Goodman Institute
Turning Ideas Into Policy

Q & A on Health Reform
A Voter's Guide

Here is a brief guide to what voters and candidates need to know about health policy as we approach the fall elections.

Policy changes need to be made that allow individuals and families the opportunity to make their own choices about health care and how their money is spent.

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What is wrong with the market where people buy their own health insurance?

For millions of Americans, health insurance has become increasingly unaffordable and increasingly useless in meeting real health care needs:

- If you combine the average premium with the average deductible faced last year by people in the (Obamacare) exchanges, a family of four (not getting a subsidy) had to pay $25,000 before getting any benefit at all from their health plan.
- All across the country, people with insurance purchased in the exchanges are denied access to the best doctors and the best hospitals, even though these providers accept private insurance and even Medicare.
- Although Obamacare reform promised to replace "junk insurance" with "good insurance," all too often the only insurance available looks like Medicaid with a high deductible; and the plan pays nothing if you go out-of-network and seek the medical care you most need.
- Parents of a child with special needs may comb through the published information to find a plan with the right doctors, only to discover that while they are locked into their choice for the next 12 months, the health plan can change the doctors in its network every week.

Some employer plans – especially in such low-wage industries as fast foods – are almost as bad. That may explain why millions of employees turn down their employer health insurance offer. Employees who do sign up often cannot afford to enroll their families.

These are not the normal results of free market competition. They are the product of unwise regulations that give perverse incentives to everyone affected by them.

If you have good health insurance through an employer, why should you care about what is happening in the individual market?

If you are laid off, retire early or become too sick to work, you will have to seek health insurance in this market. This could happen to any of us.

Why are deductibles and premiums so high in the individual market?

Because of Obamacare regulations. Although the individual mandate to buy health insurance was repealed, the mandate still applies to sellers of health insurance. The only type of plan they can offer you is bloated with benefits you may not want or need. Also, regulations allow people to game the system, i.e., by remaining uninsured while they are healthy and enrolling only after they get sick. If only sick people are enrolled, costs and therefore premiums have to be much higher.

Aren't there some alternatives to the Obamacare insurance sold in the exchanges?

Yes. The most popular alternative in many states is called "short-term insurance." These plans are not subject to Obamacare regulations and they have much lower premiums and lower out-of-pocket costs. The Obama administration tried to regulate these plans virtually out of existence – by limiting the duration of coverage to only three months, with no renewal. The Trump administration reversed course – allowing plans with 12 months' duration and renewals for up to three years. The Biden administration is threatening to revert to Obama regulations.

Since all of these changes are being made by executive order, without any act of Congress, access to affordable health insurance is see-sawing from administration to administration. Congress could make affordable insurance permanent with appropriate legislation.

If people buy insurance that meets their personal needs, won't they be tempted to avoid coverage that is socially important?

They might. For example, they might choose to avoid coverage for substance abuse or for mental health care. Or, they might have insufficient catastrophic coverage for very rare and very expensive medical events.

One solution to this problem is already part of current law. If people with a short-term plan experience an unanticipated and uninsured-for medical need, they can always return to the Obamacare exchanges and enroll in a plan that covers virtually everything.

A more thoughtful solution is to let the private sector do what markets do best – give people the kind of insurance they want to buy. If that leaves some socially important needs unmet, meeting those needs is the ideal role for a safety net.

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Do the congressional Democrats have a solution to the problem of outrageous out-of-pocket costs?

What is being offered in the individual market right now are plans that no one is buying without a large subsidy. As a result, the unsubsidized market was in a free fall (sometimes called a "death spiral") until recently. Last year, Congress passed the American Rescue Plan Act, which extended Obamacare subsidies to high-income families to try to lure them back into the market. Not only is this a regressive law, giving money to rich people through taxes paid by everyone, it is also very wasteful because the new subsidies are mainly going to people who had already found insurance alternatives.

It appears that we are spending $17,000 for every newly insured person because of the new subsidies. The subsidies end after 2022 and they are the subject of partisan divide.

Why do so many plans exclude the best doctors and the best hospitals?

In the beginning some didn't. Blue Cross of Texas, for example, started out offering individuals the same kind of insurance it offered employers. In the space of a few years the insurer lost one billion dollars. The insurer that has been the most successful (with about one-fifth of all the exchange plans sold in the country) is Centene – a company that started life as a Medicaid contractor. Centene offers what looks like Medicaid with a high deductible. It pays provider fees that are close to what Medicaid pays. Providers that refuse to accept those low fees are not in Centene's network.

In the Obamacare exchanges, health plans seem to be vying to attract the healthy and avoid the sick.

Centene's strategy works because cut-rate doctor fees allow it to charge lower premiums, and that attracts healthy people who don't care very much about provider networks. Sick people who search through insurer networks to find the best providers for their care will tend to join some other plan.

Centene's success reflects a "race to the bottom" in which the quality of coverage offered in the exchanges has gotten progressively worse through time.

How can we reform the market to give people access to the providers that can best meet their needs?

We already have a model that is far superior to what is happening in the individual market. Medicare Advantage (MA) is the only other place in our heath care system where private plans compete and enrollees choose among them in an open enrollment period. Like the individual market, Medicare Advantage has government subsidies and no discrimination based on pre-existing conditions.

But unlike the individual market, MA plans can specialize in such chronic problems as diabetes, heart disease, cancer care, etc. And because the plans get a subsidized premium that reflects the expected cost of treating their enrollees, these plans find it profitable to attract enrollees with serious problems. MA plans can ask health questions, request to see medical records and exclude people who do not have the disease the plans specialize in. As a result, there is an emerging market for chronic care in Medicare.

By contrast, in the Obamacare exchanges, health plans seem to be vying to attract the healthy and avoid the sick.

Medicare Advantage is not perfect. But it is a starting point from which to build a workable health insurance exchange.

Do the congressional Democrats have a solution for the problem of health plans with inadequate access to care?

No.

Why can't your employer buy insurance for you that you own and can take with you when you leave employment?

This is another issue on which the two parties have radically different views.

During the Obama administration, personal and

portable health insurance funded by an employer was against the law. An employer caught doing it was subject to fines as high as $100 per employee per day. President Trump countered with an executive order that not only allows employers to purchase individually owned health insurance, but actually encourages it.

Again, we are dealing with contrasting executive orders – not congressional action – and no policy can be considered permanent. That's why it is important for Congress to act.

Is virtual medicine here to stay?

Not unless Congress acts. Before the Covid pandemic, it was illegal for doctors to treat Medicare patients by means of phone, email, Zoom, Skype, etc. – with very few exceptions. For younger people, almost all communication devices violated privacy laws. When Covid hit, Congress temporarily suspended these barriers and many state governments suspended their restrictions as well. The reason telehealth exploded so quickly is because the Trump administration believed in it and had already spent several years getting ready to promote it.

Virtual medicine (telehealth) is a temporary freedom that will go away unless Congress acts to make it permanent.

All the new-found freedoms are temporary, however. They are almost all tied to Covid. If the pandemic appears to no longer qualify as an "emergency" problem, telehealth is scheduled to go away as well.

This is another area where Congress needs to act.

Why don't more people have 24/7 access to primary care?

One of the fastest growing developments in health care is the emergence of doctors (called "care" doctors) who provide round-the-clock availability for all primary care for a very modest monthly fee. Especially attractive is the ability of patients to talk to their doctors by phone or email or Skype at nights and on weekends instead of going to the emergency room. Although employers can pay for such a service, what they can't do is put money into an account for each employee and let that employee choose the direct primary care doctor of his or her choice.

The Trump administration tried to solve this problem by attempting to persuade the IRS to change federal regulations. Unfortunately, the attempt failed.

Clearly, Congress needs to act.

Why can't patients manage more of their health insurance money?

It's not for everyone, but studies show that many chronic patients (with appropriate training) can manage their own care as well or better than through traditional doctor care. If they can manage their own care, shouldn't they also be allowed to manage the money that pays for that care?

By using MinuteClinics, discount pharmacies, comparison shopping and other techniques, a great deal of money might be saved, and the patients should be able to keep what they don't spend.

More generally, it ought to be easy for employers to let employees keep the savings when they make cost-effective choices.

Why are drug costs so high?

Most drugs are not very expensive. About 90% of all drugs consumed in the U.S. are generic and the U.S. has some of the lowest generic prices

in the developed world – lower than Canada, for example. And we are getting a very good return on money spent on drugs. Drug therapy is much more cost-effective than doctor therapy or hospital therapy.

We have made enormous progress – especially in the area of chronic illness. Drugs are what keep chronic patients alive, functional and out of the hospital. Drugs are what turned AIDS from a death sentence into a chronic illness. Vaccines for Covid have saved hundreds of thousands of lives in the U.S. alone.

So, why do some people face really high drug costs? Often, it is because of perverse incentives created by unwise regulations.

Health plans in the Obamacare exchanges. You would think that these plans would have a self-interest in encouraging proper drug compliance. Giving away insulin for free is a lot cheaper than paying for emergency room visits. Giving AIDS patients drugs for free is a lot cheaper than hospitalization. But here is something that is even less expensive for health plan managers: encouraging chronic patients to leave your plan and join some other plan. The incentives to attract the healthy and avoid the sick are often stronger than the incentives to keep sick people well. Plans with really high deductibles, for example, are not going to be attractive to chronic patients with expensive drug needs.

Employer plans. The perverse incentives here are not as bad as they are in the individual market, but they are still present. Federal law gives employers incentives to adopt health plans that are not attractive to people with expensive health problems. Moreover, until recently, federal law did not allow employer plans to give free insulin to a diabetic if the employee had a Health Savings Account (as 30 million Americans do). The Trump administration revoked this restriction by executive order. But, as noted, executive orders are not permanent – they can always be challenged in court or changed by the next administration.

Medicare: The Part D drug benefit has had misplaced priorities since day one. The program pays for many small expenditures that seniors could easily afford on their own, while leaving some patients exposed to thousands of dollars of out-of-pocket costs.

All of these perverse incentives could be changed with appropriate congressional action.

What should be done about pre-existing conditions?

People who have been continuously insured should be able to enroll in plans with comparable coverage without regard to health status. But no one should be allowed to game the system – by remaining uninsured while they are healthy and then enrolling in a plan after they get sick. This is happening today and it is one reason plans in the exchanges are so costly.

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This principle of “no gaming” has long been incorporated in the Medicare program. Seniors who do not enroll in Medicare Part B when they are eligible are penalized – and the longer the delay, the greater the penalty. In the Medigap program (supplemental Medicare plans) in some states, people who do not enroll when eligible can be “underwritten” and charged a premium

that reflects their health status.

Although Obamacare was sold as a remedy for discrimination against pre-existing conditions, in fact it has become a trap. Patients who enroll and find they are not getting the care that was promised are stuck – for another 12 months. People whose health conditions change after enrollment are also stuck – until the next open enrollment period.

With adequate risk adjustment and centers of excellence that specialized in chronic diseases, there is no reason why we could not have continuous open enrollment.

At a minimum, when enrollees' health conditions change, they should be encouraged to switch to the plans best suited for their new condition.

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Why is it so hard to find out the price of health care?

In medical markets where patients pay out-of-pocket, buyers always know the price in advance of purchase, and competition based on price and quality is normal. Cosmetic surgery and LASIK surgery are examples. In addition, when Canadians come to the United States for knee and hip replacements (to avoid long waits in their own country) they are almost always given package prices, covering all elements of their procedure – by American hospitals! In the third-party payer sphere, by contrast, providers rarely compete for patients based on price. When they don't compete on price, they don't compete on quality either.

Pursuant to an executive order signed by President Trump, hospitals are now required to post their prices for common procedures in a consumer-friendly manner, and that requirement has been upheld in the courts. Congress should codify this rule and encourage price and quality competition.

Why can't seniors have the same options young people have?

About 30 million people have a Health Savings Account (HSA). They and their employers can make tax-free contributions to these accounts, and they are used to pay for expenses not paid by a third-party payer. The balances grow tax-free and people get to keep, for other uses, money they don't spend on medical care.

However, this opportunity vanishes when individuals become eligible for Medicare. How does that make sense?

The appropriate account for seniors should be called a "Roth HSA" – with after-tax deposits and tax-free withdrawals for any purpose. (That means there would be no new tax subsidy here.)

Why can't people in the Obamacare exchanges have the same options other people have?

Right now:

- They don't have Health Savings Accounts. (The appropriate account for these people is also a Roth HSA.)
- They don't have access to direct primary

care physicians, which would sometimes enable them to avoid the emergency room at nights and on weekends.
- They don't have access to health plans that specialize in their health care needs, as seniors in Medicare Advantage do.
- They don't have the ability to switch plans when their health condition changes (a problem that could be solved by continuous open enrollment).

All these problems could be solved with appropriate reform.

What did Obamacare really accomplish?

Prior to the Covid pandemic, almost all the increase in health insurance coverage under Obamacare was actually increased enrollment in Medicaid. Whether you regard this development as good or bad, it's not what voters were promised. Because Medicaid pays the lowest rates to providers, many doctors won't see Medicaid patients. Those who do tend to push Medicaid patients to the rear of the waiting lines.

A better use of Medicaid money would be to create Health Savings Accounts that families could use to purchase primary care at market prices.

Meanwhile, most of the money spent on private coverage has accomplished very little. Despite spending more than $50 billion a year on subsidies in the individual health insurance market, the increase in coverage prior to the pandemic was anemic. Dividing the small increase in the number of people with individual private insurance by the amount of Obamacare subsidies spent to encourage enrollment, we spent about $25,000 of subsidy every year for every newly insured individual, or $100,000 for a family of four. Moreover, if we consider the offsetting reduction in employer-provided coverage over the same period (partly as a result of Obamacare), you could argue that the entire $50 billion was money down the drain.

Is there an alternative to Medicaid?

Yes. And it's needed.

Almost one-third of doctors are not accepting any new Medicaid patients. Also, these patients are not allowed to top up Medicaid payment rates and pay market prices (the way they do with Food Stamps at the grocery store). That means they don't have access to MinuteClinics and other convenient sources of care. All too often they must turn to the emergency rooms of safety-net hospitals, where waiting for hours is normal.

Studies show that low-income families value Medicaid as little as 20 cents on the dollar. That means if you offered Medicaid enrollment or a cash payment equal to one-fifth the cost of Medicaid, a great many families would take the cash. That may explain why so many who are eligible for enrollment never bother to do so – 662,000 in Texas alone.

One reason for such low enrollment may be that uninsured low-income families tend to get about 80 percent as much care as those who are insured, and 80 percent of that is free.

A better use of Medicaid money would be to create Health Savings Accounts that families could use to purchase primary care at market prices. We could also use Medicaid money to give low-income families a tax credit – enabling them to purchase the same health plans that middle-income families have.

A Policy Agenda to Make Health Care Better

More than 80 think tanks and research organizations have studied these issues and produced detailed recommendations in Health Care Choices. Here are some of the most important:

1. Let families have access to insurance that meets their medical and financial needs, instead of unaffordable deductibles and sky-high premiums.
2. Let families have access to the best doctors and the best hospitals, instead of narrow networks that deny them the care they need.
3. Let employees have access to personal and portable health insurance that travels with them from job to job and in and out of the labor market.
4. Make virtual medicine a permanent option, so that patients can get more care in their own homes.
5. Let families have access to 24/7 primary care, including phone, email and virtual visits – at nights and on weekends.
6. Let patients manage more of their own health care dollars, if they are willing.
7. Let seniors have the same opportunities young people have, including access to Health Savings Accounts.
8. Let families know the price of care ahead of time, and benefit financially from smart choices.
9. Let patients with chronic diseases have access to centers of excellence that specialize in their conditions.
10. Let Medicaid enrollees have access to the same private insurance other families have.

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