

The reform agenda proposed here would radically transform the U.S. health-care system by empowering patients, liberating markets, and removing government obstacles to lower-cost, higher-quality, more accessible health care.



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# A Health Plan for President Trump<sup>1</sup>

President Donald Trump says he wants health reform that will be better than Obamacare, better than what we had before Obamacare, and better than the Democrats' Medicare for All. And he's not alone. Numerous surveys show that health reform remains a top priority for Americans, who are concerned about high costs, access, and choice.

To address these problems, health reforms should focus on making it as easy as possible for people to access innovations such as:

1. Personal, "portable" health insurance that travels with them from job to job and in and out of the labor market.
2. Round-the-clock communication with their personal physicians by phone, email, and Skype.
3. Telemedicine, so they can even "visit" the doctor from home – avoiding traffic, long waits, and unneeded emergency-room visits.
4. Centers of excellence that specialize in chronic health conditions (including preexisting conditions) and actively compete for patients.

5. Accounts owned and controlled by patients who are willing to manage their own care, including most forms of chronic care and even routine surgery.

Government should not mandate these changes. If employees and their employers like the arrangements they now have, they

should be able to keep them. But government needs to get out of the way, cut red tape and conflicting requirements, and quit interfering with the opportunity for

people to have better options.

The Trump administration has already implemented executive actions that have brought us closer to all five of these goals. But to complete the reforms, Congress needs to enact legislation.

Here are some particulars.

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<sup>1</sup>Originally appeared at [National Review](#) online.

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## 1. Personal and Portable Health Insurance.

In an ideal world, most people would own their own health insurance and take it with them as they traveled from job to job and in and out of the labor market. Some employers may have better insurance than is available on the open market. But others might prefer to make a cash contribution to help employees pay their own premiums rather than provide insurance directly.

Some employers were actually doing that before Obamacare. They used an account called a Health Reimbursement Arrangement (HRA), providing tax-free funds employees could use to buy their own health insurance.

But with Obamacare came regulations and threats of steep employer fines that effectively deep-sixed this option.

Thankfully, the Trump administration is reversing course. Beginning next January, employers will be able to use HRAs to help employees obtain their own coverage with the administration's blessing.

The Council of Economic Advisers estimates this change will affect 11 million workers. But it would affect far more if states cleaned up their individual markets to make them a more attractive option.

Congressional action should codify what the administration has already done and broaden the reform in several ways. In particular, states need broad authority to authorize insurance products that meet their residents' needs, rather than meeting Obamacare's expensive mandates. Congress also needs to give states the freedom to make reforms that would lower costs and expand access to care.

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## 2. Round-the-Clock Medical Care.

Concierge doctors used to be available only to the rich. Today, "direct primary care" is far more affordable. [Atlas MD](#) in Wichita, for example, provides all primary care along with 24/7 phone and email access and generic drugs for less than what Medicaid pays. They help patients gain access to specialist care and diagnostic tests, with minimal waiting. The cost: \$50 a month for a middle-aged adult and \$10 a month for a child.

There are [790 direct primary-care practices](#) like Atlas in the United States. Typically, they provide round-the-clock access to a physician via phone,

email, and Skype. These practices have a number of [attractive features](#) – and an excellent track record: They expand access to care, improve the quality of care, reduce overall health-

care spending, and report high levels of patient satisfaction.

This development has the potential to radically transform the way medicine is practiced in the United States. The only things standing in the way are unwise public policies.

A number of employers are creating access to [direct primary care](#) as an employee benefit. However, under current law they cannot put tax-free dollars into an account and let employees use the money to select a direct-pay doctor of their choosing.

The Trump administration has directed federal agencies to see if HRA accounts and health savings accounts (see below) can be used as vehicles to overcome the current regulatory obstacles.



In addition, the administration hopes to make Medicare more open to direct primary care. Under the arrangement, Medicare would pay a fixed monthly fee to a physician or physician group instead of the traditional fee-for-service payments. In return, the physicians would provide virtually all primary care. The fees would range from **\$90 to \$120 a month**, depending on the patient's age and medical complexity.

While this is a good start, more is needed to make direct primary care widely available to Medicare patients. The reason: Most direct primary-care doctors have opted out of all third-party insurance arrangements, including Medicare. These doctors cannot contract with a Medicare patient unless they are in Medicare. Further, once in Medicare, doctors won't be free to engage in the type of innovation that makes direct contracting so successful.

Congress can and should eliminate this Catch-22.

### 3. Access to Telemedicine.

The ability to **deliver medical care remotely** is growing by leaps and bounds. It promises to lower medical costs, increase quality, and reduce the time and travel cost of patient care. For example:

- After hip and knee replacements at **Tallahassee Memorial HealthCare**, patients are transported to rehab facilities, nursing homes, and even their own homes – where follow-up observations are made with video cameras.
- A nurse at **Mercy Virtual Hospital in St. Louis** can use a camera in a hospital room in North Carolina to see that an IV bag is almost empty. She can then call and

instruct a nurse on the floor to refill it. The telemedicine cameras are powerful enough to detect a patient's skin color. Microphones can pick up patient coughs, gasps, and groans.

The problem? **Medicare doesn't pay for any of this**. And since private insurers and employers tend to pay the way Medicare pays, the entire country is missing out on incredible advances in telemedical technology.

This is not an accident. Federal law (the Social Security Act) allows Medicare to pay for telemedicine only under strictly limited circumstances. For the most part, doctors can examine, consult with, and treat patients remotely only in rural areas, and even there, patients can't be treated in their own homes.

The CMS is **acting aggressively** to change this. As of January 1 of this year, doctors in Medicare Advantage plans and accountable care organizations can now bill Medicare if they use phone, email, Skype, and other technologies to consult with patients remotely to determine if they need an in-office visit. Patients can be anywhere, including their own homes.

Doctors can also bill Medicare to review and analyze medical images patients send them. And they can bill for telemedical consultations with other doctors.

But these are still baby steps. Congress needs to **liberate** telemedicine once and for all.

### 4. Access to Centers of Excellence.

On the Obamacare exchanges, there has been a **race to the bottom** as health plans try to attract the healthy and avoid the sick. Increasingly, enrollees have been denied access to the best

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doctors and the best facilities. In Dallas, Texas, for example, no individual insurance plan includes Southwestern Medical Center, which may be the best medical research center in the world. In Texas generally, cancer patients with Obamacare insurance don't have access to MD Anderson Cancer Center in Houston. This pattern is repeated all over the country.

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. The networks include only those doctors who will accept Medicaid fees coupled with all the hassle of managed-care bureaucracy.

Before Obamacare, most states had risk pools for the small number of people who entered the individual market with an expensive preexisting condition and were denied access to ordinary insurance coverage. The risk-pool plans looked like garden-variety Blue Cross plans, with access to almost all doctors and hospitals. While some risk pools had problems – such as being over-subscribed and unable to take new customers – those problems were discrete and addressable.

Obamacare threw out this model in favor of a D.C.-designed solution. The result? Access to care for people with preexisting chronic conditions has seriously deteriorated. That needs to change.

Entities such as Cancer Treatment Centers of America need to be able to enter the individual market, restrict enrollment to patients who have

cancer, and receive a premium that covers their expected costs.

Instead of expecting every health plan to be all things to all patients, we should encourage specialization. We need focused facilities for such chronic conditions as cancer care, diabetic care, and heart disease. To make the market work better, medical records need to travel with the patient from plan to plan, and insurers need to be able to design better risk-adjustment mechanisms rather than being forced into federal government-designed systems.

How can these changes be made? Here it is even more critical that government clear away today's barriers and let private markets function.

Some of this is already being done by executive rulemaking and through waivers. President

Trump has taken [aggressive steps](#) in this direction, giving states new authority to experiment. This has already led to [lower costs in seven states](#). In Maryland, premiums that had been expected to rise 30 percent actually fell by 13 percent thanks to state reforms.

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Congressional action will almost certainly be needed to complete the task. Ideally, states should be given [broad authority](#) to reform their private individual markets, with one important proviso: Conditions must get better for people who have health problems. "Better" means lower premiums, lower deductibles, and broader networks of providers. And people who are sick or in low-income households must be free to use their existing subsidies to pick the right plan for them, rather than being warehoused into Medicaid or Obamacare.



States must not only show unmistakable progress in this respect, but also establish as a goal a market in which sick people can get access to the doctors they need – without raising costs for everyone else, as Obamacare does today.

It doesn't take new federal mandates and programs to reach these goals. Rather, the Trump administration's regulatory relief has amply demonstrated that we move in the right direction when states are allowed to escape existing mandates that have distorted market incentives and led to our current problems.

Congress could help empower the states to carry out needed reforms by enacting the [Health Care Choices Proposal](#), developed by the Health Policy Consensus Group and [supported](#) by more than 100 conservative leaders across the country. This proposal would block-grant Obamacare funds to the states and give them wide discretion to reform their individual health-insurance markets. The Center for Health and the Economy [estimates](#) that this proposal would lower health-care premiums by as much as a third, would insure about the same number of people as Obamacare, and would better protect people with preexisting conditions and high health costs.

## 5. Patient Power.

How can we control health-care costs and at the same time improve quality and create greater access to care? Here is one answer: Give patients control over more of their health care dollars.

Roughly 25 million people now manage some of their own health-care dollars through health savings accounts (HSAs), which they own and control. The evidence shows that

these patients are conservative shoppers in the medical marketplace – saving money without any deterioration in the quality or access to care. However, the potential for these accounts is much greater.

Right now, patients use HSAs primarily to pay small medical bills below their deductibles. But they could and should be used in just about every aspect of medicine, including expensive surgery, chronic illness, custodial care, and emergency-room visits.

For example, there is mounting evidence that patients suffering from diabetes, heart disease, cancer, and other chronic illnesses can (with training) [manage a lot of their own care](#) as well as – or better than – traditional doctor therapy can. If they are going to manage their own care, they will do an even better job if they are also [managing the money that pays for that care](#).

In addition, there is no reason why patients could not manage [almost all the money used for primary care](#), including routine doctor visits and most diagnostic tests – spending from an HSA that they own and control. If patients control the money, it will flow toward cost-saving options.

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They will substitute less expensive phone and email consultations for doctor's-office visits; they will shop for better prices on everything from blood tests

to mammograms; and they will opt for walk-in clinics and free-standing emergency care instead of hospital emergency rooms when appropriate.

On the East Coast and the West Coast, [Uber-type doctor visits](#) at nights and on the weekends are an increasingly popular alternative to the emergency room. A doctor house call costs about \$100, and the doctor usually arrives within

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an hour. Emergency rooms typically charge about five times more. Give patients control of the money and you will see this service all over the country.

HSA's can also help control the cost of expensive surgery. For example, WellPoint (Anthem) in California limited the amount it would pay for hip and knee replacements to \$30,000 for its CALPER enrollees. Patients could get the procedure done at any hospital, but if the cost was greater than that amount, they had to pay out of their own pockets. This experiment had a dramatic effect, [bringing down the cost of surgery across all of California](#). But the impact would have been even more dramatic if WellPoint had deposited \$30,000 in the account of every patient who was a candidate for surgery. That way, if a patient found a hospital whose cost was, say, \$28,000, the patient would enjoy a \$2,000 "profit."

Both insurers and their enrollees would do better still if they considered traveling for care. [Health City Cayman Islands](#) offers high-quality hip and knee replacements for one-half to one-third less than what the procedures cost in California. Employers have found employees not very receptive to medical travel. But let the patient have \$30,000 in an HSA with the opportunity to save \$10,000 or more, and the willingness to travel is likely to soar.

To take advantage of the full potential of HSA's, we need three policy changes: (1) People should be able to use completely flexible HSA's, wrapping them around any health-insurance plan

and using them to pay for any medical costs the plan does cover; (2) they should be able to use their HSA's to pay premiums as well as out-of-pocket expenses; and (3) health plans should be allowed to have "shared savings programs," where enrollees who choose better and cheaper care get to keep their share of their savings in their HSA.

The Trump administration recently made a [major announcement](#) with respect to the first of these changes. Going forward, employees with HSA's will be exempt from the high-deductible requirement for the treatment of chronic disease. This means that the employer or insurer will be able to provide first-dollar coverage for some services without running afoul of HSA regulations.

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The reform agenda proposed here would radically transform the U.S. health-care system by empowering patients, liberating markets, and removing government obstacles to lower-cost, higher-quality, more accessible health care. It builds on emerging successes by innovators empowered by President Trump: doctors trying new ways of delivering care, states trying new ways of healing broken private markets, and patients demanding better care at lower costs.

President Trump should build on these successes and work with Congress to clear away the barriers blocking these innovators from spreading their wings. That's the way to provide better care at lower costs.



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