

Health Care Components of the \$3.5T (Or, Is It \$5.5T?) Spending Plan

By [John C. Goodman](#) and [Linda Gorman](#)

Congressional Democrats are proposing to spend an enormous amount of taxpayer dollars on what the *New York Times* calls a [“cradle to the grave”](#) addition to U.S. social welfare. Until late last week, few details were public beyond a [Fact Sheet](#) and various bills that members of Congress have sponsored on similar topics.

The House Energy and Commerce Committee has scheduled a hearing for September 13 on its [legislative recommendations](#). But Democrats seem deeply divided on what the final product should look like.

Normally, bills are “scored” by the budget experts on a ten-year horizon. But Democrats are apparently planning to do what Republicans have also done in the past – starting individual measures five, six or seven years late, so that much of the real cost [falls outside](#) of the ten-year window.

When these budgeting shenanigans are ignored, the [Committee for a Responsible Federal Budget](#) estimates that the full cost is not the \$3.5 trillion that has been widely advertised, but at least \$5.0 trillion and possibly as much as \$5.5 trillion. The

health care components of the plan are shown in the table below.

Health Care Components of the Plan

Expansions of home and community-based health care services	\$400 billion
New dental, vision, and hearing benefit in Medicare	\$370 billion
Closing the Medicaid "coverage gap" in non-expansion states	\$300 billion
Extension of expanded Affordable Care Act benefits from the American Rescue Plan	\$165 billion
Lower patient spending on prescription drugs	\$120 billion

Source: [Committee for a Responsible Federal Budget](#)

New Home Care Benefit

About 20 percent of hospital patients covered by Medicare are discharged to a skilled nursing facility. Part of the spending package will require that Medicare patients qualified for nursing home care be given the choice to duplicate those services at

home. Payment will be made to home care providers, not patients.

As we show below, the current home health program is deeply flawed. Instead of correcting these flaws, the proposal builds on them – all the while spending far more than is necessary. The proposal also ignores higher-quality, lower-cost alternatives, as well as alternatives that would empower patients, not bureaucrats.

Current System Flaw: Failure to Deliver Care. One of the problems with home health care is that many people do not get it even though they are approved for it. Medicare payment policies require that post-hospital home care start within 14 days after hospital discharge. A [2020 study](#) of 2.4 million Medicare beneficiaries with a home health referral at their hospital discharge found that only slightly more than half (54 percent) received any home health care within 14 days. More than a third never received any home health care despite being referred to it. Receipt of home care was even lower for those dually enrolled in Medicare and Medicaid, and patients living in high-poverty, high-unemployment zip codes.

Another [2020 study](#) found that 29 percent of patients referred to home health care did not get it. Receiving home health care did lower the probability of mortality and readmission, but the patients who did not get home care tended to be sicker.

No one knows why these patients failed to get the recommended home health care – whether because of

bureaucratic obstacles or because the patients' needs were met in some other way.

Current System Flaw: Fraud. Home health care fraud is big business. So big that in 2013, the Centers for Medicare and Medicaid Services (CMS) imposed a temporary moratorium on the enrollment of new home health Medicare providers in Miami and Chicago. This [temporary halt](#) was [extended 9 times](#), expanded to include all of Florida, Illinois, Michigan and Texas. It [was finally ended on January 30, 2019](#).

Home care is a fertile area for fraud because Medicare's structure makes patients passive recipients of care. They may be unable or uninterested in tracking whether the services billed for by a home health agency were actually rendered.

Current System Flaw: Theft. Caregiver theft is a problem that has largely been neglected in academic studies. Yet it is such a problem that legal advisors like the [Sheppard Law Firm](#) say that people receiving homecare in an unsupervised setting should "remove valuables, financial records and bank accounts, including checking accounts when hiring in-home care."

People who complain may be dismissed as subject to "theft delusions." Home health agencies can retaliate against whistleblowers by shortening visits, failing to police no-shows, or sending less proficient caregivers.

Excessive Costs. The proposal creates an add-on benefit for extended care services. It would have a fixed base payment ranging from \$2,012 to \$10,720 per day. The payment is capped at 80 percent of the national median 30-day payment account for nursing homes. In 2020, a [Genworth Financial study](#) estimated the median monthly cost of a semi-private room in a nursing home at \$7,756. Eighty percent of the nursing home median would allow spending of up to \$6,205 a month for home health care. This means that:

- The monthly cost of the new home health care benefit would be more than the monthly cost of a nursing home in 6 states,
- It would be more than the monthly cost of an assisted living facility in 45 states,
- It would be more than the cost of a home health aide in 49 states.

Ignoring Higher Quality Alternatives: Nursing Home Care.

Medicare home care provides much less medical care and supervision than a skilled nursing facility. The Medicare Home Health Benefit is currently defined as care provided by a health-care professional intermittently visiting the patient to provide skilled nursing care, physical therapy, and speech or occupational therapy. Medicare does not cover homemaker services or personal care such as cooking, bathing, or dressing.

In contrast to home care, more than 93.2 percent of patients referred to a skilled nursing facility at discharge received care

within 14 days. One study found that patients in nursing homes had hospital readmissions reduced by as much as 33 percent.

Ignoring Less Expensive Alternatives: Assisted Living. While the proposal would greatly expand payments for home health care, the Medicare program would still refuse to cover equivalent stays in assisted living facilities or adult daycare for moderately functioning patients. This is an unfortunate omission as there is [evidence](#) that assisted living can act as an effective substitute for nursing home residents who do not need a great deal of care. Patients and their families make extensive use of assisted living and the increase in assisted living beds has [coincided](#) with a decrease in nursing home beds. Assisted living may even be less expensive than home care for patients with substantial assistance needs.

Assisted living may make medical care easier to [access](#) than home care because medical personnel may see patients at their residence, or the assisted living facility may provide transportation to medical appointments. Given that many people receiving home care are homebound, assisted living may also reduce social isolation and the negative health consequences associated with it.

Ignoring Patient Power Alternatives: Cash and Counseling. This program originally began 25 years ago as a Medicaid pilot program in selected states. It has [since expanded](#) and goes under such names as Consumer Direction, Participant Direction, Self-Directed Care and a variety of other state-specific names.

Originally, the Cash and Counseling program was designed for the home-bound disabled. Today, the program is available to individuals who reside in small group homes and even assisted living facilities in some states.

Under that program, money goes to the patient, not to the care givers. Patients can hire and fire their service providers, and the type of person who can be a provider has also expanded. Some states even allow [spouses to be caregivers](#).

Early surveys found satisfaction with the program hovered in the 90 percentiles – a satisfaction rate probably unequaled in any health care system in the world today.

Cash and Counseling is consistent with an [international trend](#) toward self-directed care. As opposed to long term care delivered by government-run agencies, some European countries give cash to the families to take care of their own relatives.

New Medicare Benefits

Although details have not been made available, past Democratic proposals can give us guidance. For example, it seems likely that the proposal would expand Medicare Part B to cover 80 percent of the cost of twice-yearly preventive dental care (oral exams, x-rays, cleanings) and basic procedures (fillings, extractions) and 50 percent of the cost of major dental services (root canals, crowns, dentures). The (liberal)

Commonwealth Foundation proposes a Medicare benefit covering all three services (dental, hearing and eye care) at a cost of \$1,500 per beneficiary.

What's wrong with this idea?

There Is No Need. [Commonwealth](#) claims there are numerous unmet needs among the elderly for dental, hearing and vision care. But these findings need to be viewed with skepticism. All manner of people (including many wealthy people) need a better pair of glasses or a hearing aid and neglect their purchase nonetheless. The reasons can be many, including procrastination, dislike of dealing with the health care system and a preference to spend their money in other ways.

It is almost certain that if we gave every senior \$1,500, many –perhaps even most – would not buy insurance for these services. Hence: under the Democrats' proposal, taxpayers would be spending \$1,500 for something seniors value at less than \$1,500 – a classic definition of economic waste.

Manhattan Institute scholar [Chris Pope](#) notes that seniors are not lacking dental care relative to younger people:

[Sixty-five percent](#) of seniors received dental care in the past 12 months, similar to the figure for working-age adults. Even before the rapid growth of Medicare Advantage, seniors were [less likely](#) to have untreated cavities than were working-age adults.

There may be a case for targeted assistance to low-income seniors, and an even stronger case for targeted assistance to low-income nonseniors. Pope writes:

Thirty-three percent of working-age adults with incomes under the Medicaid eligibility cutoff, compared with only 6 percent of seniors with incomes above that cutoff, cited financial barriers as a reason for [failing to obtain](#) needed dental care.

There seems to be no rational case for a universal benefit for all seniors paid for by everyone else.

Insurance Is Already Available at Virtually No Cost. About [43 percent](#) of seniors have enrolled in private Medical Advantage (MA) plans. Most do so at no cost other than their Part B premium. In enrolling, seniors avoid the necessity of supplemental (Medigap) insurance – a savings of \$1,500 a year or more. So just by joining an MA plan, seniors have an extra \$1,500 to spend – without any expansion of Medicare.

Plus, the typical Medicare Advantage plan offers dental, vision and hearing care benefits as part of its benefit package. (See the Joe Namath TV commercials.) That leaves the senior with both insurance and \$1,500 in cash. Overall, Pope estimates that [38 percent](#) of Medicare beneficiaries will receive dental coverage from Medicare Advantage this year.

The Newly Insured Crowd Out Those Who May Have Greater Needs. When people obtain health insurance, they tend to obtain more health care – regardless of need. When health

insurance coverage is expanded without any increase on the supply side of the market, the newly insured often crowd out the formerly insured – who are often low-income patients with greater health care needs.

[Linda Gorman](#) has shown that Medicaid expansion under the Affordable Care Act (Obamacare) led to more spending on healthy, childless adults at the expense of disabled children. (See the discussion below.) Pope says the same thing happened with respect to dental care:

[When] the Affordable Care Act's expansion of Medicaid eligibility to childless adults [occurred], the increase in dental visits that it caused among childless adults seems to come [at the cost of a decline](#) in access to dental care among previously eligible adults.

Medicaid Expansion

This provision would focus on states that haven't expanded Medicaid to adults who are under 138 percent of the federal poverty level in accordance with the ACA. The proposal would likely create a Medicaid-like program to enroll the target population and would pay Medicaid rates to providers.

What's wrong with that?

Medicaid Flaw: Crowding Out Services to the More Needy.

What can we expect to happen as a result of Medicaid

expansion? If the [experience of the states](#) that have already expanded Medicaid is a guide, there will be more health care services delivered to the relatively healthy at the expense of the relatively sick.

While the Affordable Care Act expanded the demand for care, it did nothing about the supply. It did not create more doctors, more nurses, or more hospital beds.

Medicaid money spent on healthy people is money that could otherwise have been available to people with serious needs. In 2016, there were [423,735 intellectually or developmentally disabled people](#) on waiting lists for home and community-based services in the 47 states. The people on the waiting lists generally have severe intellectual disabilities, severe developmental disabilities, or are victims of traumatic brain and spinal cord injuries. To live outside of an institution with their families, they need a variety of services including home health aides, adult day care, respite care for family caregivers, and homemaker services.

Although federal law requires states to make institutional care available, it allows states with 1915(c) waivers to use waiting lists to limit home and community-based services for people who would otherwise be eligible for immediate institutionalization. Absent an emergency, like the death of a parental caregiver, families trying to avoid institutionalizing a

loved one often wait years for help, doing their best to provide needed care without Medicaid's help.

Rather than finding funds to pay for services for profoundly disabled people who needed help, the Obama administration chose to defray 90 percent of states' costs of enrolling able-bodied, working-age adults in Medicaid. Expanding Medicaid to this group cost \$148 billion from 2014 through 2016. That was money that could have been used to reduce the waiting lists for care for the disabled.

Medicaid Flaw: Fraud and Abuse. Studies estimate that [one out of every ten dollars](#) in Medicare and Medicaid is lost to fraud. To put that in perspective, think about how many times you hand a credit card to someone who disappears from your view. Yet the amount of fraud in the credit card industry is 4/10ths of 1 percent. It's tempting to conclude that we could save billions of dollars by simply turning health care administration over to American Express.

In addition, there is the problem of providing benefits to people who are not eligible for the program. Late last year, the Department of Health and Human Services released a [report](#) showing that Medicaid improper payments had ballooned to 21.4 percent, or \$86 billion, in 2020. According to Brian Blase, the true improper payment rate almost certainly [exceeds 25 percent](#), or \$100 billion per year, since

one-third of states were excluded from the report's review. In an [article in *Health Affairs*](#), Blase explains:

These estimates were completely constructed with data from before the pandemic. According to the government's report, the surging improper payments largely result from eligibility errors. State verification of eligibility data, such as income, was often not done at all, or was initiated but not completed. People qualify for Medicaid largely based on income, so failing to verify a Medicaid applicant's income is like failing to check a Medicare applicant's age.

Medicaid Flaw: Lack of Access to Care. Numerous surveys have found that many doctors refuse to see new Medicaid patients. One frequently cited 2017 survey puts the number at [31 percent](#). When they do see them, doctors tend to see these patients last.

Further, a number of top-rated medical centers that do accept Medicaid patients often refuse to accept Medicaid patients in managed care programs. Yet about two-thirds of all Medicaid enrollees are covered by a private managed care company.

The reason why access to care is such a big problem can be summarized in a single sentence: Medicaid patients are not allowed to buy health care the same way they buy food.

At last count, 44 million individuals were covered by the Supplemental Nutrition Assistance Program (SNAP). These

individuals can go into just about any supermarket other Americans patronize. They can buy the same products others buy and they pay the same prices. When they exceed the value of their food stamp allotment, they can pay the balance of the bill out of pocket with cash.

At the same time, more than 80 million individuals have health coverage through Medicaid and the Children's Health Insurance Program (CHIP). But they are absolutely prohibited from adding out-of-pocket funds to top up their Medicaid allotment and pay the market price for medical care.

Not only do we not allow the practice, we have criminalized it. A doctor or a MinuteClinic nurse who accepts money on top of the Medicaid rate (even if the price is what all other customers pay) risks going to prison!

As a result, Medicaid patients all too often turn to community health centers and the emergency rooms of safety net hospitals, where they sometimes wait hours for routine, primary care.

Well-meaning altruists who think that rationing by waiting is better than rationing by price if you are poor don't understand what it's like to be poor. For many below-the-poverty-line families, time is more of a scarce resource than money. And, if you are paid hourly, every hour spent waiting in an emergency room is an hour of lost pay.

Consider a woman who needs a blood test. If she doesn't own a car, navigating bus schedules to and from a hospital and enduring a lengthy wait while there may take up most of her day. Had she been able to obtain the test at a MinuteClinic across the street she might not secure it in a minute, but she wouldn't lose an entire day's pay.

Medicaid Flaw: An Inferior Insurance Product. In the most thorough and rigorous study that has ever been done on the matter, researchers in Oregon discovered that for the newly insured under Medicaid, there was [no improvement in physical health](#). And their reliance on emergency room doctors actually increased!

Even more astounding, the researchers found that the Medicaid enrollees valued their newly acquired coverage for as little as [20 cents and no more than 40 cents](#) on the dollar. That means if we gave these folks the cash equivalent of the cost of Medicaid, they would never buy Medicaid-like insurance with the money.

Previous studies had shown that on average low-income, uninsured patients pay only about 20 percent of their medical costs out of pocket. Put differently, about 80 percent of the care they receive is "free." So, the latest findings are consistent with the notion that there is an implicit contract between the uninsured and the "safety net" – under which they get care for a highly discounted price.

You could roughly describe the relationship by saying that the uninsured who rely on the safety net have health insurance with a 20 percent copayment. Whether others think this is a good thing or a bad thing, the people who rely on this system are not willing to pay very much for the kind of insurance middle-income families have.

This is why one of the researchers (Amy Finkelstein) thinks we should give the poor cash instead of Medicaid. (See the discussion below.)

Medicaid Flaw: Unstable Coverage. Medicaid eligibility is determined by income. In general, when a family's income falls below 138 percent of poverty, they qualify for Medicaid (but not for Obamacare). When it rises above that level, they are ineligible for Medicaid (but may qualify for Obamacare again).

People who live on the upper half of the income ladder may be surprised to learn how frequently people on the bottom half rise above and fall below that threshold. For example, [one study](#) found that in 2015 temporary income fluctuations and other eligibility issues caused adults to be enrolled in Medicaid for only 9.5 months on average and for children only 10 months.

Some in Congress are proposing to arbitrarily extend the length of eligibility once a person is enrolled. But this is a band-aid approach. Chronic patients in particular need a continuing

relationship with providers. That usually means having a continuing relationship with a health plan.

Ignoring Better Alternatives: Competition. A popular idea among many Democrats in Congress is the “public option.” That means allowing a government-run plan to compete against private plans on the Obamacare exchanges.

As it turns out, we have already experimented with this idea through heavily subsidized nonprofit cooperatives under Obamacare. When these plans are startups, run by managers with no experience – as was the case with the heavily subsidized nonprofit cooperatives – they fail miserably. Of the 23 co-op plans created under Obamacare, only four still survive — a 79 percent failure rate!

When public plans are managed by entities that have been in the business for many years, they often succeed – but that doesn’t seem to make much difference. When public plans compete on a level playing field with private plans, the ones that succeed are the ones that are [managed just like the private plans](#).

Still, if allowing public plans to compete against private plans is a good idea, shouldn’t we also allow the reverse? Why not subject Medicaid to private competition?

To make that work, we would need a level playing field: the government subsidy would need to be the same regardless of

the choice made by the enrollee, just as it is in the Obamacare exchanges. There would also have to be a “no dumping” rule. That means that plans can’t profit by mistreating high-cost patients and encouraging them to enroll in some other plan.

For example, if a high-cost patient leaves Plan A and enrolls in Plan B, Plan A would have to compensate B for the extra costs it incurs. (While we are at it, this should be the rule in all competitive insurance markets.)

Finally, private plans would need the freedom to give customers the kind of insurance (including Health Savings Accounts) that people want, rather than what bureaucrats think they should have.

Ignoring Better Alternatives: Giving People Cash. Earlier this year, MIT health economist [Amy Finkelstein](#) wrote a remarkable editorial for the *New York Times*. It was remarkable both for its radical departure from liberal orthodoxy and for the fact that the *Times* published the editorial at all. Her idea: give people cash instead of health insurance. She explains:

The reason is simple: The uninsured already receive a substantial amount of health care, but pay for only a very small portion of it, especially when their medical bills are high.

Moreover, while Medicaid is spending an average of \$5,500, recipients value that coverage at only \$2,200, at most.

To be clear, Finkelstein is not arguing that safety-net care is as good as Medicaid. But she argues that

people in need also benefit greatly from cash. And there is evidence that cash transfers can also [save lives](#).... In addition, a [large body of work](#) shows that wage subsidies to low-income workers with children help lift their families out of poverty, increase economic self-sufficiency, and improve their health and well-being.

It's an alternative worth considering.

Obamacare Expansion

In The [American Rescue Plan Act](#), enacted in March 2021, the Democrats in Congress increased Obamacare subsidies for those already receiving them and created new subsidies for the unsubsidized part of the market for the next two years. This means that more low-income buyers are now paying little to nothing for insurance and the maximum contribution has been reduced from 10% of income to 8.5%, even for people who are above 400% of the poverty line.

In the new spending proposal those subsidies would be made permanent.

What's wrong with that?

Obamacare is a flawed program that has failed to insure the uninsured with affordable, comprehensive coverage and its failure has come at enormous cost to taxpayers. Instead of

fixing these flaws with sensible (bipartisan) reforms that need not cost the taxpayers an extra dime, the Democrats are proposing to throw more good money after bad.

Obamacare Flaw: Outrageous Out-of-Pocket Exposure.

Currently, the Obamacare deductible can be as high as \$8,550 for an individual and \$17,100 for a family. If you combine the average premium 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.

Obamacare Flaw: Lack of Access to Needed Care. According to its supporters, a primary benefit of Obamacare is protecting people who enter the individual market with a pre-existing condition. Yet people who leave an employer plan and shop for insurance in the individual market today will face three unpleasant surprises: higher premiums, higher out-of-pocket costs, and more-limited access to care than a typical employer plan provides.

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 also Medicaid contractors. The plans that have survived in the exchanges look like Medicaid managed care with a high deductible. The networks include only those providers who will

accept Medicaid fees coupled with all the hassle of managed-care bureaucracy.

Increasingly, Obamacare enrollees have been denied access to the best doctors and the best facilities. In Dallas, Texas, for example, no individual insurance plan available under Obamacare 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.

Obamacare Flaw: Wasting Taxpayer Money. The primary (advertised) purpose of the Obamacare exchanges was to insure the uninsured with private insurance. In fact, the program has done a miserable job of achieving that goal. As [Brian Blase](#) notes at the *Health Affairs Blog*:

The Congressional Budget Office (CBO) [expected](#) that 25 million people would be enrolled in the exchanges by now. Yet, enrollment, on an annualized basis, has been stuck at around 10 million people since 2015 – 60 percent below expectations. [Annualized enrollment](#) in 2020 was 10.4 million people.

In fact, if we compare the number of people who had individual insurance before the enactment of the Affordable Care Act with its number today, enrollment has increased by only 2 million. Blase says that works out to a cost of \$25,000 for every newly insured person.

And it gets worse. Blase writes:

Since these two million people, on net, were shifted from employer coverage to the individual market rather than newly acquiring private coverage, the ACA has resulted in the federal government sending about \$49 billion in net subsidies to private health insurance plans with *no net gain in coverage*. (Emphasis added.)

Subsidizing the Rich. 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? For millions of people the answer is “no” when it comes to Obamacare. A [Kaiser Foundation study](#) estimates that there are almost 11 million people who have elected to remain uninsured *even though they qualify for subsidies* in the (Obamacare) 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.

And of course, this is only a partial market test, since attractive alternatives to Obamacare were effectively outlawed in the Affordable Care Act.

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.

But rather than fix the problem (including the sensible suggestions described below), the congressional Democrats have chosen to throw more money at it.

As Brian Blase has pointed out in a [Galen Institute study](#), most of the new money is going to people who appear not to need it. For example, a 60-year-old couple with two kids, making \$212,000, is receiving a benefit of \$11,209. In contrast, a family of four making \$39,750, regardless of the age of the couple, is receiving a benefit of just \$1,646.

In some parts of the country, households earning more than \$500,000 now qualify for Obamacare subsidies. For example, a 64-year-old couple in Kay County, Oklahoma, earning \$500,000 per year, qualifies for a subsidy of \$5,946.

Since more health care spending inevitably exacerbates health care inflation, which affects everyone, this really is a case of taking (in part) from the poor to subsidize the rich. In addition, under the new subsidies, men get more help than women and white families almost certainly are getting more help than Black and Hispanic families.

Ignoring Better Options: Employer Funding. As of January 2020, employers can now use Health Reimbursement Arrangements (HRAs) to provide tax-free funds to employees to buy the health insurance of their choice. This is health insurance that employees can take with them as they travel from job to job and in and out of the labor market. It is

especially important at a time of labor market uncertainty, when millions of Americans are lacking job security.

This opportunity, made possible by a Trump administration executive order, 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.

The Council of Economic Advisors [estimated](#) this new rule will benefit more than 11 million workers and their families. But it could affect many times that number if states cleaned up their individual markets to make individual insurance a more attractive option. (More on that below.)

According to Blase, this reform, which some congressional Democrats oppose, is:

projected in the near term to add nearly eight million people to the individual market—far more than will likely be added by boosting subsidies to health insurers—without any new federal spending as employer contributions are used. This should help improve the overall individual market without the adverse effects from expanding the ACA subsidy structure.

Ignoring Better Options: Risk Management. Before there was Obamacare, many states set up risk pools to segregate the burden of high-cost patients and keep premiums down for those who were relatively healthy. The insurance for risk pool

enrollees tended to be a standard Blue Cross plan that offered better coverage than Obamacare insurance provides today.

No one today is advocating a resurrection of risk pools. But the same financial result could be achieved by “invisible reinsurance,” which allows insurers to obtain protection from catastrophic costs without enrollees even being aware of the reform.

Two thorough studies of the matter and the experience of an actual program show what might be achieved.

Milliman Study. This April 17, 2017 [study](#) estimated the effects of an invisible risk pool, where health plans could reinsure their high-cost enrollees (with costs exceeding \$10,000 a year). The results: the average premium would fall by 16% to 31% and the number of people with health insurance would increase by 1.2 to 2.0 million people. (Attachment A, p.25)

These results assume the risk pool would pay providers Medicare rates – which is not an unreasonable assumption, since most health plans in the exchanges these days are paying less than what Medicare pays.

The extra annual cost is estimated to be \$4.4 billion, which Milliman assumes would be paid by the federal government. But since most of the high-cost patients coming to the individual market are migrating from the group market, a fairer system would impose a small premium tax on group insurance

to make sure that group plans are not profiting by dumping their most expensive enrollees on the individual market.

American Action Forum Study. [This study](#) modeled the [Health Care Choices reform proposal](#), which has been designed by a large number of think tanks and related organizations.

Essentially, Obamacare funds would be sent to the states in the form of a block grant. Health plans would be able to protect themselves against catastrophic costs through reinsurance, and they would have greater flexibility in setting premiums and other matters. The study found that even though there would be no additional government spending (either federal or state):

- Silver plan premiums would decrease by 18 to 24 percent beginning in 2022.
- Nearly 4 million more people would purchase insurance by 2030.
- More people would enroll in private coverage versus public insurance over the same period.

Medicare Advantage. In general, insurance plans are not allowed to specialize. They are required to offer a full range of services to all enrollees. Yet if health plans are not allowed to focus and get good at meeting some patient needs, they are likely to be mediocre when they try to meet all patient needs.

Instead of expecting every health plan or medical practice to be all things to all patients, we should encourage specialization. We need [focused factories](#) 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 health plans need to be able to ask health questions at the point of enrollment.

How can this be done? We're already doing it.

Medicare Advantage Chronic Condition Special Needs Plans (C-SNPs) can specialize in [15 chronic conditions](#). These plans can exclude applicants who don't have the condition. They can ask health questions and request medical records. Currently, [1.2 million](#) Medicare Advantage enrollees (6 percent) are in C-SNPs. The initial growth has been in the most competitive markets and enrollment can be expected to expand into other areas in time.

Congress needs to apply the same type of reforms to the Obamacare exchanges. For example, Cancer Treatment Centers of America (CTCA) should be able to partner with plans that restrict enrollment to patients who have cancer.

A New Medicare Drug Benefit

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 ranged from \$2,622 to \$16,551. And those are *annual costs*!

Not every drug is covered by Part D. For 14 specialty drugs not covered, the study found that the annual out-of-pocket cost per patient averaged \$26,209 for Zepatier to \$145,769 for Gleevec.

Congressional Democrats are proposing to lower the catastrophic exposure to high drug costs by Medicare enrollees under the Part D program.

What's wrong with that?

Medicare Drug Coverage Flaw: Poor Insurance Design. The problem is not that government is spending too little money on the elderly. The problem is that the money it does spend is poorly allocated.

From the very moment of its inception, more than 55 years ago, Medicare has violated fundamental principles of sound insurance.

Here they are. In a proper insurance arrangement, people self-insure for small expenses which they can easily afford from their own resources and where cost control and waste management are best done by the buyer, 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.

Medicare has always done the reverse. It has always paid for small expenses that almost any elderly enrollee could afford, while leaving seniors exposed for very large bills that could literally bankrupt them.

[Medicare drug coverage](#) is a prime example. In 2021 it works like this. After a deductible of \$445, Medicare pays 75 cents of the next dollar of cost. And it pays 75 cents of the dollar after that. It keeps on doing this until the patient's out-of-pocket expenses reach a limit of \$6,550. Above that amount, in the "catastrophic phase," the patient is responsible for 5 percent of any additional costs.

For the 28 drugs mentioned above more than half (61 percent) would require an average cost of [\\$5,444](#) in out-of-pocket costs in the catastrophic phase alone.

Ignoring Better Alternatives: Patient Management of Low-Cost Drugs. Instead of spending more taxpayer money, Medicare could instead 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 relying on any more taxpayer money.

When most of the cost of prescription drugs is paid by a third-party insurer, patients have weak incentives to economize and reduce the cost of their purchases. When patients are paying the full cost of their own prescriptions, the incentives to economize are much stronger.

In a [2004 study](#), Devon Herrick looked at some commonly prescribed drugs that are said to be cheaper in Canada than they are in the United States. Herrick found that he could beat

the Canadian price in the U.S. market by using up to ten smart buying techniques. The methods included quantity buying, pill splitting, online buying, generic and over-the-counter substitutes, etc.

Ignoring Better Alternatives: Private Insurance. Writing in the [New York Times](#), MIT economist Amy Finkelstein explains why the newly approved Alzheimer's drug costs \$56,000: It's because of Medicare. It turns out that Medicare payment for drugs is based on what the private sector pays. For physician-administered drugs (which include a lot of "[specialty drugs](#)"), this practice has encouraged drug makers to increase their prices for all payers.

That's because Medicare patients make up a large share of the market for these drugs and private patients generally don't have anyone negotiating on their behalf.

In the case of Alzheimer's, more than 95% of the patients are Medicare patients. Finkelstein writes: "What price might *you* charge if the major purchaser for your drug has committed to pay whatever 'other customers' pay? Biogen, the drug's manufacturer, came up with a price of \$56,000 per year."

However, when Medicare started paying for drugs dispensed at pharmacies, prices for Medicare patients went down. That's because private insurers, with greater market power and bargaining savvy, negotiated lower prices for all patients.

Mistaken Ideas about “Payfors.” We address below the main Democratic ideas on how to pay for their spending program with new taxes. Yet another frequently mentioned idea is having Medicare negotiate drug prices. The [Congressional Budget Office](#) has previously found that this proposal would save very little money – as long as Medicare insists on paying for virtually every drug on the market. And we now know that the private companies who administer the Part D drug benefit for Medicare are doing a better job of controlling costs than Medicare did – and better than the experts thought they would do. Ten years into the [program costs were half](#) of what the CBO originally predicted they would be.

As Finkelstein suggests, the better solution is to let private companies do the negotiating.

Ignoring a Lower-Cost Alternative: Deregulation. Although it seems to be very popular with congressional Democrats, regulating the price of drugs has adverse consequences. In separate articles in the *New York Times*, health economists [Austin Frakt](#) and [Amy Finkelstein](#) note that if the United States imposed the kind of price regulation other countries have adopted, a [large body](#) of [evidence](#) shows that pharmaceutical companies would spend less on research and development, and develop fewer new drugs.

Moreover, Economists David Henderson and Charles Hooper point out that because of price controls and other regulations,

between [114 and 260 drugs](#) are unavailable or in short supply in this country right now.

There is, however, a different approach: deregulation. Henderson and Hooper argue that [excessive regulation](#) is a major cause of high drug costs. Among the steps they recommend to lower the price of prescription drugs are: allowing more drugs to be sold over-the-counter and allowing pharmacists to dispense more drugs.

The two economists also argue for a more [radical reform](#). Right now, the FDA keeps drugs off the market until the manufacturers can prove safety and efficacy. But since the real test of efficacy (including all the “off label” uses) is only really established through thousands of doctor-patient encounters, let all drugs be available once the FDA establishes that they are safe.

Paying for the Plan

We still don't know precisely how the Democrats plan to finance their plan, but it seems likely they will draw heavily on the proposal made by candidate Joe Biden during the last election. That proposal would impose [\\$2.5 trillion in new taxes on business](#) – in part by undoing half of the 2017 corporate tax cuts, raising the top income tax rate from 21 percent to 28 percent.

Biden also said the burden will only fall on the wealthy. “No one making less than \$400,000 will pay any [new] taxes,” he promised.

How does that work? The administration reasons that corporate taxes lower profits and therefore lower corporate dividends, interest payments and stock prices. Since wealthy people own a lot of stock, their wealth will go down.

But doesn't this same reasoning apply to everyone with an IRA or a 401(k) plan? They will also be worse off – regardless of their income. And what about teachers, public employees, firefighters and millions of blue-collar workers who are relying on the stock portfolios of their retirement pensions? Schools, hospitals and other charitable institutions also own stock – in some cases a lot of stock.

Finally, there are the people who work for the corporations who are the target of Biden's new taxes. Virtually all economists believe that some part of the corporate income tax falls on ordinary workers. According to the Joint Committee on Taxation, workers ultimately [bear 25 percent](#) of the burden of corporate taxes. Other economists peg the worker burden at [a much higher amount](#).

In a [study for the Goodman Institute](#), Laurence Kotlikoff predicts that the Biden corporate tax plan will lower future wages by 2 percent per year – or a \$1,000 annual loss for a worker earning \$50,000. Kotlikoff is a Boston University professor whose work influenced the [tax reform bill](#) passed by Congress almost four years ago.

“We live in an international economy where capital can go where it is most welcome,” says Kotlikoff. “The best way to help the American worker is to make it as attractive as

possible to invest here. More investment makes workers more productive, which leads to higher wages.”

The Biden tax plan doesn't just target corporations. It also goes after individual taxpayers.

The Biden plan, for example, would create a new 12.4 percent Social Security tax on all wages above \$400,000. However, that income threshold is not indexed for inflation. For that reason, it will eventually hit all families, even if they have had no increase in real income.

Take a two-earner 20-year-old couple earning \$100,000. With a 2 percent inflation rate and 2 percent productivity growth, that couple will be paying the Biden payroll tax sometime in their 50's.

Although the Biden plan is aimed at the wealthiest households, it doesn't treat them all equally. Once people retire, or if they can avoid wage income altogether, they no longer pay the new payroll tax – no matter how rich they are.

“High-income people in their 30s get hit with a new burden that is almost six times the burden imposed on people in their 60s,” says Kotlikoff. “Under this plan, it's better to be old rich than to be young rich.”

The Biden plan also restores the previous income tax rates for high-income households. For the top 1 percent of taxpayers, all the Biden taxes combined will create a lifetime marginal tax rate of 62 percent. Blue state residents with high state income

tax rates could face up to a 70 percent rate.

“We would be in danger of returning to the tax-shelter environment of the 60s and 70s – when people were encouraged to spend time and energy avoiding taxes instead of producing goods and services,” says Kotlikoff. “This is the very thing Presidents John Kennedy and Ronald Reagan wanted to stop.”

Conclusion

The Congressional Democrats are proposing to spend an enormous amount of money on what they perceive as unmet health care needs. But in every instance, the proposal would spend money on existing programs that are deeply flawed. If instead of throwing good money after bad, we focused on rational reform of existing programs, we might find that the “unmet needs” could be adequately met – without spending any additional taxpayer dollars at all.

