is effectively purchased with after-tax dollars and is on the same footing with take-home pay. This means that workers, on the average, can have the same tax relief they had before without perverse incentives to over-insure. It also means that if employers and employees eliminate wasteful insurance they can convert it dollar-for-dollar into take-home pay. Here is a reasonable guess: I think the average household will end up with $2,000 a year in extra income.

If employers and employees eliminate wasteful insurance they can convert it into take-home pay.

Choices in the Market for Risk Avoidance.

President Obama promised a marketplace in which health insurers would no longer discriminate against chronic patients with pre-existing conditions. What we have instead is a race to the bottom, with networks so narrow that patients are finding it harder and harder to find the specialist care they need.

At the time of enrollment, insurers face perverse incentives to attract the healthy and avoid the sick. The conventional wisdom in the industry is that healthy people buy on price. Only the sick spend time looking to see what doctors and facilities are in the health plan's network. Only the sick pay close attention to copays and deductibles – especially for medications for chronic conditions.

After enrollment, the insurers have a perverse incentive to over-provide to the healthy (to keep the ones they have and attract more of them) and under-provide to the sick (to encourage the exodus of the ones they have and discourage enrollment by any more of them). They are acting on those incentives.

On the buyer side, the Obama administration has made it very easy for people to choose skimpy insurance or no insurance at all while they are healthy and then switch to a very rich plan after they get sick.

Under the WGHP, things will be different. Just as in the Medicare Advantage program, when enrollees change health plans the new plan will receive a premium that is actuarially fair. We call this "health status risk adjustment."

The enrollees themselves will pay a community rated premium. If there is an additional expected cost, it must be paid by the enrollee's previous insurer. The amount will be initially based on the Medicare Advantage risk rating formulas. However, the plans will be able to voluntarily improve on those formulas and ultimately they will be determined in the marketplace.

Risk rating will make all potential enrollees equally attractive, regardless of health status. No insurance plan will be able to dump its high-cost, sickest enrollees on another plan, the way they are doing today.

Under the current system, insurers cannot ask health questions of potential buyers of health insurance. That is supposed to protect those with pre-existing conditions. By contrast the WGHP encourages health plans to specialize in the treatment of chronic conditions (e.g., heart disease or cancer) and actively try to recruit patients who could benefit from their services. Unlike the current system, where medical records rarely follow patient from plan to plan, under the WGHP records will automatically follow the patient unless the patient objects.

Unlike the current system, buyers of insurance will not be allowed to game the system. For example, no one will be allowed to upgrade to a richer plan, paying a community rated premium, after they develop a costly illness. After a one-time enrollment, people who wish to upgrade to a richer plan will be charged the full actuarial cost of the upgrade. If they downgrade, they will realize the full actuarial savings. Similarly, no one will be allowed to remain uninsured until sickness arrives and then buy insurance for the same premium everyone else is paying. As in the Medicare Part B and D programs and in the Medigap market, people will be penalized if they do not insure at the first opportunity or if they do not remain continuously insured. Although states will make the decisions under the WGHP, the ideal penalty is medical underwriting.

The Results.

The WGHP does not correct the many distortions and perverse incentives created by state and local governments. At the federal level, however, we will have started with a health system in which incentives are perverse in every direction and converted it into one in which everyone's economic incentives are sound.

Although the legislation is introduced by two Republicans, Democrats may find a lot to like here. In fact, I would be surprised if the proposal doesn't get considerable bi-partisan support. After the election, of course.

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