Health Affairs Blog

# Improving Health And Health Care: An Agenda For Reform

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The debate over, and eventual enactment of, the Affordable Care Act (ACA) brought to the surface of American politics a long-standing divide over the proper orientation of health care policy. On one side are those who tend to promote more federal control and government regulation over insurance markets and the organizations delivering services to patients. On the other side are those who are more inclined to support consumer incentives and market mechanisms to improve the value and quality of patient care. Of course, there is overlap in the kinds of policies advanced by the two sides in this debate, but the underlying philosophical disagreement is deep and makes reaching broad-based consensus difficult.

At the moment, the proponents of the ACA believe the new law is working, and initiatives are being readied to build upon what was enacted in 2010 by further bolstering the federal government's power to control costs through additional regulation.

We are among those who opposed the ACA because of its heavy emphasis on federal control. But we also believe that unless a credible and practical alternative reform plan is presented to the public, and supported by policymakers, the long-term trend toward ever-increasing governmental control will continue unabated in the years ahead.

The plan we present is not confined to replacing the ACA. We propose major reforms to the tax treatment of employer-sponsored health care, Medicaid, Medicare, Health Savings Accounts, and other areas of existing policy. The cumulative effect of this comprehensive plan would be to decisively

reorient health care policy away from bureaucratic regulation and toward the preferences of patients and consumers.

## Overall Principles

The following are the principles that guided the development of our reform plan.

### Empowered Citizens, Not Government Agencies, Should Control Health Care

It is our firm belief that U.S. health care would be far better, of higher quality, and less burdensome economically, if citizens, in their roles as patients and consumers of health services, rather than the national government, were ultimately in charge of making the important decisions of how to allocate scarce resources.

### Government Subsidies Should Come In The Form Of Defined Contribution Payments

Any federal subsidization of health care should take the form of defined contributions to support consumer choices in highly competitive open markets, rather than defined benefits to control provider behavior in highly restricted markets. The government subsidy should not vary based on a person's choices of coverage or where they get their care. Those selecting more expensive options should pay for the added cost out of their own pockets. Those choosing low-cost, high-value options should pocket the savings, ideally in personal health savings accounts.

### Reform Should Move Power And Control From The Federal Government To The States And The Empowered Patient-Consumer

The nation's policies for health care must be true to the Constitution and embody a genuine federalist philosophy; they must reflect an understanding of the need for states to have the flexibility to address their particular needs and circumstances consistent with the preferences of their citizens. Federal rules should be as few and as flexible as possible.

### Suppliers Of Medical Services Must Have Greater Freedom To Innovate And Provide Better Services To Empowered Patient-Consumers

Advances in information technology and medical knowledge have the potential to revolutionize the way medical care is delivered to patients over the coming decades. Insurance companies and government bureaucracies should have less influence over resource allocation and control of health care. Suppliers of services must be given the freedom to meet consumer demand with products that improve the convenience, efficiency, and effectiveness of medical care.

### Reform Must Improve The Federal Fiscal Outlook By Reducing Long-Term Health Obligations

Federal health entitlement obligations threaten to overwhelm government finances in the coming years. A reform plan should include significant and specific reforms that lower long-term spending and result in an overall improvement in the budget outlook.

## Replacing The ACA

The ACA exchanges are showing significant signs of instability, with rising premiums and enrollment that falls short of expectations. We recommend transitioning away from this unstable framework to one that relies less on coercion and regulation and more on consumer preferences.

### Retain The Tax Preference For Employer-Paid Premiums, With An Upper Limit

Most Americans get their health insurance today from their employers, and that should not change with a new reform plan. Employers should be free to organize health insurance offerings that are attractive to their workers. The existing federal tax break for employer-paid premiums should be

retained. The only modification should be an upper limit to inject additional cost discipline into the most expensive plans. We propose a limit at approximately the 75th percentile of employer plan cost, indexed to general inflation in subsequent years. This new limit would replace the poorly-designed and unfair "Cadillac" tax of the ACA.

### Provide Refundable Tax Credits To Households Without Access To Employer Coverage

Before the ACA, those obtaining health coverage through employers received a tax break while those obtaining coverage on their own did not. We propose that those outside employer coverage should receive a refundable tax credit that is age-adjusted and roughly equivalent to the current value of the average tax break for an employer plan.

The credits could be adjusted according to income, but that would make them harder to administer and would discourage work by raising implicit marginal tax rates. With these credits, all Americans would have access to an affordable insurance plan that provides, at a minimum, protection against high medical expenses. The credits could be used to purchase plans approved by states without the significant federal restrictions of the ACA.

### Allow States To Regulate Insurance Offerings And To Establish Mechanisms For Consumer Choice Of Plans

We recommend giving states much more control over the mechanism by which consumers select plans, and the plans that are allowed to be offered to them by insurers. States could retain the exchange mechanism established by the ACA, but it would not be a federal requirement. All state-approved plans would qualify for the federal tax credits, and those plans would be freed of most of the ACA's benefit requirements (while being subject to state regulations).

### Provide 'Continuous Coverage Protection' For Persons With Preexisting Conditions

The ACA forbids using health status in coverage decisions or insurance policy pricing, and attempts to prevent instability in the insurance market by requiring individuals to purchase coverage. This mandate to purchase insurance is among the law's least popular provisions, and it is far from clear that it will work effectively.

We recommend an alternative approach that relies on incentives. Individuals who have maintained continuous insurance coverage (defined as three or fewer months without coverage over the preceding three-year period) would be guaranteed access to coverage and protected against higher premiums because of a preexisting condition. Insurers would also be prevented from charging higher premiums to customers with continuous coverage who subsequently develop serious health conditions and from imposing coverage restrictions tied to changes in a person's health status.

States would be free to regulate insurance offerings differently for those without continuous insurance enrollment. The existence of refundable tax credits for those without access to employer plans ensures that all Americans would be able to maintain continuous insurance enrollment.

### Allow States To Adopt A Default Enrollment Program

Even with a widely available tax credit for insurance, some portion of the population would likely still go uninsured. It is possible, however, to boost insurance coverage among the hard-to-reach population through a default insurance option. States would be allowed to direct tax credits to several insurance plans (on a random basis) that they may choose to designate as default coverage options for persons who are eligible for a refundable tax credit but who have failed to sign up for coverage on their own.

Default insurance plans would adjust the up-front deductible as necessary to ensure premiums for coverage were equal to the value of the tax credits; thus, persons assigned to such plans would not be charged any additional premium. The insurance plans offered for default coverage could also be

made available to all other persons eligible for the tax credit. Individuals would, however, retain the ability to turn down this default coverage.

### Allow For A Gradual Transition From ACA Subsidies

A replacement plan for the ACA will need to include a transition — a bridge from the ACA to a working health-financing system and, in particular, to the replacement plan's alternative tax credits and Medicaid coverage. We recommend an exemption that prevents abrupt disruption of coverage for those in the Medicaid expansion population or those receiving the ACA's premium credits and cost-sharing subsidies. They would also have the option to shift to the new program if they choose.

New applicants would be considered under the replacement plan rules, which would ensure a natural transition from the old to the new program. We believe the new options made available under the reforms we recommend would prove attractive to current Medicaid and ACA beneficiaries, and thus also hasten the transition.

## Reforming Medicaid To Allow More State Control And Consumer Choice

Medicaid has experienced rapid cost growth over many years, even as the services it provides to lower-income households are far from adequate. The program's fundamental problem is rooted in its original legislative design. As a shared federal-state program, Medicaid is financed partly by the federal government and partly by the states, resulting in split political accountability. State officials often blame the federal government for imposing costly mandates in Medicaid, even as federal officials and agencies increasingly blame the states for using the program as a means of tapping federal taxpayers to solve their budgetary problems.

There is ample evidence that Medicaid falls far short of the quality care it should be providing to its beneficiaries.

### Pursue Separate Reform Strategies For Medicaid's Two Distinct Parts

Reforming Medicaid requires recognition of the very different service needs of the program's two primary populations. Medicaid enrollment is dominated by able-bodied adults and their children, who rely on the program to finance routine primary care and periodic episodes of acute care. Medicaid spending, however, is tilted heavily toward services provided to the disabled and elderly, who require both expensive health care assistance and assistance with activities of daily living. Different reforms are needed for these two very different components of Medicaid.

### Finance Medicaid With Fixed Federal Funding

Medicaid reform must begin with a restructured relationship between the federal government and the states. Instead of open-ended federal matching payments, the federal government should provide fixed, predictable funding streams to the states, and the states should have substantial flexibility to manage the program without excessive federal interference.

One approach would be to provide two separate per capita federal funding allotments, one for the disabled and elderly and the other for everyone else. These allotments would be based on historical spending patterns, and would be adjusted based on enrollment in the program (ensuring that federal funding adjusts to changing economic conditions). States would then have every incentive to manage the program prudently, and to maximize its value for program enrollees.

### Integrate Acute Care Medicaid Into Market-Driven Health Insurance Reform

States would have substantial discretion to run Medicaid without federal intervention, but the presumption should be that the program for able-bodied adults and their children will be integrated into the reform structure put in place for other working age families. That means giving Medicaid-eligible households the refundable tax credit as a primary source of support, with Medicaid serving as a

supplement. The combined tax credit-Medicaid support could be used by eligible families to purchase a state-approved private insurance plan. The very lowest-income households would receive assistance covering most of the cost of a standard plan, and the Medicaid subsidy would be reduced gradually for those with higher incomes.

### Empower The Disabled And Frail Elderly

We do not recommend a universal template for state reform of Medicaid assistance for the disabled and elderly. However, many states have been pursuing reforms over the past decade to give disabled and elderly beneficiaries more control over the resources devoted to supporting their daily activities and medical needs. A per capita federal payment would allow states to pursue these reforms more aggressively without federal interference, as well as to try new approaches.

## A Market-Based Reform Of The Medicare Program

Medicare is pivotal to an effective reform of U.S. health care because of its dominant regulatory role. Medicare's rules for paying hospitals, physicians, and other providers of services heavily influence how care is delivered to all patients, not just Medicare enrollees.

### Adopt The Premium Support Reform Model

Under premium support, all beneficiaries would receive a uniform subsidy to purchase insurance from competing health plans, including traditional fee-for-service (FFS) Medicare. The subsidy amount would be based on bids from the competing plans. Beneficiaries choosing more expensive plans would pay any extra premium themselves. This gives seniors an incentive to select lower-cost and higher-value plans and provides plans with an incentive to provide appropriate services in a cost-effective manner.

The Congressional Budget Office estimates that moving to a premium support model could substantially reduce costs both for the federal government and the beneficiaries. Total federal Medicare spending would decline by 4 percent in 2020 compared to current law, and the beneficiaries would pay 6 percent less in premiums and other costs for their care.

Improve The Competition Between Medicare Advantage And Fee-for-Service Beneficiaries who do not explicitly select a Medicare Advantage (MA) plan are enrolled in FFS Medicare. Once enrolled in either MA or FFS, beneficiaries tend to stay put. Consequently, current policy is biased toward more enrollment in traditional FFS Medicare.

The default could be changed, with newly eligible beneficiaries who do not select coverage randomly assigned to a low-cost MA plan instead of FFS Medicare. The bidding process could also be improved to promote direct price competition between MA and FFS. Current policy allows MA plans that are lower-cost than FFS Medicare to provide premium rebates to their enrollees, but the rebates come in the form of adjusting the Part B premium withheld from Social Security checks. Because this is not transparent to the beneficiaries, MA plans compete by offering additional benefits instead.

To promote price competition, MA plans could be permitted to send rebate checks directly to their enrollees, or to their Health Savings Accounts, so that enrollees would see the savings clearly.

### Promote Consumer Decision-Making

Medicare offers several online decision-support tools to help beneficiaries sort through their plan options, but those tools produce information that is overly complicated and incomplete. A reformed program must commit itself to developing consumer-friendly information on the cost of alternative plan options, provider performance measures, and the out-of-pocket costs patients are likely to bear for specific treatments.

### Modernize Medicare's Benefits

FFS Medicare has a complex benefit design with separate rules for inpatient care under Part A and physician and outpatient services under Part B. Because traditional Medicare will continue to attract enrollees, it should be modernized to simplify the benefits and extend necessary financial protections to enrollees. Part A and Part B should be combined into a single program, with one premium that covers both parts. In addition, cost sharing should be simplified and catastrophic protection should be added.

### Reform Medigap And Other Supplemental Coverage

Supplemental coverage through Medigap, retiree plans, and Medicaid reduces or eliminates the amount beneficiaries pay out of pocket, which reduces their cost sensitivity and promotes the use of services that may contribute little to their health. To address this issue, beneficiaries with Medigap or retiree plans could be required to pay part of the deductible personally. The recently passed Medicare Access and CHIP Reauthorization Act limits Medigap coverage to costs above the Part B deductible amount. That limit could be extended to supplemental coverage offered by employers to retirees.

Beneficiaries with supplemental coverage should be given a new option within traditional Medicare, with care provided through an approved integrated system at lower cost to the individual. This is similar to the "in-network" and "out-of-network" structures common in private insurance. Such a system could be based on a replacement for the ACA's accountable care organizations (ACOs) that gives beneficiaries the option to enroll in the integrated plan of their choosing, and to share in the savings from more efficient care.

### Reform Medicare's Payment Policies And Eliminate Unnecessary Bureaucratic Controls

Medicare should continue to test alternatives to FFS, including bundled payment approaches and shared savings. The Centers for Medicare and Medicaid Services (CMS) should adopt a more flexible approach, allowing plans and providers participating in those tests to adapt the payment models to local conditions.

The Independent Payment Advisory Board (IPAB), which is charged with holding the overall growth of Medicare spending below a specified target, should be abolished. It was given too much power by the ACA to impose changes in Medicare payments for services, which can inappropriately reduce access to care for Medicare beneficiaries and drive up costs for everyone else.

The Center for Medicare and Medicaid Innovation (CMMI) was also given too much power to implement what it believes are technocratic improvements but that will inevitably have unintended negative consequences. CMMI also should be abolished.

### Provide Greater Administrative Flexibility In Local Markets

Medicare operates as a national program, but health care is delivered locally. Traditional FFS Medicare should be restructured so that it can adjust its policies to local conditions, making it easier to develop and implement innovations on a local level that can reduce cost or improve value.

### Gradually Raise The Eligibility Age To 67

The Medicare program has maintained an eligibility age of 65 for its nondisabled enrollees since the program was enacted in 1965. During that time, average male life expectancy at age 65 has increased by five years, from 78 to 83. The improvement in longevity at age 65 has been similar for women, from an average age at death of just over 81 in 1965 to nearly 86 today.

Raising the eligibility age to keep up with improvement in lifespans does not fundamentally change the structure of the program. But it makes the program more consistent with demographic reality. Moreover, persons age 65 and 66 who would no longer be eligible for Medicare would get an age-adjusted federal tax credit for the purchase of coverage in the private market, so there would be no reason for a gap in coverage for this population.

## Lifelong Use Of Health Savings Accounts (HSAs)

HSAs should be a central component of health care in the United States. The accounts offer strong incentives for their owners to seek the best value for their health care purchases, and they provide additional protection against high medical expenses.

### Provide A One-Time Federal Tax Credit Matching Enrollee Contributions To HSAs

To rapidly increase enrollment in HSAs, a tax credit should be provided to all persons who have established an account and have contributed to it by the end of 2017. The credit would provide a matching contribution of $1 for every $2 contributed to an account in calendar year 2017, up to the maximum credit of $1,000.

### Eliminate The Minimum Deductible Requirement

Currently, only persons enrolled in a qualified high-deductible health plan (HDHP) are eligible to make tax-preferred annual contributions to HSAs. We recommend allowing all Americans to establish and contribute up to $2,000 per year for individuals and $4,000 per year for families (both indexed to the CPI), independent of their participation in a qualified HDHP or any insurance program. The federal tax credit provided in 2017 would not count against this maximum contribution.

### Increase The Maximum Allowable Contribution For Persons With High-Deductible Insurance Plans

Participants in a qualified HDHP should be allowed to make contributions up to the maximum amounts allowed under current law, plus the $2,000/$4,000 contribution allowed for all Americans as recommended in this proposal. This would ensure the HSA-HDHP combination remains attractive in the marketplace, especially among employers.

### Allow Nontraditional Payment Methods

Today, HSA withdrawals must be directly tied to a medical service for the amount of the withdrawal, which hinders the development of new models for financing care that do not rely on FFS. HSA withdrawals should be allowed for fixed monthly payments to cover the cost of services provided by an integrated health plan, or by a specific physician or other provider. An HSA enrollee could make payments to his or her primary care physician under a direct-pay arrangement, independent of insurance or any network requirement.

### Include HSAs In Medicaid Reform

Indiana has pioneered the use of HSA-like accounts in Medicaid through a waiver program negotiated with the federal Department of Health and Human Services. HSAs should be offered as a standard feature in every state Medicaid program. Medicaid beneficiaries should be allowed to use their combined federal tax credit and Medicaid supplementary support to enroll in coverage that combines a higher deductible with an HSA. Enrollees electing this option would be able to keep their accounts as their earnings rise and they exit Medicaid.

### Integrate HSAs Into Medicare

HSAs could be made a much more prominent and viable part of the Medicare program through two steps. First, the Medicare Medical Savings Account program should be modified to allow beneficiaries with preexisting HSAs to keep those accounts and use them to pay for Medicare-covered services, in combination with high-deductible Medicare Advantage offerings. Second, HSA holders should be allowed to continue to make tax-free contributions even after they become eligible for Medicare.

### Allow Withdrawals Tax-Free After Age 75 Above A Minimum Balance

HSAs could be an important source of protection against the high cost of nursing home and other long-term care needs. HSA enrollees could be encouraged to build and maintain balances to protect against such a need by allowing them to take tax-free withdrawals out of their HSA, at age 75 or older, so long as they maintain a sufficient balance (such as $75,000). This would reward people who, over a lifetime, saved and provided for their own health care needs. It would also lessen reliance on the Medicaid program.

### Allow Tax-Free HSA Rollovers To Designated HSAs At Death

Under current law, when an HSA holder dies, the HSA balance automatically goes to a spouse and is kept as an HSA. However, if there is no spouse, then the HSA balance is distributed through either an estate or other designated persons and is fully taxed at that point. The law should be amended to allow HSA holders to designate family members who are not spouses as recipients of their HSA balances at death. The balances would retain the HSA designation for the new owners and could be added to the balances of any HSAs they already own.

## Additional Reforms

Over many years, the federal government and the states have put in place policies that reach into every corner of U.S. health care. Changes to some of these policies would reinforce the new direction we recommend for the major tax and entitlement provisions of current health care policy.

### Reform Federal Funding Of Graduate Medical Education

The federal government exerts substantial control over the training of new physicians through outdated funding streams provided by Medicare. There is no evidence that approach improves the quality of the nation's physician corps. The federal role should be reduced by cutting the funding substantially and converting what remains to a discretionary grant program.

### Reform The Federal Employees Health Benefits Program

A comprehensive reform plan should also reform the health insurance benefit for federal employees so that it operates like a defined contribution program. The government's contribution would be fixed for every geographic area of the country and would not increase with the expense of the plan chosen by a worker.

### Integrate Veterans Into Mainstream Coverage, And Refocus VA Health Care

Health services for the nation's veterans should also be modernized so that veterans can more easily access high-quality care in the private sector. The VA should focus on essential services that cannot be replicated elsewhere

### Improve The Transparency Of Useful Cost And Quality Data

Federal data on health care costs and clinical outcomes should be made more widely available to private sector companies and researchers. This data can speed up the process of assessing the cost-effectiveness of various health procedures and products and thus stimulate better decision-making by consumers.

## Summing Up

The health of Americans is influenced by many factors that are well beyond the boundaries of health insurance financing and even the normal services provided by medical professionals. These key factors include education, nutrition, family, culture, early childhood development, income adequacy, physical environment, and prolonged exposure to stress.

Nonetheless, the manner by which medical services are delivered and financed is critical for the health of millions of American families. The set of health care reforms we propose will improve the value of those services for every segment of the U.S. population. The guiding principle is patient-centered care, which ensures those providing services are committed to finding ever more effective ways of keeping people healthy or restoring them to their full health.

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HEALTH POLICY LAB

ASSOCIATED TOPICS: COSTS AND SPENDING, INSURANCE AND COVERAGE, MEDICAID AND CHIP, MEDICARE, QUALITY

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