Restoring Quality Health Care

A Six-Point Plan for Comprehensive Reform at Lower Cost

Scott W. Atlas, MD

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A Six-Point Plan for Comprehensive Reform at Lower Cost

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Acknowledgments

My sincere thanks go to many of my colleagues and friends for their helpful discussions and insights, especially John Cogan and Alvin Rabushka.

Preface

The Affordable Care Act, now known as ObamaCare, has pushed health care in the United States onto a drastically different, far more government-dominated pathway than in the past. Massive expansion of failing entitlement programs, huge new tax burdens, and unprecedented regulatory authority of the federal government over health insurance and the health care industry are now in place. These changes were instituted while ignoring, indeed even doubling down on, the fundamental problems with the existing system—the perverse incentives that have caused runaway costs and excluded millions of Americans from accessing the world's best medical care. Simultaneously, those countries with the longest experience under government-centralized health systems, including Sweden, the United Kingdom, and others, are increasingly footing the bill to shift patients toward private clinics and outside doctors to remedy their scandalous waits, poor quality, and escalating costs.

Time is of the essence. Years after its initial rollout, the American people, the health care industry, and the courts still struggle to navigate the Affordable Care Act. Further implementation of the ACA will undoubtedly reverse the superior access and outstanding quality of care that distinguish American health care from the centralized systems that are failing the world over. Meanwhile, America's aging population will increasingly require medical care at an unprecedented level. To meet these demands, technological advances in our emerging era of clinically relevant molecular biology offer great promise for new treatments and breakthrough cures. Yet the current trajectory of the health system, particularly under Obamacare, threatens both the sustainability of the system and the essential climate for the innovation necessary to reach these potentials.

As the ACA proceeds to erode the positives of US health care without repairing the system's most important flaws, it is time for a fundamentally different approach to improving America's health system. Instead of framing health reform with the traditional trade-off, i.e. "take away benefits, or raise taxes," my plan centers on a

completely different paradigm—restoring the appropriate incentives in order to increase the quality of health care and simultaneously reduce its costs. To accomplish that, I propose a six-point, strategic, incentive-based reform plan for US health care. The foundation of my plan centers on highly incentivized, lower cost catastrophic coverage and institution of universal health savings accounts. The plan transforms the US health care system by instilling market-based competition and empowering consumers while reducing the federal government's authority over health care. It restores the originally intended purpose of health insurance—to protect against the risk of significant and unexpected health care costs. Using specific incentives and detailed proposals, the plan enhances the availability and affordability of 21st century medical care and ensures continued health care innovation. Once this plan is fully implemented, conservative estimates indicate that private national health expenditures and health expenditures by the federal government will decrease by trillions of dollars over the decade, and access to high quality health care will significantly improve. And perhaps most importantly, the health reforms in this plan reflect the important principles held by the American people about what they value and expect from health care, in terms of access, choice, and quality.

Introduction

The overall goal of any US health reform plan should be to increase the opportunity for good health care for Americans and their families. To accomplish that goal, I propose a six-point, strategic, incentive-based reform plan for US health care. Instead of framing health reform with the traditional trade-off, i.e. "take away benefits, or raise taxes," my plan centers on a completely different paradigm. I focus on restoring the appropriate incentives in order to increase the quality of health care and simultaneously reduce its costs. The foundation of my plan centers on highly incentivized, lower cost catastrophic coverage and universal health savings accounts. My plan fundamentally transforms the US health care system by instilling market-based competition and empowering consumers while reducing the federal government's authority over health care. It restores the originally intended purpose of health insurance—to protect against the risk of significant and unexpected health care costs. Using specific incentives and detailed proposals, the plan enhances the availability and affordability of 21st century medical care and ensures continued health care innovation. Once this plan is fully implemented, conservative estimates indicate that private national health expenditures will decrease by roughly $2.75 trillion over the decade, federal government health expenditures will decrease by approximately $1.5 trillion over the decade, and access and quality of health care will significantly improve.

Before recognizing the rationale for the proposed reforms necessary to achieve the above goals, it is essential to clearly understand the current state of US health care. This document will first examine the status of US health care, particularly in light of the Affordable Care Act, and then delineate key reforms to meet the significant health care challenges facing the nation. My plan details six major reforms, each with its underlying rationale, as follows: 1) expand affordable private insurance; 2) establish and liberalize universal health savings accounts to leverage consumer power; 3) instill appropriate incentives with rational tax treatment of health spending; 4) modernize Medicare for the 21st century as the population ages; 5) overhaul Medicaid to

eliminate the two-tiered health system for poor Americans; and 6) strategically enhance the supply of medical care while ensuring innovation.

US Health Care Today: Setting the Record Straight

America is facing its greatest health care challenges in history. Unprecedented demand for medical care is a certainty. According to the Dept. of Health and Humans Services' Administration on Aging and US Census Bureau statistics, the number of Americans 65 and older has increased by a full 6 million in the past decade alone to over 13% of the overall population, while those 85 and older have increased by a factor of 10 from the 1950s to today's six million (Figures 1, 2).

Older people harbor the most disabling diseases, including heart disease, cancer, stroke, and dementia—the diseases that depend most on specialists and complex technology for diagnosis and treatment. Simultaneously, obesity, America's most serious health problem, has increased to crisis levels, already affecting more adults and children in the US than in any other nation (Figure 3); given the known lag time for such risk factors to impact health, the next decades promise to reveal obesity's massive cumulative health and economic harms.

These daunting demographic realities combine with serious fiscal challenges in US health care that promise to worsen over the near future in the absence of change. America's national health expenditures (NHE) now total over $3.1 trillion per year, or over 17.4% of GDP, and project to reach 19.6% GDP by 2024[1]. Medicaid, originally covering 250,000 beneficiaries, has expanded to cover over 70 million people[2] at a cost of $500 billion per year. Medicare spent less than $1 billion in its first year, but today it spends over $260 billion annually on hospital benefits alone and $615 billion in total. With the aging of the baby boomer generation, the program's costs in its current form appear unsustainable when one understands that in 1965, at the start of Medicare, workers paying taxes for the program numbered 4.6 per beneficiary, whereas that number will decline to 2.3 in 2030[3] (Figure 4).

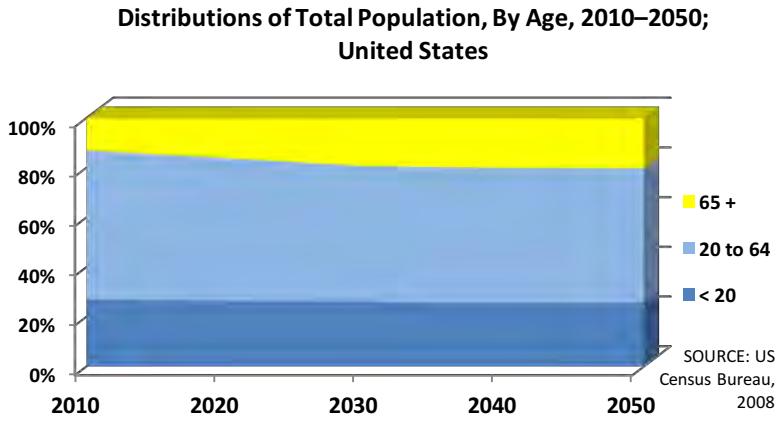


Figure 1. The population of seniors is rapidly growing.

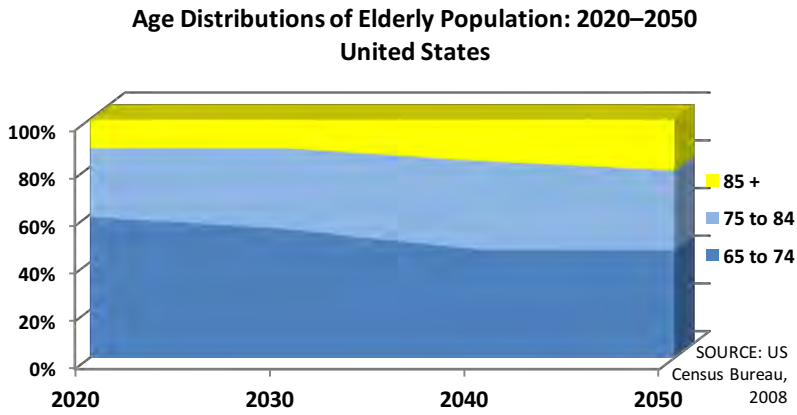
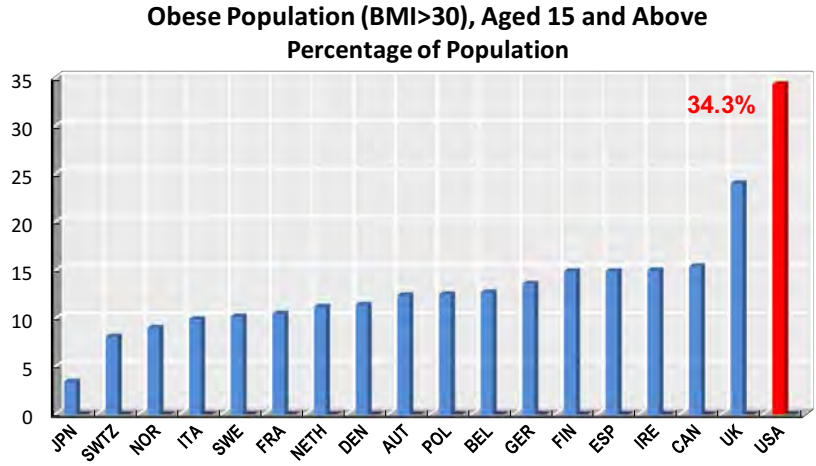


Figure 2. For those over 65 years of age, the proportions of seniors over 75 and over 85 are rapidly growing.



Prevalence of Obesity (percent BMI of 30 or more) in United States and selected OECD Nations

Source: OECD Fact Book 2010

Figure 3. The US harbors more obesity than any other nation.

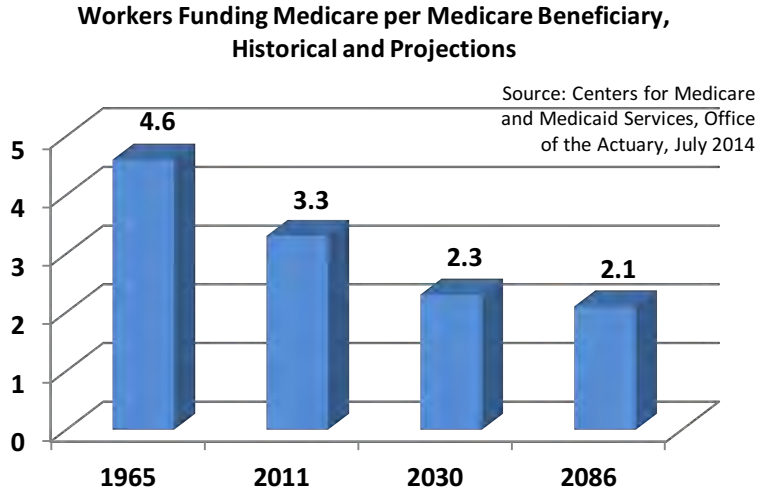


Figure 4. The number of workers per beneficiary supporting Medicare is far less than at the beginning of the program and rapidly declining.

The 2014 Annual Medicare Trustees report projects that the Hospitalization Insurance (HI) trust fund will face depletion in 2030. Regardless of trust fund depletion, Medicare and Medicaid must compete with other spending in the federal budget. Barring new taxes and benefit cuts, by 2049, federal expenditures for health care and social security are projected to consume all federal revenues, eliminating capacity for national defense, interest on the debt, or any other domestic program[4].

At the same time, we have entered an extraordinary era in medical diagnosis and therapy. Innovative applications of molecular biology, advanced medical technologies, new drug discoveries, and minimally invasive treatments promise earlier diagnoses and safer, more effective cures. The possibilities of improving health through medical advances have never been greater.

Before designing reforms to reach the promise of 21st century health care for all Americans, it is essential to understand the state of US health care prior to the Affordable Care Act (ACA, or Obamacare). Whether defined by preventive screening tests[5]; waiting times for diagnosis or specialist appointments[6]; access to treatment for the major chronic diseases[7]; timeliness of biopsies for cancer[8]; waits for life-saving and life-changing surgeries[9]; or availability of safer

medical technology[10] and the newest drugs[11] that save lives, Americans enjoyed unrivalled access to care[12]. And just as important, the objective data from the world's leading medical journals proves that American medical care already delivered exceptional results for virtually all of the most serious diseases[13]. That includes superior survival for major and rare cancers[14], better outcomes from heart disease and stroke treatment[15], and more successful treatment of chronic diseases[16] such as hypertension and diabetes than in those countries with centralized health systems heavily controlled by governments. The inescapable conclusion based on the facts is that both quality of medical care and the access to it have been superior in the US than in those nationalized systems heralded as models for change by Obamacare supporters (Figures 5–7).

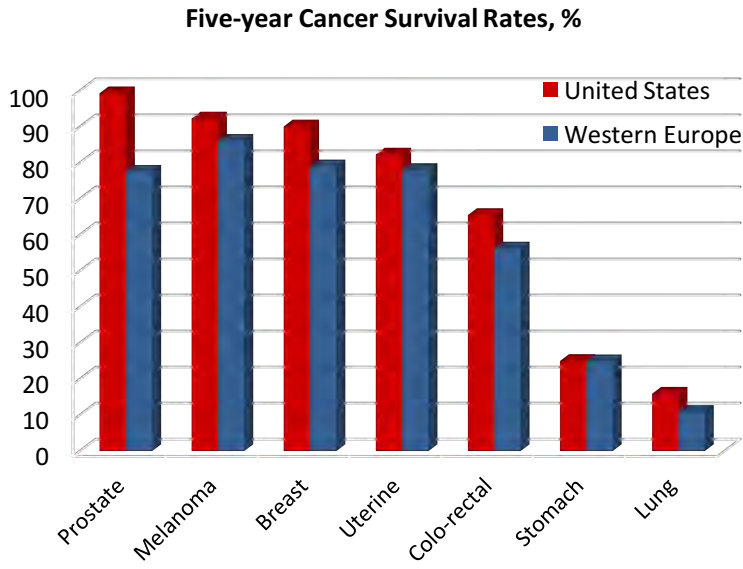


Figure 5. Comparison of 5-year survival rate, US versus Western Europe, 2000–2002, seven common cancers (from Verdecchio, 2007). The US has superior survival from all common cancers compared to Western European nations.

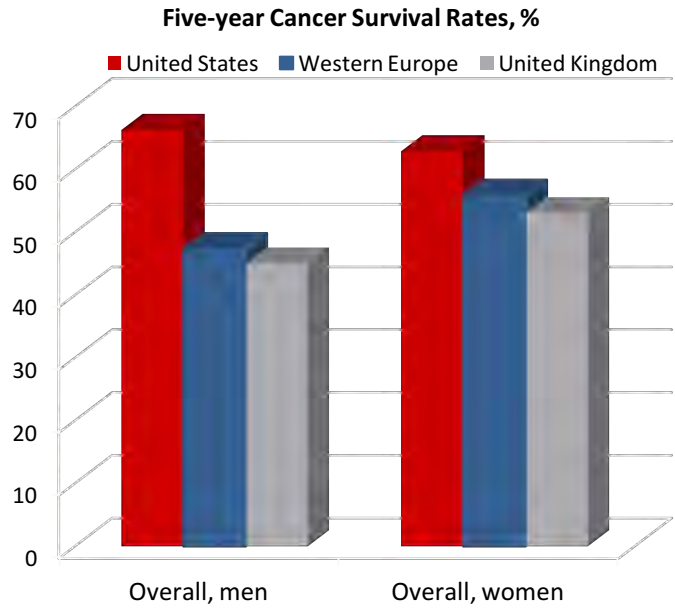


Figure 6. Comparison of 5-year survival rates for men and women, US versus western European nations. Note a statistically significant increased survival for American men and women (data source: Verdecchio, 2007) compared to the average western European and even more advantage over the UK.

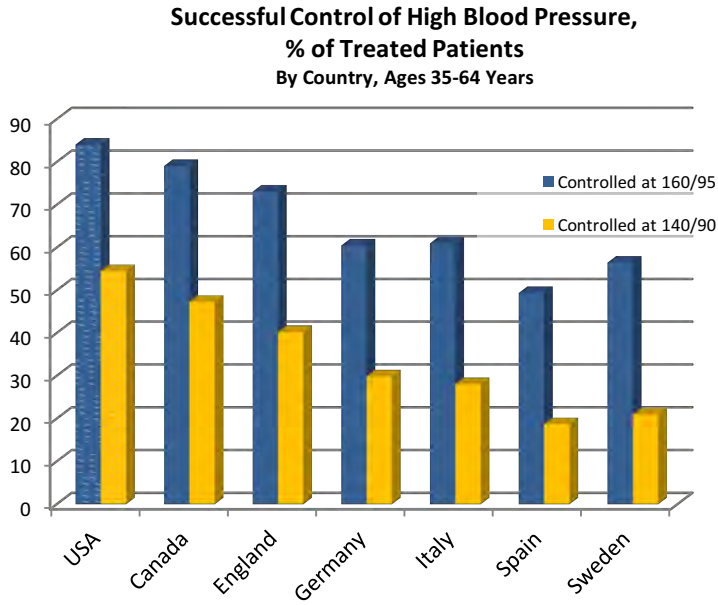


Figure 7. The US has more effective medical care for high blood pressure compared to other developed countries, including those held as models for Obamacare. (From Wolf-Maier et al, Hypertension Treatment and Control in Five European Countries, Canada, and the United States; *Hypertension* 2004;43:10–17).

Partly based on now discredited studies[17] alleging the poor quality of America's health care, the ACA was enacted. Its two core elements, a significant Medicaid expansion and subsidies for exchange-based private insurance, will each cost about $850 billion over the next decade[18]. Fundamentally, the ACA consists of a huge centralization of health care and health insurance to the federal government, driving government centralization of health insurance to unprecedented levels while dramatically pushing up private insurance premiums. During the first three quarters of 2014, 89% of the newly insured under Obamacare were enrollees into Medicaid, not private insurance[19]. Coupled with population aging, Centers for Medicare and Medicaid Services (CMS) projects that the 107 million under Medicaid or Medicare in 2013 will rapidly increase to 135 million just five years later, a growth rate tripling that of private insurance[20]. At the same time, we are witnessing increasing consolidation under Obamacare in

several areas of health care, including insurers, doctors, hospitals, and pharmaceutical companies. This ongoing consolidation is going to reduce competition and therefore hurt consumers.

But the goals of health reform demand quite the opposite. Facts show that private insurance is superior to government insurance for both access and quality of medical care (see next section, *Reform #1*). History shows that the best way to control prices is through competition for empowered, value-seeking consumers. Instead of shunting more people into insurance and care provided by the government, heavily subsidized by the government, or massively regulated by the government, reforms should focus on how to produce competition-driven markets that will deliver innovation and cost savings, thereby maximizing the availability and affordability of best care for everyone. The key is to move away from centralized models based on misguided incentives necessitating more and more taxation to one of individual empowerment with personal responsibility.

Reform #1:
Expand Affordable Private Insurance

Reform #1: Expand Affordable Private Insurance

- All states must permit all insurers (including all companies available on any state or federal exchanges) to offer true high deductible, limited-mandate catastrophic coverage (LMCC) plans to all citizens, covering hospitalizations, outpatient visits, diagnostic tests, prescription drugs, and mental health
- Coverage is owned by individual and portable; employer still available for sign-up and automating payments
- Insurers are permitted to eliminate Obamacare's 3:1 age-based premiums
- Insurers are permitted to risk-adjust premiums for obesity, as is already allowed for smoking
- Eliminate the Health Insurance Premium excise tax

The Importance of Private Health Insurance

Broad access to doctors and hospitals comes from private insurance, not government insurance. The harsh reality awaiting low income Americans is that most doctors already refuse new Medicaid patients due to government-defined low reimbursements, numbers that dwarf by 8 to 10 times the percentage that refuses new private insurance patients[21]. According to a 2014 Merritt Hawkins report, 55% of doctors in major metropolitan areas refuse new Medicaid patients[22]. HHS reported in December, 2014 that even of those managed care providers signed by contract and on state lists to provide care to Medicaid enrollees, 51% were not available to new Medicaid patients[23].

Like Medicaid, a superficial look at Medicare appears satisfactory to most of its beneficiaries, but on scrutiny we see a different scenario unfolding today. While the population ages into Medicare eligibility, a growing proportion of doctors do not accept Medicare patients.

According to the Medicare Payment Advisory Commission, 29% of Medicare beneficiaries who were looking for a primary care doctor back in 2008 already had a problem finding one. In 2012 alone, CMS reported that almost 10,000 doctors opted out of Medicare, tripling from 2009. In a 2014 physician survey, about one-quarter of doctors no longer see Medicare patients or limit the number they see; in primary care, 34% refuse Medicare patients[24]. The percentage of doctors who closed their practices to Medicare or Medicaid by 2012 had increased by 47% since 2008[25].

Beyond access to care, the quality of medical care is also superior with private insurance. For those with private insurance, that includes fewer in-hospital deaths, fewer complications from surgery, longer survival after treatment, and shorter hospital stays than similar patients with government insurance[26]. It is highly likely that restricted access to important drugs, specialists, and technology under government insurance account for these differences.

The Harmful Impact of the ACA on Private Insurance

Affordable private insurance options have clearly not been improved by the ACA. As a direct result of the ACA's new regulations on pricing and its new mandates on coverage, the law has already forced more than 5 million Americans off of their existing private health plans. The Congressional Budget Office (CBO) projects that a stunning 10 million Americans will be forced off their chosen employer-based health insurance by 2021—a ten-fold increase in the number that was initially projected back in 2011, at the onset of the law[27]. Meanwhile, private insurance premiums have greatly increased under Obamacare and are projected to skyrocket in 2016, in some cases increasing by 30 to 50% and more. The shift into government insurance itself also increases private insurance premiums. Because government reimbursement for health care is often below cost, costs are shifted back to private carriers, pushing up premiums. In some calculations, the underpayment by government insurance adds $1,800 per year to every family of four with private insurance[28]. Nationally, the gap between private insurance payment and government underpayment has become the widest in 20 years, doubling since the initiation of Obamacare, according to a 2014 study by Avalere Health[29]. More ominously, consolidation among the five big private insurers has accelerated, a trend that most believe will raise premiums for individuals and small businesses. This not only impacts the

individual, but taxpayers as well, because taxpayers subsidize those increasing premiums under Obamacare.

Choices of private insurance and covered providers under them are dwindling as well, despite the theory that the law would increase insurance choices and competition. According to a December 2014 study[30], the exchanges offer 21% fewer plans than the pre-Obamacare individual market, with a decrease in participating exchange insurers in 2015 to 310 nationally compared to 395 in the individual market in 2013, the last year before this implementation of Obamacare.

For middle-income Americans dependent on the subsidized private insurance through government exchanges, Obamacare is also eliminating access to many of the best specialists and best hospitals. McKinsey reported 68% of those policies only cover narrow or very narrow provider networks, double that of the previous year[31]. The majority of America's best hospitals in the National Comprehensive Cancer Network are not covered in most of their states' exchange plans. And as of late 2014, the specialists essential to diagnose and treat stroke, one of the most disabling and lethal diseases in the US, are in severe shortage (in some cities, down to zero) under Obamacare insurance plans[32]. The narrow network strategy is hitting even more Americans in 2015, as Obamacare exchanges restrict access to doctors and hospitals far more than insurance bought off of exchanges, in an attempt to quell insurance premium increases caused by the law itself[33].

Keys to Expanding Affordable Private Insurance

Fundamental change to private insurance is vital to leveraging consumer power and expanding health care access for everyone. The ACA has made private insurance less affordable and pushed health insurance reform in the wrong direction. It has furthered the erroneous view that insurance should subsidize the entire gamut of medical services, including routine medical care. When combined with the cloak of secrecy shielding health care prices and provider qualifications, consumers have neither an incentive nor the necessary means to invoke value into health care decisions.

On the other hand, high deductibles with catastrophic coverage would restore the essential purpose of insurance—to reduce the risk of incurring large and unanticipated medical expenses. Because consumers pay for most medical care directly, they have the incentive to choose

wisely. Provider prices become more visible and align with what consumers value, rather than being set artificially or by government decree.

The behavior of American consumers counters the ACA's approach to insurance reform and validates that higher deductible coverage generates more affordable insurance and reduces health spending. In the decade since their tracking, consumers have increasingly selected high deductible plans (Figure 8), and among those enrollees, a shift toward higher deductibles has continued[34] (Figures 9, 10). Consumer spending is significantly reduced for those in high deductible plans[35], without any consequent increases in emergency room visits or hospitalizations and without the hypothesized harmful impact on low income families or the chronically ill[36]. Health spending reductions averaged 15% annually, and the savings increased with the level of the deductible and when paired with health savings accounts. More than one-third of the savings by enrollees was due to lower costs per health care utilization[37] i.e., value-based decision-making by consumers. Additional evidence from magnetic resonance imaging (MRI)[38] and outpatient surgery[39] show that introducing price transparency and defined-contribution benefits further incentivizes price comparisons by patients.

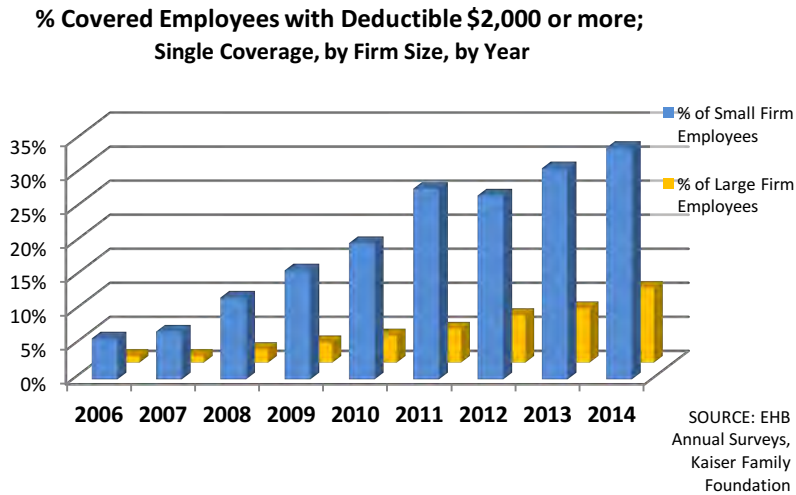


Figure 8. Consumers have increasingly chosen high deductible coverage.

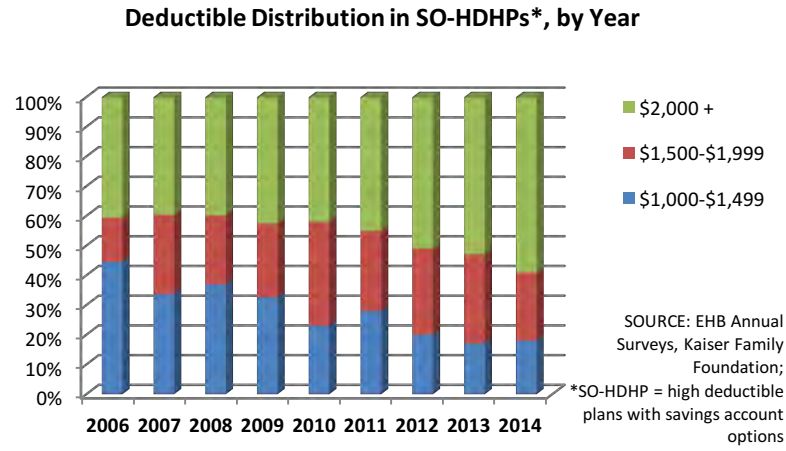


Figure 9. Among those enrollees into high deductible coverage, consumers have shifted to higher deductibles.

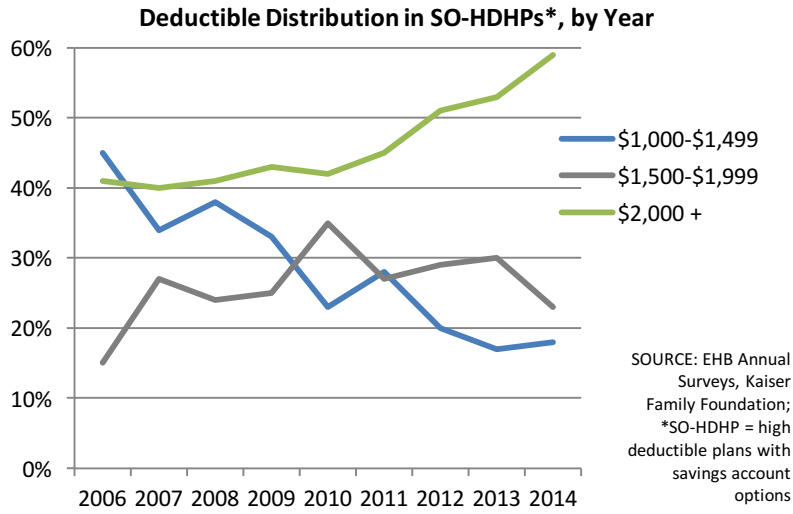


Figure 10. The shift of enrollment into higher deductibles for enrollees in high deductible plans with associated savings accounts comes at the expense of the low deductible range.

Moving toward private, high deductible insurance and health savings accounts (HSAs) should be the principal focus of health care reform (see next section, *Reform #2*) in order to both improve benefits and reduce costs. To expand affordable private insurance options, it is essential to reduce onerous regulations on insurance, many of which have specifically harmed high deductible plans. While consumers are still increasingly opting for plans with deductibles greater than $2,000, the growth rates have slowed compared to the growth before ACA mandates and restrictions (Figure 11). In addition, the premiums of high deductible plans are accelerating faster after the ACA passage than any other coverage[40] (Figures 12, 13), although they remain less costly than other types of coverage. It is uncertain if these changes are entirely caused by Obamacare's regulations, such as limits on deductibles, but it is clear that reforms should not selectively make these plans less affordable for consumers. Restoring the choice of limited-mandate catastrophic coverage with truly high deductibles would add more affordable coverage that many consumers value.

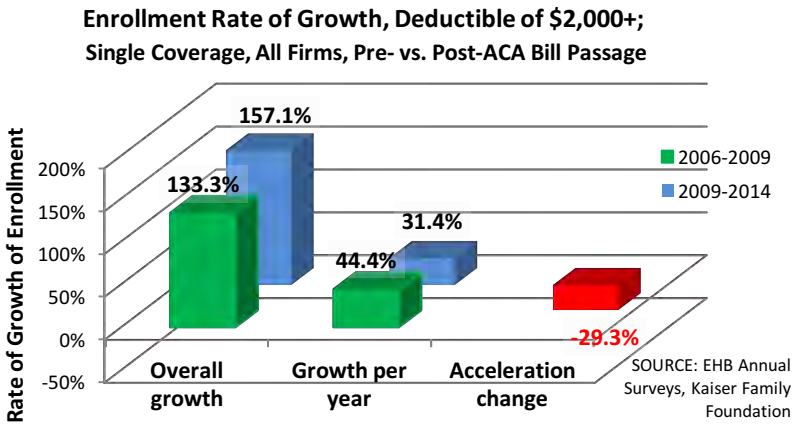


Figure 11. The growth rates of enrollment into high deductible plans have decelerated since the ACA passage.

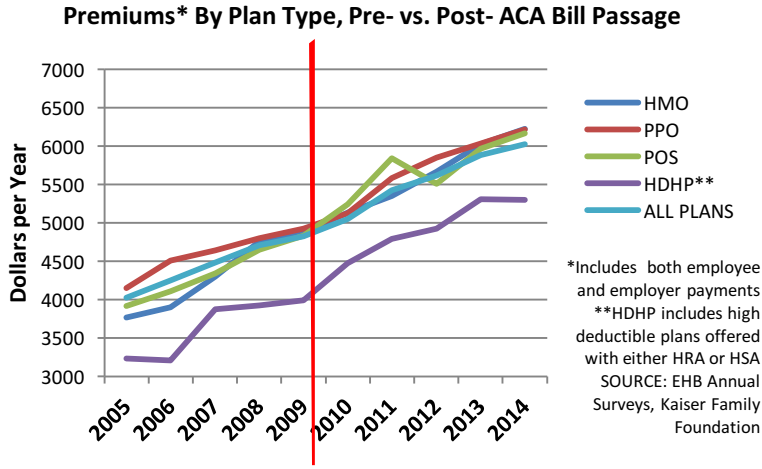


Figure 12. The annual premiums for all types of insurance coverage have increased over the past decade (vertical line indicates passage of ACA bill).

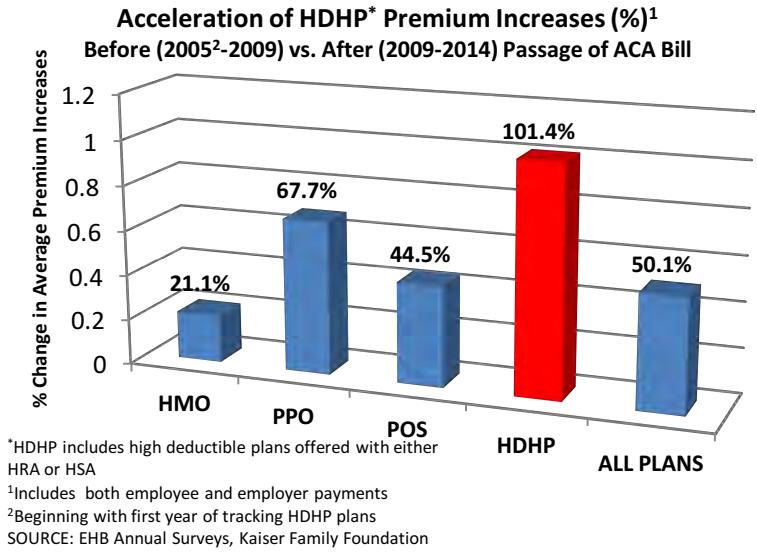


Figure 13. While all types of insurance plans have increased in price faster after the bill passage compared to before the bill passage, Obamacare regulations have accelerated the increase in premiums of high deductible plans more than any other type of coverage.

We should eliminate unnecessary coverage mandates that have ballooned under the ACA. Obamacare's so-called "minimum essential benefits" have increased premiums by almost 10%[41], and strip back the more than 2,270 state mandates[42] requiring coverage for everything from acupuncture to marriage therapy. We should remove archaic obstacles to competition, including barriers to out-of-state insurance purchases. To eliminate unfair cost shifts imposed by the ACA that raised premiums for younger, healthier enrollees by 19–35%[43], we should remove the 3:1 ACA dictate on actuarial regulations for age-rated premiums. Finally, we should repeal the ACA's new annual Health Insurance Providers Fee ($11.3 billion in 2015) that insurers pass on to enrollees through increased premiums, according to the CBO[44]. The ACA imposed this new sales tax on health insurance beginning in 2014, and the Joint Committee on Taxation estimated the tax burden will exceed $100 billion over its first decade and raise consumers' premiums by up to 3.7% per year. This specific tax will increase insurance costs by thousands of dollars over the decade for individuals, families, businesses, and even for the beneficiaries of the government's own insurance programs—both Medicare and Medicaid[45].

Additionally, health insurance reform is a powerful opportunity to incentivize healthy lifestyles. Two behaviors deserve special consideration. Cigarette smoking and obesity are the two most important lifestyle behaviors, both proven to increase risk for highly morbid chronic disease and worsen outcomes from those diseases, regardless of health care quality. Smoking causes $193 billion in direct health-care expenditures and productivity losses each year, according to the Centers for Disease Control (CDC)[46]. Extra medical care for obesity comprises up to 10% of total US health care costs[47]. Due to obesity's high prevalence and its association with multiple chronic diseases, worse treatment results, and more complications from even the best care, the annual US societal costs of obesity exceed $215 billion[48]. While smoking has declined, the burden of obesity to the US health care system and taxpayers has increased to crisis levels. This will only increase over the coming decades, given that disease from these risk factors typically show a lag time of 20–25 years. Even without a reduction, Eric Finkelstein of Duke University projected "*Keeping obesity rates level could yield a savings of nearly $550 billion in medical expenditures over the next two decades*". Health care reform in the US urgently needs to embrace a new era of

personal responsibility, and obesity, today's most serious public health problem of American society both because of costs and its damage to people's health, should be the highest priority.

Just as in other insurance, premiums that reflect the higher risk of disease and more frequent use of medical care as a consequence of voluntary, high-risk behavior are sensible, especially since three-fourths of health insurance claims may be due to lifestyle choices[49]. Life insurance premiums are markedly higher for dangerous behavior like smoking. Risky driving is a key factor in determining automobile insurance rates. Obesity and smoking are high risk lifestyles, both of which are major drivers of health expense with well-known health hazards. A 1998 study showed that claims of high BMI beneficiaries cost $3,537 (2015 dollars) more per year than claims of low BMI beneficiaries[50]. A 2012 study showed annual medical costs for people who are obese were $1,429 higher in 2006 than those of normal weight; for Medicare patients, this difference was $1,723, with almost 40% due to extra prescription drugs[51]. These numbers exceed the extra medical costs from smoking. A growing number of employers charge smokers higher insurance premiums. In the individual insurance market, "obese BMI' category paid 22.6% more in premiums, and those with "overweight BMI" paid 12.8% more than "normal BMI" enrollees[52]. While acknowledging the complexity and limited knowledge about the influence of genetics on obesity development as well as the harmful health effects of obesity in any individual, actuarially-based premium differences for obesity should be allowed in all health insurance plans.

Reform #2: Establish and Liberalize Universal Health Savings Accounts

Reform #2: Establish and Liberalize Universal Health Savings Accounts

- Automatically opened for every citizen with a social security number (or at birth)
- All HSAs owned by individual and portable
- Employer still permitted to serve as center for HSA sign-ups and automating contributions
- Eliminate requirement for specific deductibles in accompanying insurance coverage
- Higher contribution maximums to equal those of total annual out-of-pocket limits
- Broader uses permitted (health care products, services)
- Eased limits on employer-provided financial incentives for wellness programs
- Tax-free rollovers of all HSAs permitted to surviving family members

Independent health savings accounts (HSAs) allow individuals to set aside money tax-free for *uncovered expenses*, including routine care. Both contributions and disbursements from the HSA are tax-free as long as they are spent on health care. The tax incentives of HSAs are different from those in a policy of simply allowing a tax deduction for all out-of-pocket health spending. If all out-of-pocket spending was tax deductible, overall health spending would pay roughly 70 cents for each dollar of health care consumed. On the other hand, HSAs lower the cost of saving. They counter the tax bias against high deductible plans in a unique way. Instead of simply introducing incentives that subsidize health care spending relative to other spending, they also incentivize saving.

Despite the ACA's restrictions, HSAs continue to grow. Indeed, by increasingly choosing HSAs when given the opportunity, American consumers are approving their value (Figure 14). HSAs have grown rapidly over the past decade, with a one-year jump of 29% as of the end of 2014, reaching a record high of 14.5 million as of mid-2015[53]. Nearly one-third of all employers (31%) now offer some type of HSA, up from just 4% since 2005. HSA account holders deposited $21 billion in 2014, and investment assets increased by 40% since the previous year to an estimated $3.2 billion by year-end. By the end of 2017, the HSA market will surpass $46 billion in assets held in almost 25 million accounts.

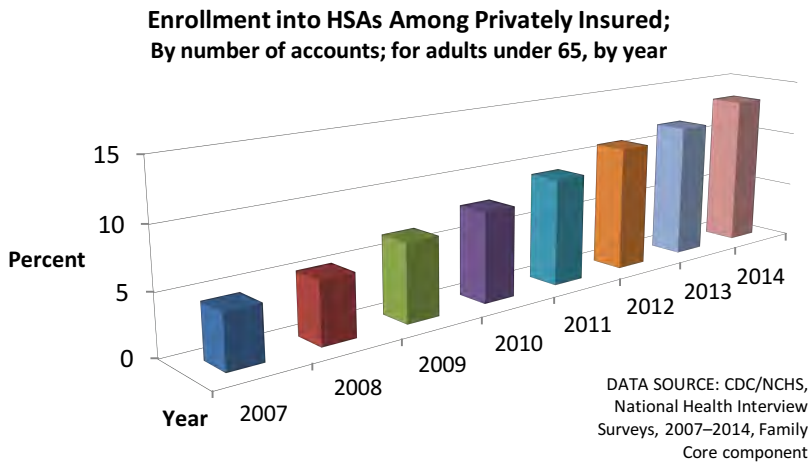


Figure 14. Enrollment into HSAs has steadily increased since their introduction.

Beyond increasing the options for affordable private insurance, these consumer-empowering shifts pairing HSAs with high deductible coverage reduces costs—the main goal of health system reforms in the first place. Adding HSAs to high deductible plans provides more incentive to save than other arrangements; in Haviland's 2011 study, adding HSAs to high deductible plans correlated to an increased savings of from 5.5–14.1%, or 50% to more than double the savings of high deductible plans alone. System-wide health expenditures would fall by an estimated $57 billion per year if only half of Americans with employer-sponsored insurance enrolled in plans

combining HSAs with high deductibles[54]. Savings would increase further if deductibles were truly high, e.g. $4,000–$5,000, and if these plans were freed from the added costly mandates of the ACA. Total savings from these reforms could approach $2 trillion over the decade.

The fundamental point is that HSAs, especially with high deductible coverage, incentivize and leverage the power of consumers. This consumer power is crucial to making health care more affordable while maintaining health care excellence, access, and innovation. The issue is not whether these accounts are effective; it is how to maximize their adoption and eliminate the government rules that serve as obstacles to their use. First, HSAs should be available to all Americans, automatically opened for every citizen with a social security number or at birth. All HSAs should be owned by individuals, eliminating more restrictive variants that are tied to specific employers. We should immediately liberalize maximum contributions to the level of total annual out-of-pocket expenses under the ACA (for 2016, $6,850 total for individuals and $13,700 for families), ease restrictions on their uses, and allow rollovers to surviving family members. That would lower the after-tax burden to high spenders, i.e., those with chronic diseases, so HSAs would be more attractive to them. We should also eliminate the counterproductive requirement of owning coverage with government-specified deductibles in order to open an HSA. This would introduce more consumer power and incentivize more families to save for out-of-pocket expenses.

The differences between current regulations on HSAs and the proposed new rules for HSAs are summarized in the following *Table* (also see *Questions and Answers* appendix):

Topic	Current HSA	New HSA
General eligibility	Must meet many specific requirements (see below and text)	Universal for all citizens; automatically opened at birth
Insurance requirement to contribute to HSA	Government-specified high deductible coverage	No specified deductible range of coverage
Limits on maximum contribution per year (e.g., 2016)	$3,350 (individual) $6,750 (family)	$6,850 (individual) $13,700 (family)
Uses of HSA funds	Not for non-prescription drugs other than insulin	OTC drugs are eligible without need for MD prescription
Tax deductibility	Contributions and withdrawals deductible	Contributions and withdrawals deductible
Eligibility if enrolled in Medicaid	Not eligible without exemption	Eligible
Eligibility if enrolled in Medicare	Not eligible	Eligible
Eligibility if receiving Social Security	Not eligible	Eligible
Special Medicare Advantage MSAs	List of restrictions limiting contribution levels, contribution sources, others	Full conversion to standard HSA without any special limits or restrictions
Penalty for ineligible withdrawals	20% penalty (plus taxation)	50% penalty (plus taxation)

continued on next page

Topic	Current HSA	New HSA
Use for insurance premiums (seniors only)	At age 65, can reimburse yourself for the money that Social Security withholds from your benefits to pay Medicare Part B (which will be $104.90 per month for most people in 2015), and you can also make tax-free HSA withdrawals to pay Medicare Part D and Medicare Advantage premiums (but not Medigap premiums).	Allowed for all premiums only if coverage is limited-mandate catastrophic plan
Seniors and ineligible withdrawals	After 65, no penalty (just taxation)	After 70 (new Medicare eligibility age), 20% penalty (plus taxation)
Transfers into HSAs from retirement accounts	Not allowed	Allowed without penalty for seniors
Tax treatment to beneficiary on death of HSA holder	If spouse, tax-free rollover into HSA; otherwise, taxable income	If spouse or other family member, tax-free rollover into HSA

A growing number of employers are charging smokers higher insurance premiums while also offering wellness programs and medical screenings for risk factors such as blood pressure, body mass index, and cholesterol. In 2015, 96.7% of employers offered lifestyle programs[55], increasing from 73% in 2011 and 57% in 2009. More than one-third of firms with wellness programs include financial incentives to participants, including lower insurance premiums, reduced cost sharing, and higher employer contributions to individual HSAs[56]. Consumers have demonstrated the efficacy of smoking cessation and obesity interventions, including cash financial

incentives. Significant gains in productivity, marked reductions in health claims, improvement of chronic illnesses, and major cost savings have resulted and benefitted both participant employees and their employers[57]. Medical costs and absentee day costs fall by about three to six dollars for every dollar spent on wellness programs[58]. We should remove the ACA-specified limits of 30% of the cost of health coverage to financial incentives from employers, including cash deposits into employee HSAs. This would expand these powerful motivators for employees to participate in more wellness programs, already proven to benefit workers and firms by improving health and reducing health costs.

Reform #3:
Instill Appropriate Incentives with Rational Tax Treatment of Health Spending

Reform #3: Instill Appropriate Incentives with Rational Tax Treatment of Health Spending

- Tax treatment of health expenses is universal, i.e., equal for all, whether individual, self-employed, or employer-based
- Income tax and payroll tax exclusions require limited-mandate catastrophic coverage purchase and are limited to only two categories of expenses:
  - Health savings account contributions
  - Limited-mandate catastrophic insurance premiums
- Income exclusion based on new maximum HSA contribution (approximately 50th percentile of current employer health benefits)
- Income exclusion increases indexed to CPI-U

The income tax subsidy for unlimited health spending is one of the great mistakes of modern US tax policy. It creates harmful incentives for consumers that are counterproductive to competition and pricing, it replaces higher wages, and it is regressive, preferentially giving high income earners more tax breaks.

Tax preferences for health care spending arose as a somewhat unintended tax policy, from the fact that pension and health insurance fringe benefits provided by employers were not subject to wage controls imposed during World War II to maintain war production[59]. Later, employer payments for health benefits became deductible to employers and tax-excluded to employees in IRS tax code[60]. The current tax code sets no limits on this income exclusion, contrary to the original intent of Congress in 1954[61].

The largest tax subsidy for private health insurance—the exclusion from income and payroll taxes of employer and employee

contributions for employer-sponsored insurance (ESI)—costs approximately $250 billion in lost federal tax revenue in 2013[62]. In addition, the federal tax deduction for health expenses (including premiums) exceeding 10% of the adjusted gross income is estimated to cost $12.4 billion in lost tax revenue in 2014[63]. CBO projects that tax expenditure for employment-based insurance (including income and payroll taxes) will remain close to 1.5% of GDP during the coming decade. The tax subsidy is highly preferential to individuals with higher incomes, i.e., it is highly regressive. About 85% of the subsidy goes to the top one-half of the income distribution[64]. In addition, the tax exclusion distorts the labor market[65] by limiting job mobility and strongly influencing retirement decisions. On the other hand, certain positives come from ESI, such as risk pooling as well as the employee's opportunity for insurance selection over more than one year.

Beyond the numbers, the tax exclusion creates perverse incentives. Indeed, the direct observation that "the tax subsidy is responsible for much of what is widely perceived as a health care crisis" may sound like it was written only recently, yet this statement dates back at least 35 years[66]. The exclusion makes health spending seem less expensive that it is. The incentive to allocate more money for health care encourages more expensive insurance policies with more elaborate coverage as well as higher demand for medical care, regardless of cost. The current tax exclusion is preferential to insurance over out-of-pocket spending (as opposed to the incentive of HSAs, particularly as structured in this reform proposal). The distortion of health insurance to its now dominant form that covers almost all billable services, including minor, fully predictable medical care, while minimizing direct payment by patients, is partly attributable to the tax preference. This has greatly increased the overall cost of health care[67].

Changing the tax treatment of health spending is an important part of urgently needed health care reforms; unfortunately, comprehensive tax reform into a broad-based, low-rate, simple system seems unlikely at this time. Removing the existing tax exclusion entirely would be problematic[68]. Serious repercussions could arise from total removal of the tax exclusion, including a significant increase in the number of uninsured, abrupt disruption of the labor market, and a dramatic increase in taxes.

Given those realities, the herein proposed tax reform eliminates the Obamacare excise tax and incorporates three main features: 1) universality, regardless of source of health benefits; 2) limits on total allowed exclusion, and 3) new criteria on eligible spending for tax exclusion, limited only to HSA contributions and premium payments for limited-mandate catastrophic coverage. These new tax reforms would reduce expenditures and encourage value-based insurance purchasing, i.e., they would realign incentives in health insurance and health care markets to benefit consumers. Once the reforms are enacted, the increase in the individual's purchasing power for medical care goes up far more than compensates for the loss of certain tax subsidies for health care spending.

1) Universality:

The current system is unfair and preferentially benefits higher income earners who receive health benefits from employers. Current law permits families without employer-based health insurance to deduct medical expenses only if they itemize their deductions, a strategy chosen far more frequently by upper income earners; moreover, the deduction is limited to expenses that exceed 10% of adjusted gross income. To level the playing field, all citizens should be allowed the same deductibility of health expenses in my proposal, if they purchase the basic limited-mandate catastrophic coverage. The proposed income exclusion for health spending will be universal, applicable to all, regardless of employment or source of health benefits.

2) Total allowable exclusion limit:

The proposed allowable exclusion from income and payroll taxes is based on the maximum allowable HSA contribution ($6,850), roughly equal to the 50th percentile of current health benefits paid through employment[69]. For 2014, the estimated annual health insurance premium paid per worker equaled $6,025 for individual coverage; the average premium paid for high deductible coverage percentile equaled $5,280. However, the term "high deductible" was defined as plans with annual deductibles only greater than or equal to $1,250 for an individual ($2,500 for a family); it also included coverage bloated by all of the ACA mandates and regulations. In the final year pre-ACA regulations, 2009, the average premium of high deductible plans equaled 82.6% of the average cost of employer-provided health insurance. Therefore, given other reforms in this six-point proposal that would further reduce the cost of true high

deductible coverage, the new exclusion should cover the entire cost of high deductible plans plus significant deposits to HSAs.

CBO and JCT estimate that setting income exclusion limits based on the estimated 50th percentile for health insurance benefits (including, but not limited to premiums) paid by or through employers in 2015 (and indexed in subsequent years for inflation using the CPI-U), with the same limits for the deduction for health insurance available to self-employed people, would reduce deficits by $537 billion over the next decade. This cap would have far greater impact on upper income earners[70] (*note*: for contrast, the Urban Institute estimated that capping the exclusion at the 75th percentile of total health benefit through employment would produce $264 billion in new income and payroll tax revenues over the coming decade[71]).

3) Eligible spending for income exclusion:

Current health spending eligible for tax exclusion is both unlimited in size (until the 2018 Obamacare "Cadillac tax" implementation) and essentially unlimited in scope of eligible expenses. My proposal would add incentives for purchasing basic catastrophic coverage, beyond limiting the amount of the income exclusion and in addition to other incentives already described. Excludable health spending will apply only to two health expenses: 1) deposits to HSAs; and 2) premium payments for high deductible limited-mandate catastrophic coverage. It would be counterproductive to encourage the purchase of insurance bloated with expensive coverage requirements that minimize copays and effectively eliminate concern about prices of care. Added insurance coverage, including expensive "comprehensive" coverage, will always be available to those who wish to purchase it.

Note that my plan replaces the changes to the current tax exclusion under Obamacare set to begin in 2018. Under Obamacare, a new excise tax is set to be imposed on employment-based health benefits whose total value—including employers' and employees' tax-excluded contributions for insurance premiums and contributions made through HRAs, FSAs, or HSAs for other health care costs—is greater than specified thresholds (subsequently to be indexed to the growth of the consumer price index for urban residents). The Joint Committee on Taxation (JCT) and CBO project that those thresholds will be $10,200 for single coverage and $27,500 for family coverage in 2018. The excise tax (known as the "Cadillac tax") will equal 40%

of the difference between the total value of tax-excluded contributions and the threshold. But designing a policy whereby a government imposes new taxes on products whose prices became unnecessarily high directly because of the government's policies is not only bad for consumers, but frankly absurd. Moreover, the Cadillac tax is set to include contributions that employers and individuals make to HSAs toward the thresholds for invoking the 40% excise tax. This is a classic example of a misguided government intervention harming an excellent consumer-oriented program (HSAs and high deductible plans), ironically penalizing individuals trying to lower their health expenses.

Reform #4:
Modernize Medicare for the 21st Century

Reform #4: Modernize Medicare for the 21st Century

- Introduce competitive bidding to add private insurance options for all Medicare enrollees
  - Defined-benefit premium support for regional benchmark average price of three lowest-priced approved plans
  - Benchmark options will also include LMCC high deductible coverage, including prescription drug benefits
  - Cash rebates to individual HSAs if premium less than benchmark; payment due from enrollees if premiums cost more than benchmark
- All plans must also include catastrophic coverage (i.e. annual out-of-pocket limits)
- New coverage would combine old Parts A, B, and D to simplify deductibles and payments
- Establish expanded Health Savings Accounts for all Medicare enrollees
  - Automatically opened for every Medicare enrollee; limits and uses match other HSAs
  - Convert current HSA variants under Medicare to match universal HSA regulations
  - Tax-free rollovers of all HSAs permitted to surviving family members
- Phase out taxpayer subsidies for high income-earning seniors
- Modernize eligibility with gradual phase-in to age 70
- Repeal the Independent Payment Advisory Board

Medicare is a tax expenditure targeted at the elderly who have already at least partially paid tax contributions over the years for their future health care insurance. Originally, Medicare was put forward as a safety net for protecting the elderly from financial ruin by

catastrophic illness. A key rationale for Medicare was that the program would enable seniors to avoid financial dependence, as evidenced by their lower incomes. This ignored the fact that the elderly had more substantial assets than younger adult populations during the years of Medicare bill passage[72]. Even more ironically, original Medicare never had, and even today, traditional Medicare still does not include catastrophic insurance for asset protection.

Regardless of its origins, today's Medicare is highly fragmented, almost undecipherable in its complexity, flawed in its coverage, and inadequate in its benefits. After decades of coverage additions and patchwork remedies, today's Medicare is a confusing amalgam of four relatively separate insurance programs, each with complicated and diverse funding sources. *Part A* (Hospital Insurance) covers inpatient services, some home care, skilled nursing services, and hospice care. It is funded through the federal payroll tax by today's working population and employers. Most people don't pay a premium for Part A, because they or a spouse have already paid via their payroll taxes while employed, although they do pay deductibles and copayments. *Part B* (Medical Insurance) covers doctor bills, outpatient treatment, screening and lab tests, and certain medical supplies, subject to deductibles and copayments. It is funded partly by beneficiaries via income-adjusted monthly premiums and partly by general tax revenues. *Part C* (Medicare Advantage, or MA) is a private insurance system that includes Part A and Part B benefits (i.e., it replaces Parts A and B, so-called "traditional Medicare" coverage), as well as some prescription drug coverage, for regional beneficiaries. As opposed to traditional Medicare, MA plans must have annual out-of-pocket limits (i.e., catastrophic coverage). In MA, Medicare contracts with private insurers to offer health services through a variety of provider networks, most commonly HMOs. MA is funded partly by member premiums and partly by capitated payments from taxpayer funds (note: since 2006, Medicare has paid plans under a bidding process, whereby Medicare receives bids from private insurers for coverage equal to Parts A and B, and then pays the insurer for coverage relative to formulaic benchmarks by county or region). *Part D* (Prescription Drug Coverage) is funded by income-adjusted enrollee premiums and taxpayer funds, as is Part B; copayments and deductibles vary by plan. In Part D, private insurance companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. In addition to this enormous

programmatic complexity, Medicare administrators process nearly 4.9 million Medicare claims each business day, according to CMS. Unsurprisingly, the Medicare program is fraught with errors, fraud, and waste estimated by the Government Accountability Office (GAO) to have totaled $60 billion in 2014[73].

Medicare is not only a disjointed and antiquated system designed for decades long past, but more acutely, Medicare is in serious financial trouble. As noted, the Medicare Trustees report projects that the Hospitalization Insurance fund will be depleted in 2030. Meanwhile, the population of seniors is dramatically expanding, and the taxpayer base financing the program is dramatically shrinking. In its first year, Medicare spent under $1 billion for 250,000 elderly, but in 2014 it spent over $615 billion for over 52 million enrollees. Nearly 4 million Americans now reach age 65 every year. In 2050, the 65-and-over population is projected to reach 83.7 million, almost double the 43.1 million in 2012. And the future health care needs for seniors have dramatically increased. The already high health expenses for a 65-year-old (Figure 15) will triple by 2030[74]. Americans live 25% longer after age 65 now than in 1972[75], with an average life expectancy of about 85 years, approximately five years longer than at the inception of Medicare (Figure 16). Today's seniors need to save money for decades, not just years, of future health care.

Despite expanding needs from demographics, Obamacare imposed a new obstacle to health care access for seniors. Its Independent Payment Advisory Board (IPAB), a group of political appointees, is specifically tasked with formulaically reducing payments to doctors and hospitals. As Howard Dean, former Chair of the Democratic National Committee, warned, "The IPAB is essentially a health-care rationing body. By setting doctor reimbursement rates for Medicare and determining which procedures and drugs will be covered and at what price, the IPAB will be able to stop certain treatments its members do not favor by simply setting rates to levels where no doctor or hospital will perform them." The IPAB adds to Medicare's already significant access constraints; contrary to the administration's demonization of private insurers, *Medicare already ranks at the top of the charts for the highest rates of claim refusals—more than nearly all comparison private insurers every year*[76].

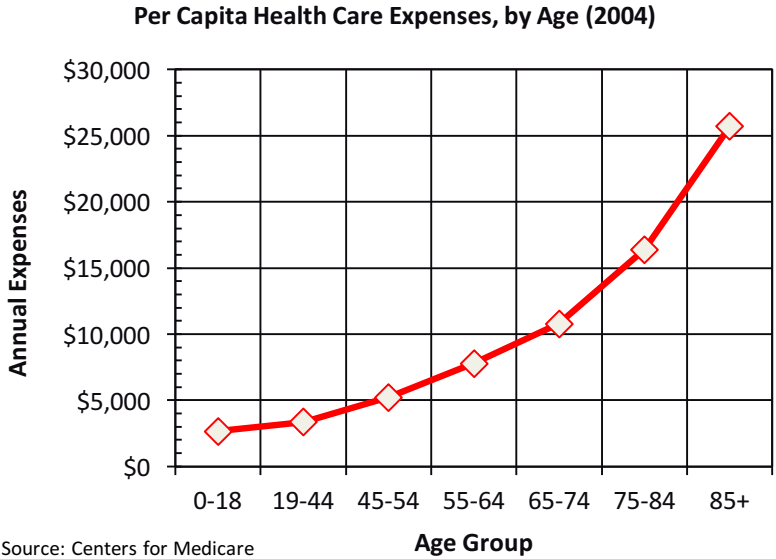


Figure 15. Age is a clear predictor of health care utilization and health care costs per person.

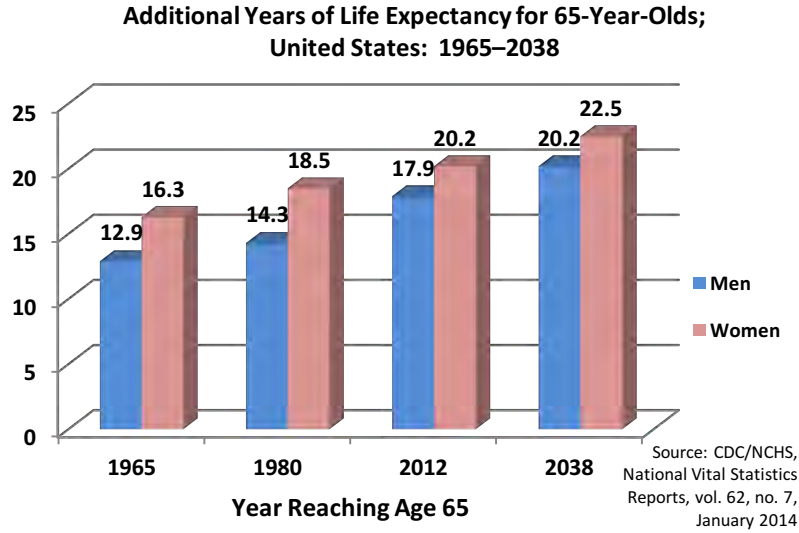


Figure 16. The additional life expectancy for those already reaching 65 years of age has increased greatly since 1965, when Medicare began.

Traditional Medicare often obstructs the delivery of health care and limits choices of doctors by virtue of its complex restrictions and rules about accepting "assignment" of Medicare insurance. Assignment means that a doctor has agreed to accept the Medicare-approved amount as full payment for services. Other doctors have not agreed to accept assignment, but they can choose to on a case-by-case basis. For these "non-participating" doctors, Medicare pays 5% less than their usual fees. Regardless of how much the health care provider charges non-Medicare patients for the same service, a Medicare patient cannot be charged more than 15% over the amount Medicare approves, i.e., the "limiting charge". Doctors who formally "opt out" can charge patients whatever they want, but they must forgo filing Medicare claims for two years, and their Medicare-eligible patients must pay out of pocket to see them. By law, seniors are not allowed to use their Medicare benefits to pay doctors privately via their own arrangement.

The resulting trend is clear—doctors are increasingly refusing traditional Medicare and opting out of Medicare entirely. This promises to accelerate[77]. In order to prevent escalation of two-tiered access to quality medical care, available only to affluent seniors, empowering all seniors to become value-seeking health care consumers is essential. This empowerment also promises to be particularly effective for reducing inflated expenditures system-wide, since seniors are the heaviest users of health care.

Seniors have shown the path toward Medicare reform—and that path is private insurance. In fact, about 75% of Medicare beneficiaries already purchase private insurance to supplement or replace traditional Medicare. About 23% of beneficiaries buy Medigap plans. These state-based private insurance plans that supplement non-drug Medicare benefits are available only to those enrolled in traditional Medicare (A and B) and not to MA enrollees. Voluntary enrollment in alternative Medicare Part C aka Medicare Advantage (MA), private health plans, with catastrophic coverage missing from traditional Medicare, has expanded to 31% of all Medicare beneficiaries, tripling since 2004 to 16.8 million in 2015. Private prescription drug coverage in Part D, also with catastrophic caps, has also been highly favored by beneficiaries. However, even in these private plans, Medicare ultimately defines the prices for medical care via complex and rather arbitrary capitated payments and other benchmarks[78], thereby controlling access while, in some cases, wasting money.

Some elements of the 50-year-old Federal Employees Health Benefits Program (FEHBP)[79], Congress' successful health insurance benefit program based on competition and consumer choice, serve as a model for reforming Medicare. In fact, the FEHBP served as the model for successful parts of current Medicare that rely on competition, i.e., MA and the prescription drug Medicare Part D. Instead of government-directed traditional Medicare, the FEHBP contains almost 300 plans from almost 100 different companies that compete for business. The government provides money toward the premium of the plan chosen by the enrollee. Plan design, covered services, and costs emerge from competition and the value-seeking decisions of the individual consumer. In direct contrast to traditional Medicare, FEHBP's oversight Office of Personnel Management does not establish payment rates to providers. Prior to Obamacare's mandates, each plan was free to offer benefits within very broad limits, including deductibles, covered services, limits on services, and copays. Other Medicare reform proposals, particularly the *Saving the American Dream* plan from Butler et al[80], also serve as models for the reforms herein proposed.

Modernizing Medicare for the 21st century centers on a three-pronged strategy that will empower seniors to move to affordable private health insurance and HSAs, improving benefits and reducing costs:

1) A defined-contribution model that offers private insurance options for beneficiaries with competition-based premiums and simplified benefits, as well as consumer incentives to seek value:

The basic concept of this model is that the government would make a defined, fixed contribution, i.e., a "premium support," to the private health plan of a Medicare enrollee's choice. Medicare will make market-based payments to competing insurance plans, not arbitrarily set prices and then pay health care providers. This way, the government's role changes from being a direct insurer to helping beneficiaries buy insurance. The amount of the government's defined-contribution benefit will be based on the average of the three lowest priced plans put forth to Medicare, similar to a number of previous reform proposals. This index group forming the calculated benchmark would include one limited-mandate high deductible plan. All plans would also be required to have annual out-of-pocket limits, that is, the catastrophic coverage that is missing from current traditional

Medicare. All plans would be required to offer prescription drug benefits.

If a beneficiary chooses a plan with a premium less than the benchmark, then a rebate payment of the entire difference would be made into that individual's HSA; if payment was due from the enrollee because of higher cost than the benchmark, the enrollee would be responsible. This would save more than the $15 billion per year CBO estimates based on using higher benchmarks[81]. In this plan, the taxpayer premium subsidies for the highest income earners would be lower but completely phased out at the highest levels. Medicare enrollees would be able to purchase more coverage by paying more in addition to the fixed government contribution.

Coverage would simplify the current separation of inpatient and outpatient expenses, unifying deductibles and payments fragmented into Medicare Part A and Part B. Ultimately, the goal is to eliminate the confusing and unnecessary separation of all inpatient and outpatient coverage, including MA plans and prescription drug coverage. In the long run, traditional Medicare will have been moved to private health insurance to improve access to doctors, hospitals, and modern medical technology and drugs, to improve benefits, and to reduce costs for all enrollees. For those over age 35 today, traditional Medicare will still remain an option; for those under 35, traditional Medicare coverage will no longer be provided.

2) Expanded eligibility and uses of HSAs that share all features and limits with HSAs outside of Medicare:

HSAs will now form an important part of the newly modernized Medicare program. Presently, HSAs are quite limited in their allowed role for seniors. In fact, the current laws prohibit Medicare enrollees from HSA eligibility. Seniors who have applied for or accepted Social Security cannot contribute to an HSA. Restricted accounts called "Medicare Advantage MSAs" are available but require enrollment in a high deductible MA health plan. Among other restrictions (see *Questions and Answers*), deposits into these MSAs are prohibited except from Medicare itself and are limited in amount to typically less than half of the required deductible of the accompanying coverage. Upon death of the owner, HSAs are deemed taxable unless the beneficiary is the spouse.

Given that future health care needs for today's seniors now last decades, expanded HSAs will be of great importance to a modernized Medicare, and are particularly suitable to HSA withdrawal because most health expenditures are relatively small and routine. HSA holders also participate more in wellness programs that focus on obesity and other major health risks, so these would be increasingly important to senior care. New Medicare HSAs will be transformed into highly flexible vehicles for seniors to seek the best value for their health care spending (see *Questions and Answers*). Under this plan, Medicare enrollees will automatically open HSAs if they had none prior to entering Medicare eligibility. In this plan, all Medicare enrollees will be fully eligible for HSAs, regardless of enrollment into any specific coverage or program and without any specified level of deductible on insurance. The only requirement for making contributions to the HSA will be catastrophic coverage. HSAs under New Medicare will have far higher maximum contribution limits (approximately double those for 2016), matching all other HSAs in the newly reformed system; likewise, they will have the same broadened uses of non-Medicare HSAs, including non-prescription medications and home health care devices. All current Medicare MSA limits and rules for uses will be updated to match universal HSA regulations, including removal of the requirement to enroll in coverage with arbitrarily-defined deductibles and eliminating Medicare MSA's restrictions on deposits. Knowing that seniors typically incur greater health care costs, seniors will be allowed to rollover, tax-free, money from retirement accounts into their HSAs. Seniors, their families, and their employers will all be allowed to contribute to the new HSAs up to the annual maximum. Even if Social Security benefits have begun, seniors will still be allowed to fund their HSAs. In New Medicare HSAs, a 20% penalty would be in place for non-qualified HSA withdrawals once the owner of the HSA becomes 70 years old. Upon death, New Medicare HSA balances will be allowed to be rolled over to the tax-free HSA of the surviving spouses or other family members. This will also enhance HSA balances of younger family members and perpetuate increased consumer leverage on pricing.

3) Modernized eligibility from obsolete criteria of 50 years ago to reflect demographics and health needs of today's seniors.

The rationale to update archaic eligibility criteria for Medicare is straightforward. Modern medical care in the US has increased life

expectancy from birth by 1.6 years per decade for a half-century. Life expectancy from age 65 has increased about five years since program inception, equating to about one year longer from age 65 per decade that passes. This means that those currently 35 years old will add another three years to their post-65 life span. Moreover, older people now remain in the work force longer. Retirement age has increased by five years since the early 1990s[82]. In the proposed new Medicare, the age of eligibility would increase by two months per year until reaching age 70; after that, the eligibility age would be indexed to life expectancy. From CBO estimates, savings of about $65 billion over the decade would result from slowly phasing in this change.

Reform #5: Overhaul Medicaid and Eliminate the Two-Tiered System for Poor Americans

Reform #5: Overhaul Medicaid and Eliminate the Two-Tiered System for Poor Americans

- Provide private insurance options for all Medicaid enrollees without need for special waivers
  - All states must permit all insurers (including all companies available on state and federal exchanges) to offer true high deductible, limited-mandate catastrophic coverage (LMCC) plans to entire state population, including Medicaid eligibles, covering hospitalizations, outpatient visits, diagnostic tests, prescription drugs, and mental health
- Establish and seed-fund Health Savings Accounts for all Medicaid enrollees
  - Automatically opened for every Medicaid enrollee; limits and uses match other HSAs
  - New incentives for healthy behavior, which will save and protect growing financial assets
  - Seed funding goes directly into HSAs as part of federal contribution every year
  - Tax-free rollovers of all HSAs permitted to surviving family members
- Federal contribution for Medicaid is fixed amount, but with threshold-based incentives
  - At least 50% of Medicaid enrollees must enroll in LMCC plans
  - At least 50% of Medicaid enrollees must have at least partially funded HSAs

Medicaid is different from Medicare. Medicaid is generally a subsidy for the poor, paid by federal funds and state funds. Medicaid is intended to help provide access to good medical care and improved health for those who cannot afford it. Instead of providing a pathway

to excellent health care for poor Americans, however, Obamacare's expansion of Medicaid continues and even exacerbates their second-class health care status, at a cost of $500 billion per year to taxpayers that rises to $890 billion in 2024[83]. As an alternative, a few states have taken the lead within the confines of the ACA via special waivers to facilitate a transition into private coverage with better access to medical care. Arkansas and Iowa have received approval to use the "private option" in which Medicaid provides premium assistance to purchase private plans in lieu of direct Medicaid coverage[84]. In Arkansas, about 85% of Medicaid beneficiaries are now eligible for the private option, while as of January 1, 2015, Iowa has used it as an option for enrollees with income between 100% and 133% of federal poverty level. Additionally, Michigan and Indiana have added HSA options for Medicaid beneficiaries, and Arkansas has begun the approval process. Although still burdened with a mandated set of benefits and other regulations under the ACA, these are steps in the right direction.

The time is long overdue for a more fundamental overhaul to Medicaid, with more aggressive reforms to truly modernize it into a program with improved benefits and ultimately reduced costs. My plan eliminates the two-tiered system that has been propagated for decades. Traditional Medicaid is sham insurance that most doctors don't even accept (Figure 17a,b).

My plan transforms Medicaid into a bridge program geared toward enrolling beneficiaries into affordable private insurance, instead of a parallel second-class system funneling low income families into substandard traditional Medicaid coverage. The plan establishes and seed-funds HSAs, a vital component of empowering enrollees with the same control and incentives as all other Americans, while instilling incentives for good health. These reforms would change the purpose and culture of Medicaid agency offices from running special government-administered Medicaid plans to establishing HSAs and finding private health plans for Medicaid beneficiaries.

First, new Medicaid will include a LMCC private insurance option for all enrollees, without any need for special waivers. Second, new Medicaid will establish and seed-fund HSAs for the program's low-income American enrollees, in turn creating growing assets and

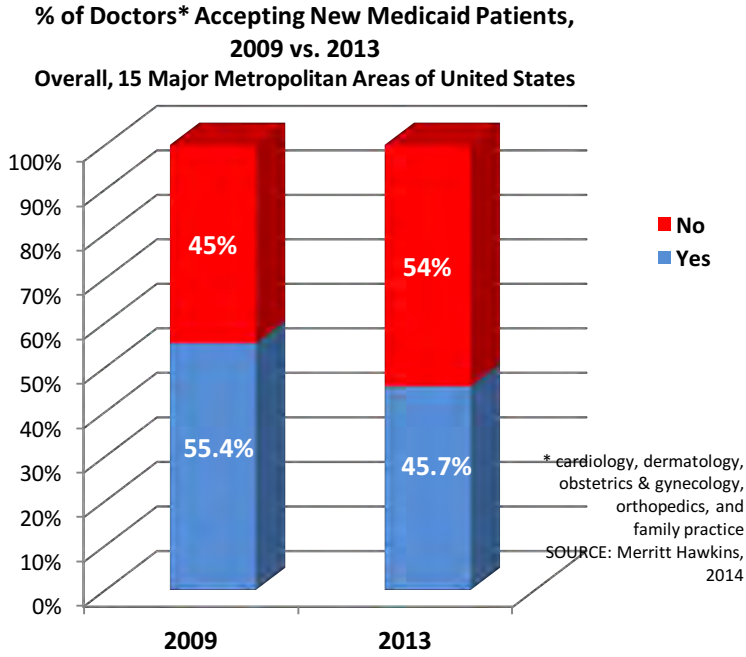


Figure 17a. Most doctors do not accept Medicaid patients, and the proportion of doctors who accept new Medicaid patients has been decreasing.

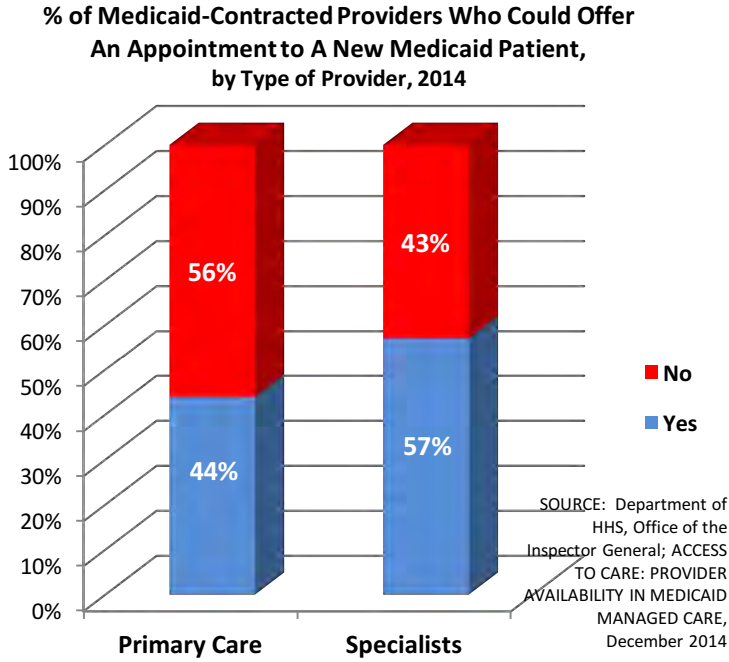


Figure 17b. Even of the doctors already contracted by Medicaid and listed as accepting patients, a large percentage do not accept new Medicaid patients. Obamacare has massively expanded Medicaid enrollment, but most will not be able to find doctors who will accept them as patients.

incentivizing healthy lifestyles to protect those assets. To ensure these objectives for beneficiaries, federal funding to states will require states to offer these same private coverage options to the entire state population, including all Medicaid-eligible families; moreover, that funding will also be contingent on meeting certain enrollment thresholds for Medicaid enrollees into LMCC private coverage and funding into HSAs. Funds will be allocated via fixed dollar amounts to states, but directly toward individual HSAs or insurance premium payments, rather than into inefficient state bureaucracies. Ultimately, traditional Medicaid coverage will be eliminated over decades as new enrollees move toward private plans with HSAs.

The new Medicaid will financially empower low income Americans to 1) purchase affordable, private insurance identical to what any American citizen could buy; and 2) fund HSAs that provide control and choice, but just as important, build assets worth protecting. These incentive-based Medicaid reforms would move Medicaid enrollees to private coverage, with equal access to doctors, specialists, treatments, and medical technology as the general population, eliminating the two-tiered health system that Obamacare furthers. It would give control of the health care dollar to low income families to empower value-seeking and foster provider competition for that money. Medicaid HSAs would provide new incentives for lower income families to seek good health through wellness programs and healthy behavior in order to save and protect their new, growing financial assets.

Reform #6:
Strategically Enhance the Supply of Medical Care While Ensuring Innovation

Reform #6: Strategically Enhance the Supply of Medical Care While Ensuring Innovation

- Stimulate and publicize private retail clinics staffed by nurse practitioners and physician assistants, and minimize obstacles and unnecessary regulatory burdens
- Encourage streamlined training programs for MDs, and abolish fixed quotas by medical specialty societies that artificially restrict supply of trained specialists and inhibit competition
- Loosen scope of practice restraints on nurse practitioners and physician assistants
- Institute national physician licensing via state reciprocity
- Repeal innovation-limiting ACA taxes on medical devices and brand name drugs
- Streamline FDA bureaucracy for device and drug approvals
- Strategic immigration reforms to target high-skill foreign workers and facilitate longer term visas for highly educated immigrants

Challenges to health care access cannot be met without strategically modernizing the supply and delivery of medical care. Private-sector clinics owned by pharmacies and staffed by nurse practitioners and physician assistants can provide routine primary care, including flu shots, blood pressure monitoring, blood tests, and inexpensive drugs. Eleven medical conditions (outside of preventive care and immunizations) accounted for 88% of acute care visits to retail clinics in a 2011 review; all of them involved relatively low medical costs[85]. Care initiated at retail clinics is 30–40% cheaper than similar care at physician offices and about 80% cheaper than at emergency departments[86]. Patients seek care at these clinics for several reasons,

particularly convenience (i.e., extended hours and no need for appointments), low-cost services, convenient locations, short wait times, and transparent pricing[87]; they have generally reported high levels of satisfaction with their care. Accenture estimates that retail clinics can potentially save hundreds of millions of dollars per year while increasing neighborhood access to routine primary care[88]. While private ownership by stores or pharmacies is common, an emerging trend is for independent retail clinics to develop formal relationships with hospital systems or physician groups. The use of such clinics increased ten-fold between 2007 and 2009[85], and is continuing to grow at 15% annually. The percent of large employers providing benefits covering retails clinics nearly doubled between 2008 and 2009. Nearly all accept private insurance (97%) and Medicare fee-for-service (93%)[89] but only 60% accepted traditional Medicaid.

The key to incentivizing the proliferation of these clinics may rest on preventing government and special interest obstacles to their use. Retail clinics should not be held to higher standards or more burdensome documentation than other health care clinics. Credentialing requirements for insurance reimbursement should be simplified. Additionally, states should follow the recommendations of the Institute of Medicine[90] and remove outmoded scope-of-practice limits and politically-based practice restrictions on nurse practitioners and physician assistants, starting first with the dozen states categorized as “restricted practice” regulations.

States should also modernize physician licensing. Non-reciprocal licensing by states unnecessarily limits patient care, especially as telemedicine proliferates. It is also time to relax tight limits to physician supply that have stagnated medical school graduation numbers for almost 40 years, and bring to light the strictly controlled residency training practices in place for decades. And increasing physician supply is not only necessary for primary care. Almost two-thirds of the 2025 doctor shortage of 124,000 will be in specialists, not in primary care[91] (Figure 18). It remains extraordinarily difficult for residency training programs to increase the number of their trainees, even when paying fully for the additional residency positions. Medical societies that set restrictive quotas harm consumers by artificially limiting the supply of doctors and consequently restricting competition among doctors. These anti-consumer practices need to be open to public scrutiny and abolished.

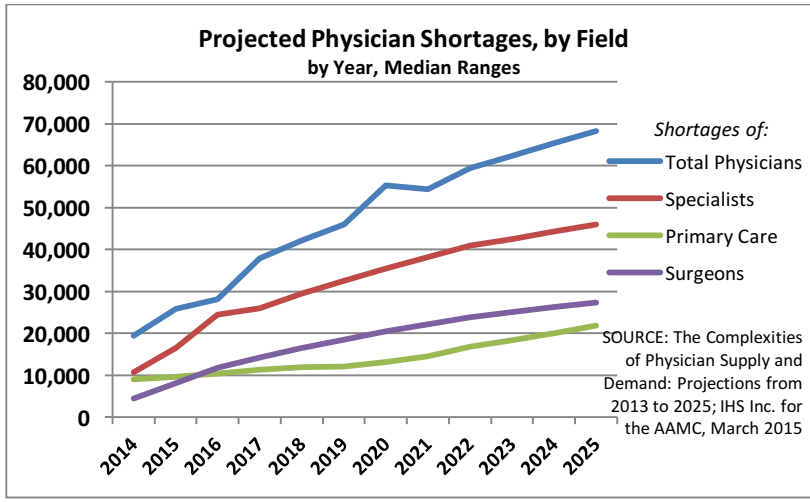


Figure 18. Shortages of specialists and surgeons exceed the projected shortage of primary care doctors.

In reality, virtually all patients with serious diseases today are managed by specialists. For seniors, visits to specialists have increased from 37% of visits two decades ago to 55% today[92]. And that's appropriate, because those are the doctors who have necessary training and expertise to use the complex diagnostics, new procedures, and novel drugs of modern medicine. To increase the supply of doctors who are trained to use advanced technology and to ensure clinical innovation, we must keep attracting top students into medicine. Specific estimates vary, but while the direct payments for malpractice amount to less than 1% of health spending, *if one includes the $45 billion in costs of defensive medicine, the total tallies 2.4% of health care spending, or over $55 billion per year*[93]. Therefore, rein in malpractice lawsuits that waste money and discourage pursuit of careers in top specialties, and encourage streamlined training when possible. Then, add common sense—it would be destructive to artificially determine salaries by government price fixing for those who have the most valuable and unique expertise. Price transparency and more consumer empowerment, prompting competition among providers, more effectively sort out these issues.

Perhaps the most insidious consequence of the ACA is the threat to innovation in drugs, devices, and medical technology—the tools that

streamline diagnosis, ensure safer treatment, and save lives. The importance of continuing the stream of new medical technology and highly specialized, targeted treatments cannot be overstated, and the overwhelming majority of the world's health care innovation occurs in the US (Figures 19–21). This includes ground-breaking drug treatments, surgical procedures, medical devices, patents, diagnostics and much more. R&D leaders from 63 countries in a recent *R&D Magazine* survey ranked the US No. 1 in the world for health care innovation.

But that environment is changing. Growth of total US R&D expenditures from 2012 to 2014 averaged only 2.1%, down from an average of 6% over the previous 15 years[94]. Although the slowdown is partly attributable to the weak economy since the 2008 financial crisis, it has been exacerbated by Obamacare's new taxes and regulations. According to CBO estimates, the law will impose more than $500 billion in new taxes over its first decade to help pay for its insurance subsidies and Medicaid expansion. These include significant taxes on key health care industries, including manufacturers of medical devices and drugs, and their investors. Because of the Obamacare tax burden, small and large US health care technology companies are moving R&D centers and jobs overseas. Already a long list of such companies—including Boston Scientific, Stryker and Cook Medical—have announced job cuts and new centers overseas for R&D, manufacturing, and clinical trials.

Bureaucracy at the Food and Drug Administration is also hindering medical technology and drug development. According to a 2010 survey of more than 200 medical technology companies[95], delays for approvals of new devices are now far longer than in Europe. In the European Union—not exactly known for minimizing red tape—it takes seven months on average to gain approval for low- to moderate-risk devices. In the US, FDA approval time averages 31 months. Price Waterhouse Cooper's 2011 Innovation Scorecard for medical technology found a worsening in the US over the past five years[96]. They stated that "although the United States will hold its lead, the country will continue to lose ground during the next decade." Meanwhile,

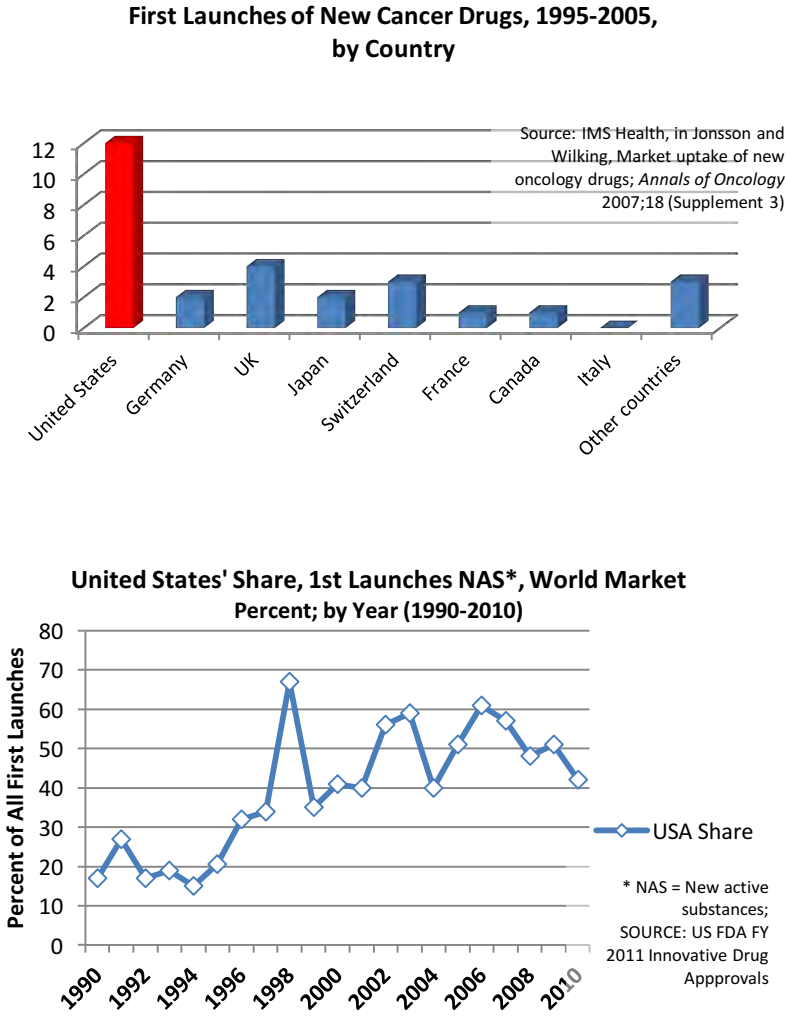


Figure 19. The United States has been the dominant initiator of new drug launches, including new cancer drugs (*top figure*), originating about half of the entire world's new active substances for almost two decades (*bottom figure*).

Rank	Technology	Description	Country of Origin
1	Magnetic resonance imaging (MRI); Computed tomography (CT)	Non-invasive diagnostic imaging	USA, UK; USA, UK
2	Angiotensin converting enzyme (ACE) inhibitors	Drugs for hypertension and heart failure	USA
3	Balloon angioplasty	Minimally-invasive surgery to unblock arteries	Switzerland
4	Statins	Cholesterol-reducing drugs	USA, Japan
5	Mammography	Breast cancer detection	Indeterminate
6	Coronary artery bypass graft (CABG) surgery	Surgery for heart failure	USA
7	Proton pump inhibitors	Antiulcer drugs	Sweden, USA
8	Selective serotonin re-uptake inhibitors (SSRIs)	Antidepressant drugs	USA
9	Cataract extraction and lens implant	Eye surgery	USA
10	Hip replacement; knee replacement	Mechanical prostheses	UK; Japan, UK, USA

Figure 20. The US has been the dominant country-of-origin for the most important medical innovations in recent history (based on Fuchs V, and Sox H; Physicians' Views of the Relative Importance of 30 Medical Innovations, *Health Affairs* 2001;20: 30–42).

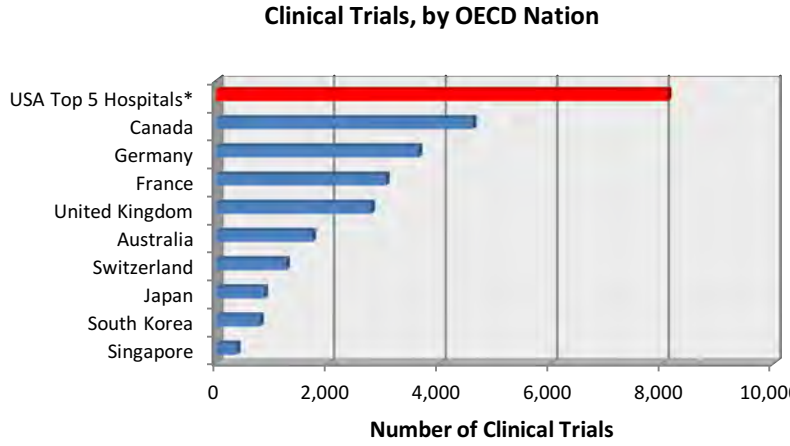


Figure 21. The top five US hospitals conduct more clinical trials than any OECD nation * Top five US hospitals as ranked by *U.S. News & World Report*, 2007 (Source: Accounting for the cost of US health care: a new look at why Americans spend more, McKinsey Global Institute, December 2008, based on National Institutes of Health; *US News & World Report*)

emerging nations including India and China have significantly improved their own environments for innovation and entrepreneurs.

What can be done to reverse these damaging trends? First, strip back the heavy tax burdens on industries and investors that inhibit innovation, starting with repealing the ACA's $24 billion medical device excise tax and the $30 billion tax on brand-name drugs. Repeal the Obamacare investment tax to restore tax incentives for essential funding of early stage medical technology and life science companies. And simplify processes for new device and drug approvals, so that the FDA becomes a favorable rather than an obstructionist environment for these life-saving and cost-saving discoveries.

Finally, immigration reforms are needed to encourage educated, high-skill entrepreneurs to stay in the US. Many of the best and brightest who come to the US to study science, technology, engineering and math—STEM subjects crucial to health care innovation—are now choosing to return to their home countries. In contrast to a decade ago when from two-thirds to over 90% of foreign students studying in the US remained here, only 6% of Indian, 10% of Chinese, and 15% of

European students expect to make America their permanent home today[97]. Although some of this is undoubtedly due to improving opportunities in those students' home countries and incentives for them to return home, many graduates want to remain in the US but are unable to do so. Lawmakers should take a fresh look at easing counterproductive immigration restrictions. New skills-based visa programs should be instituted that specifically target highly educated individuals, particularly students completing American university graduate-degree programs in STEM areas.

Conclusion

Even if one recognizes the unsurpassed excellence of medical care that has been widely available in the United States, reforms are urgent, particularly in light of the deleterious impacts of Obamacare. Costs are high and escalating; government expenditures they would soon overwhelm the entire federal budget in the absence of change. This causes great concern about the sustainability of access to medical care and its excellence for Americans in the long term. Reforms to the system are essential—the debate is about what specific reforms are appropriate to fix the inadequacies and reduce the cost without jeopardizing its excellence and without stifling innovation.

Paradoxically, as Obamacare is doubling down on government authority over health care, the solution in those countries with the longest experience of nationalized health care, from Britain to Denmark to Sweden, is increasingly to shift patients toward private health care to remedy their failed systems[98]. Likewise, Europeans with means or power are increasingly circumventing their centralized health systems. Private insurance in the EU has grown by more than 50% in the past decade[99]. In reaction to their unconscionable waits for care[100], about 11% of Britons hold private health insurance, including almost two-thirds who earn more than $78,700—even though they are already paying taxes to the tune of £114 billion ($175 billion) for their "free" NHS insurance[101], and despite the government's sharp rise in an Insurance Premium Tax to thwart private insurance[102]. In Sweden, despite the fact that an average family already pays nearly $20,000 annually in taxes toward healthcare, almost 600,000 Swedes now use private insurance, a number that has increased by 67% over the last five years[103]. Unless Obamacare is drastically altered, America's health care will also become even more divided. If sustained, it will be driven toward two parallel systems with even more inequality; as in the UK and elsewhere, only the lower and middle classes in America will suffer the full harm of Obamacare.

As outlined herein, specific reforms that would improve the availability for all Americans to high quality care and reduce costs,

without damaging the excellence of America's medical care, are within reach. Using specific incentives and detailed proposals, the plan enhances the availability and affordability of 21st century medical care and ensures continued health care innovation. These reforms promise to be disruptive and drive important efficiencies into health care. Once fully implemented, the quality of health care will improve and total national health spending will substantially decrease, generating significant savings and increased economic activity into other areas of the US economy. Modernizing US health care should center on expanding high deductible insurance coverage and health savings accounts (HSAs). These fundamental reforms expand the purchasing power of consumers, the necessary basis for enhancing market competition that will ultimately lead to better value and more consumer choices. And voters overwhelmingly support such reforms. In answer to the question "What would do more to reduce health care costs—more free market competition between insurance companies or more government regulation?," 62% of voters chose more free market competition, while only 26% chose more regulation[104]. A vast majority of Americans—a full 73%—say they have a right to choose between health insurance plans that cost more and cover just about all medical procedures, and other plans that cost less while covering only major medical procedures (only 12% are opposed)[105]. An even greater majority, 85% to only 7%, say individuals should have the right to choose between health plans that have higher deductibles and lower premiums versus plans with lower deductibles and higher premiums. It is the responsibility of government leaders to work in creating health reforms that reflect these important principles held by the American people.

Appendix:
Questions and Answers on the Atlas Plan

The State of US Health Care

If the US health care system was so good before Obamacare, then why does US life expectancy lag behind so many other countries?

- Life expectancy figures are poor indicators of health system quality (reviewed in: "The Limited Value of Life Expectancy Comparisons in Ranking Health Systems"; *In Excellent Health: Setting the Record Straight on America's Health Care*; SW Atlas, 2011, Hoover Press). Many factors significantly impact overall life expectancy; many have little or nothing to do with quality of health care. For example, the US ranked near the bottom of OECD (the world's economically developed nations) life expectancy tables. Ohsfeldt and Schneider in 2007 then standardized countries for all immediate deaths from homicide, suicide, high speed motor vehicle accidents (situations where health care is irrelevant). The US moved to the top of the ranking! Personal life style choices involving nutrition, exercise, obesity, cigarette smoking, and safe sexual practices impact life expectancy. The US has a greater commitment to caring for vulnerable newborns and the elderly. Individual decisions to follow doctor recommendations about treatments, follow-up, or taking prescribed medications all influence life expectancy.

- Countries differ greatly in their population heterogeneity, which strongly influences mortality rates due to genetic susceptibility to disease, socioeconomic variations, differences in education, and other factors separate from quality of medical care. Differences in technology, disposable income, violence, urbanization, marriage rates, and economic inequality also change life expectancy. Some of these bias the statistic against US life expectancy, due to the world's largest historical burden of smoking and rising obesity, the two major lifestyle risk factors for premature death, independent

of health care quality. The OECD estimates that the lifespan of an obese person is up to 8–10 years shorter than that of a normal-weight person, matching the loss of longevity seen in cigarette smokers.

If the US health care system was so good before Obamacare, then why does US infant mortality rank lower than so many other countries?

- Infant mortality rate is a complex and multifactorial end-point that oversimplifies multiple inputs, many of which have no tie to health care at all. It is plagued by widely varying definitions of key terms, registration biases, and a large number of risk factors that distort the final statistic, all of which render the figure invalid as a comparison measure of health care. And the US is different from other countries in important ways regarding infant mortality, including: 1) the US adheres strictly to WHO criteria to define "live births" and records all births, while most other countries don't count high-risk newborns who die early; 2) medical standards differ among countries, in that the US uniquely prioritizes a "full-court press" to resuscitate and save even the most premature infants with the least likelihood of survival; and 3) the US has the highest frequency of preterm births, the dominant risk factor for neonatal mortality (these factors and others are reviewed in detail in: "Infant Mortality as an Indicator of Health and Health Care"; *In Excellent Health: Setting the Record Straight on America's Health Care*; SW Atlas, 2011, Hoover Press).

Expanding Affordable Private Insurance

Did Obamacare improve anything about private insurance? If so, does this plan keep those features?

- Yes—Obamacare eliminated lifetime caps on total benefits and prevented insurers from dropping already insured people if they became diagnosed with a disease. Obamacare also put in place annual out-of-pocket maximums. These would be maintained in this plan.

Is there a mandate in the Atlas plan forcing individuals to purchase health insurance?

- No—no one is forced to buy health insurance, or penalized for not buying it. Despite the failure of the Roberts Supreme Court to stop such a mandate, it is not the role of the US government to force Americans to purchase a good or service that they don't want. That is both anti-competitive and anti-consumer. And there is another reason—mandates are typically not very effective and quite complicated to enforce. From decades of experience in the United States with mandates for automobile insurance and even income taxes, mandates have a 14% to 18% non-compliance rate …a percentage strikingly similar to the percentage cited as uninsured without any mandate. You may have also noticed all of the unanswered questions and concerns about enforcement of the Obamacare mandate, not to mention the massive number of waivers being granted since its implementation for temporary political gain.
- My plan takes a different approach—it brings incentives to the system to generate insurance products that are more in line with what consumers want, and gives consumers incentives to buy those products. This way, consumers will purchase the coverage (and health care) that they think is a good value. After all, the money belongs to individuals and their families, not to the government.

But what about the "free riders" who don't buy insurance? Aren't those of us who buy insurance paying a lot more for our premiums because of them?

- No—this is one of the great myths behind the idea of forcing everyone to buy insurance. We all care about "fairness" but facts are important. In reality, Hadley in 2008 showed that "private insurance premiums are at most 1.7% higher because of the shifting of costs of the uninsured"; if a more realistic estimate of cost-shifting is used, premiums are less than 1% higher due to the shift from people without insurance. This is a very minimal impact.

Under the Atlas plan, would I be refused care at the emergency room if I have no health insurance?

- No—my plan does not change the laws protecting uninsured patients. For decades in the US, it has been illegal to turn away any individual seeking medical care—regardless of insurance status or ability to pay—at any hospital since the 1986 Emergency Medical Treatment and Active Labor Act. Even decades before this law, safeguards for uninsured patients already existed. According to Hadley in 2008, $86 billion per year of medical care is administered to the uninsured. Roughly $43 billion is paid by federal, state, and local governments; another $30 billion or so is paid out-of-pocket. America's doctors contribute another $8 billion per year in free charity care. And contrary to popular belief, free care is not only given through the emergency room in emergency circumstances. A full 86% of this is through offices and clinics.

Won't the uninsured people clog up emergency rooms and cause a great financial burden on the rest of us who have insurance?

- No—first, the Oregon study showed that when uninsured people become insured, they use the emergency room more frequently, not less. This contradicts the theory that uninsured people overutilize emergency rooms, and with that, shift costs to the insured. Second, the estimated cost shift from the uninsured to insurance premiums paid by the insured is less than 1%, i.e., a very small amount. This will not disappear under my proposal, but it will diminish, because a) more of the poor will have incentives to enroll in coverage (to protect their new assets in HSAs); and b) the cost of care and insurance will be lower.

If everyone used high deductible insurance, wouldn't that eliminate coverage for preventive care and screening and require out-of-pocket payment?

- No—nearly all high deductible insurance already covered those visits and procedures, i.e., they are not subject to deductibles. My plan does not change this. The real problem is that most enrollees are not aware of this.

What about office visits to doctors? Are they covered in this plan?

- Yes—every limited-mandate plan will include three routine office visits per year that are not subject to any deductible. This is unchanged from the catastrophic insurance coverage under Obamacare.

Would the new insurance plans require co-pays?

- The new plans would be designed by the insurers, not by my plan or the government, so it is likely that there would be a variety of arrangements. Consumers would decide what coverage suits their needs, just like consumers decide what food to buy, what sort of clothing and shelter they desire, and what level of safety features they value in a car. Individuals would purchase coverage with the level of co-payments that they personally value. As in all other goods and services in a free market, the private sector responds to consumer demands by designing products that will sell, and explaining the benefits of those products, in order to meet the demands of the empowered buyers.

Limited-mandate catastrophic coverage would not cover some aspects of medical care that many people want covered by insurance. How would people pay for that type of care under the Atlas plan?

- For those people that want coverage for treatments such as chiropractors, or acupuncture, or even marriage therapy and massage, i.e., for any benefits that are not included in LMCC, consumers are still free to purchase more comprehensive coverage. Just as in other sorts of products, if consumers want to purchase products with added features, the free market is always interested in selling those added features. Plans covering all of those benefits will remain available, just like today, but the premiums for those expensive policies will not be tax-deductible. Alternatively, people who value that type of service could pay out-of-pocket from their HSA balances when that service is desired.

Aren't you forcing people to buy a specific type of insurance?

- No—my plan does not force anyone to buy any insurance—there is no mandate or penalty coercing anyone to buy any form of health coverage. My plan increases choices for consumers, instead

of forcing people to buy insurance coverage for services that many people don't want and would never use. Instead, my proposal provides financial incentives to buy low-cost catastrophic coverage. The catastrophic coverage that this reform package encourages is insurance that is already proven to be a good value, because consumers have increasingly moved to purchase this type of insurance when it has been available. Additionally, my plan will generate more options for individuals. Insurers will respond to the new environment that has fewer restrictions on insurance plans and where consumers are free to look for insurance tailored to their personal goals for coverage.

Under the Atlas plan, could I be dropped from my insurance if I get a serious disease?

- Americans who stay in continuous insurance coverage should not be penalized for developing costly diseases. In my plan, you cannot be dropped from coverage if you acquire or harbor a disease once insured; this serves as another incentive to become insured and then maintain insured status.

But could I buy insurance in the Atlas plan if I already have a disease and I did not have insurance beforehand??

- Yes—but it would probably cost you significantly more money than if you had bought it beforehand. You are referring to the rules put in place by Obamacare. Obamacare required "guaranteed issue" of insurance. Obamacare prohibited insurers in the individual market from denying coverage, increasing premiums, or restricting benefits because of any pre-existing condition. Those rules are actually bad for consumers. First, the rules provided an incentive to those who simply avoided paying for insurance until they acquired a serious disease. This is unfair to everyone else, those who took the personal responsibility and bought insurance while they were healthy, in anticipation of possibly needing insurance to protect against the financial risk of becoming ill. Second, we knew from states' experience with "guaranteed issue" that two things would happen: coverage would become less available because carriers would leave the market, and premiums would increase for everyone else. States with those regulations are typically those with the least affordable health insurance (The

Most Affordable Cities for Children's & Family Health Insurance, 2006). The young and healthy—typically those who earn the least and are most likely to be uninsured—are forced to subsidize the rates of older and often wealthier individuals, which also interferes with risk pools. Under Obamacare, new "guaranteed issue" rules increased insurance premiums by about 20–45%, according to Milliman's report of 2013. My plan is fairer for everyone and better for consumers. It rewards people for being responsible and maintaining insurance, so that they cannot be dropped once they become ill.

- In my plan, states will form high risk pools using new models to help those with diseases buy more affordable insurance. For instance, as a condition for selling insurance in a given state market, private health insurance companies would establish a risk pooling cooperative into which they would pay premiums to protect against the risk of very high health claims. Premiums would be related to the actuarial value of the risk characteristics of their enrollee populations. Importantly, my plan would lower the cost of insurance for everyone, so more people would be able to afford health insurance before they became ill in the first place.

Under the Atlas plan, will I lose my Obamacare subsidy to purchase private insurance on Obamacare exchanges?

- Yes—but the $850B of Obamacare subsidies given to help pay for private insurance under the ACA is necessary because the law itself caused prices of private insurance to skyrocket. My plan is more sensible—I remove many of the factors (e.g., excessive mandates) that caused the cost of coverage to become so expensive. Under my plan, insurance coverage will become far less expensive, so that people will be able to afford the insurance and actually choose to pay for it because it represents a good value. Additionally, take home wages will increase from the tax reforms in my plan, so Americans will have more money for themselves to spend how they choose.

Won't I lose my employer-provided health benefit if the income exclusion is capped that low?

- No—under my plan, the maximum allowable health benefit provided by employers will be set to match the maximum allowed

for an HSA under my plan. That benefit is fully deductible for the employer and the employee under my plan. In addition, virtually all economists agree that the employer-employee market trades benefits for wages, and in the long run, that implies that employers would be forced by competition to raise wages commensurate with reduced benefits. Employees would receive higher take-home pay.

Won't the Atlas plan, with its removal of certain tax subsidies and other changes, result in millions of people becoming uninsured?

- No—the reforms in this plan will markedly increase the consumer's purchasing power for medical care, and this increase will more than compensate for the loss of tax subsidies for purchasing health care or insurance. The prices of health care will decrease as competition ensues, and once the counterproductive, perverse incentives in our current system are removed.

What about prescription drugs, especially for people with chronic diseases? How will they pay for their medication?

- All limited-mandate plans will also include coverage for prescription drugs. And people will still have the same options to buy coverage that includes lower deductibles, or even exempts drugs from being subject to deductibles. My plan will result in more choices of insurance coverage, not less. That is what experience shows in all other goods or services in a free market—the private sector supplies products that consumers want; consumers have the control of the money in my plan. Even today, some states already include plans with separate (lower) deductibles for prescription drugs; my plan will probably result in even more of these tailored deductibles.

Why pick on obesity?

- Obesity is the most serious public health problem in the US, in terms of both its costs and its harmful impact on health. Just like cigarette smoking, obesity is a high-risk voluntary lifestyle for most individuals, and a major driver of health expense with well-known health hazards. As is the case for virtually every other form of insurance, rates for health insurance that reflect the higher risk

of disease and more frequent use of medical care as a consequence of voluntary behavior are totally appropriate. Risky driving is a key factor in determining automobile insurance rates. Although difficult to do, the way to eliminate the vast majority of cases is well known and in the hands of individuals. My plan does not discriminate against obese people; in fact, it extends more help to those who need it, with more wellness programs, including nutritional counseling and exercise training.

Establishing and Expanding Universal Health Savings Accounts

The Atlas plan eliminates the requirement for a government-defined deductible in order to open an HSA. Is any health insurance required to fund the HSA? If so, what type?

- Yes—to be eligible to contribute to an HSA in any given year, you must also have insurance that covers catastrophic care. My plan does not specify the level of deductible, though—the only contingency is that catastrophic care is covered.

But isn't the purpose for the HSA to cover the high deductible, so that health expenses which are smaller than the deductible are paid by the HSA?

- That's partly true. Money in an HSA also could be used for co-pays, for example, but not for insurance premiums. The new limits on contributions to HSAs would roughly equal the maximum allowed for annual out-of-pocket spending, including deductibles and co-pays (and those maximums would increase as indexed to the CPI). But it also might also be valuable to have money in the HSA to pay medical services that may not be covered by the new insurance plan. Remember, many people will probably buy a limited-mandate plan, because it would be cheaper. At some point, it might be true that the enrollee might want to use an uncovered medical service; that could be paid out of the HSA. And finally, take-home wages will be higher, since employers will shift much of the previous payments for tax-preferred benefits to direct wages because of the tax reforms under this plan.

Why wouldn't people just withdraw money from HSAs for other uses?

- It is true that money could be withdrawn from HSAs for non-eligible uses. However, the financial penalty for withdrawals of funds from HSAs will be significant—it will be raised to 50% from the current 20%. More importantly, most insurance under my plan will likely have a high deductible, so it will be important for everyone to save money in the HSA for health care expenditures.

Do you get to keep the HSA as a tax-sheltered account, even if you drop the insurance plan after you've established and funded the HSA?

- Yes—this is the law today, and this plan does not change it.

Would seniors be allowed to withdraw from their HSAs for other reasons outside of health care without penalty?

- Once age 70, seniors would be allowed to withdraw from their HSAs without the full 50% penalty. However, the HSA is not intended to be a retirement account for expenditures other than health care. In New Medicare HSAs, a 20% penalty would be in place for non-health care withdrawals, starting once the owner of the HSA became 70 years old. And these accounts will now be able to be passed on to living family members without penalty.

People can't really shop for medical care—it's too complicated, isn't it?

- No, it is not too complicated for most individuals—as long as the information necessary to make informed decisions is visible, then shopping for non-emergency medical care would be quite simple. We know that Americans find it straightforward to shop for computers and other far more complicated things. Under my plan, price transparency and competition create even more visible information for consumers. And remember, the vast majority of medical care episodes are not an "emergency" where life and death decisions must be made quickly.

If everyone had a new HSA at birth, who would keep track of those accounts?

- The federal government would be the repository of the information. This is already true—the federal government regulates and keeps track of all HSAs today.

Instilling Appropriate Incentives Through Rational Tax Reforms

Why not allow income tax exclusions or deductions for all insurance, including low deductible insurance, if the premiums are low (i.e., why not just cap the level of the deduction?)

- The purpose of my tax reform is not solely to cap the amount of the deduction (or income exclusion). It would be counterproductive to allow a tax preference for insurance that covers care by hiding the costs of that care—that's a fundamental cause of rising costs. I want to put the consideration of value and price back into the consumer's purchasing decisions, as they are in every other good and service. My plan reforms health insurance back to the way it was intended to function, i.e., to cover only *significant* and unexpected costs. That way, individuals would have the power—because they pay directly (up to the deductible), they shop for value and market forces will reduce costs of care down to what consumers determine would be a good value for their money.

What level of deductible does the Atlas plan use to define an insurance plan as "high deductible"?

- The definition of high deductible is based on 75% of the maximum allowable HSA contribution. For example, to qualify as a high deductible plan for 2016, during which the allowable HSA contribution will be $6,850.00, the definition of high deductible equals $5,137.50. This linkage ensures that the HSA contribution maximum will always potentially be higher than covering just the deductible.

Why not allow a tax deduction for all health care spending, instead of limiting the tax preference to HSAs and high deductible insurance premiums?

- Tax deductions for all health care spending give an incentive to spend more money on health care; in other words, there is an opportunity cost if you spend money on something other than health care, because the money is worth more when spent on health care. That preference generates more and more spending on health care, rather than other desired goods and services. My plan eliminates that misincentive. Instead, the incentive is to put money into an HSA and then seek value when it is spent on necessary care; the opportunity cost is when it is spent, because it could be saved and grow by investment (or bequeathed to the account owner's survivors).

Won't the tax preference for basic catastrophic coverage cause higher prices for that coverage, due to subsequent increased demand?

- It is generally true that high demand for goods leads to price increases. However, increasing demand is not a significant driver of the cost of insurance premiums. Health insurance premiums rise mainly in response to increases in the cost of providing health care services, not demand for the insurance itself. Prior and anticipated payouts for medical services are by far the single largest component of health insurance premiums. When the cost of health care services increases, insurance premiums rise. Other factors do have some impact on private insurance premiums, including government regulations, in particular mandated coverage, characteristics of the insured individual (e.g., age and certain behaviors), and cost-shifting due to underpayment by public insurance. It is very important to recognize that the main reason for the lower premiums of catastrophic coverage with high deductibles and fewer mandates lies in the very structure of limited-mandate coverage. Premiums of high deductible catastrophic coverage are lower than premiums of so-called comprehensive coverage because of the anticipated lower costs of covering the medical care under the plan.

Won't the new tax reforms hurt the middle class?

- No—my tax reforms specifically help the middle class and target more affluent individuals. The current tax preference is unfair—it gives a high-value tax deduction for high spending on health insurance that covers everything without limits. This overwhelmingly benefits the upper income earners, i.e., the people that enjoy the biggest value from the present tax deduction. The existing tax preference gives a disproportionate benefit to the wealthy due to their higher marginal tax bracket. My plan simplifies the tax reform and removes the special benefit that high income earners accrue from the current tax exclusion. Ultimately, the cost of insurance premiums and medical care will be reduced by this plan more than the tax benefit for health spending that has distorted the market for health care.

- As of 2018, Obamacare institutes a new "Cadillac tax"—a 40% tax on expensive health insurance plans. But the logic for that tax approaches absurdity. Obamacare assesses a new tax on health insurance that exceeds a certain price. Obamacare by its regulations simultaneously caused the prices of health insurance to rise. Therefore, the government ends up imposing a tax on insurance whose price became high, and consequently subject to the tax, directly because of the government's own policy to begin with. Additionally, the Cadillac tax will count HSA contributions (from employers and individuals) toward the threshold for invoking the tax penalty, thereby penalizing consumers for trying to keep health care costs low.

- My tax plan is simpler and also fairer to everyone, because it levels the playing field. Under my plan, small business employees, part-time workers, and self-employed people will all have the same deduction as those working for large employers. My plan also gives a tax deduction for significantly expanded HSA contributions, which will increase everyone's savings for out-of-pocket medical costs. Moreover, this plan will help the middle class with more affordable insurance coverage and more control of costs because they have new purchasing power.

Won't the new tax reforms hurt employees by reducing benefits, because employers will lose some of their deductions for health benefits?

- No—the truth is that to a large extent employees pay for their benefits by receiving lower wages than they would have otherwise been paid. Employment benefits, including health care benefits, replace wages. If I limit the tax deduction for health benefits paid by employers, then employers would likely pay less of those benefits at first. But over time, employees will instead receive higher wages and more take-home pay as employers are forced to compete with higher wages to attract labor.

Won't reducing the allowable income exclusion from taxation constitute a new tax increase?

- No—this six-point health reform plan will reduce the medical care costs by more than the lost value of the old tax exclusion on health benefits to consumers. The proposed tax reform herein is a cut in a tax expenditure program (see FY 2016 Analytical Perspectives of the US Government of the Federal Budget, p. 255). In addition, the reforms in this plan will increase take-home wages, as employer behavior changes in response to the health reform plan.

Modernizing Medicare for the 21st Century

Isn't this plan going to destroy Medicare?

- No—quite the opposite. My plan will introduce competition among insurance companies, so cheaper insurance options become available for consumers. This plan will expand choices for beneficiaries, so beneficiaries can decide if they want more comprehensive coverage or lower cost insurance coverage. It also helps seniors allocate more savings to cover out-of-pocket expenses through new eligibility for expanded HSAs, and it allows seniors more flexibility on paying for those health-related items from their HSAs. This plan will significantly reduce the cost of Medicare, so that it will be available for generations to come. And this is crucial, because Medicare will be even more important in the future, as more people live longer and medical advances continue. In the long run, traditional Medicare will be moved to private health insurance to improve benefits and reduce costs, and

to eliminate the increasing problem of seniors to find doctors and hospitals who accept Medicare. For those over age 35 today, though, traditional Medicare will still be an option when Medicare-eligible.

How is this Medicare reform different from previous reform proposals?

- This plan shares some key principles of reform with prior proposals, most notably the fundamental idea of defined benefits for premium support and competition among insurers for enrollees. However, this plan differs from previous proposals in a number of important ways, including the following:
  - The benchmark used to calculate Medicare's payment for premiums would be determined by an average of the three lowest-priced private plans submitted; included in those would be a limited-mandate plan;
  - New Medicare would contain a major expansion and liberalization of HSAs, including new eligibility for universal HSA ownership and continuing contributions for all beneficiaries; significant expansion of HSA limits; broader HSA uses; new rules allowing transfers from retirement accounts; and new permission to pass on HSA balances to surviving family members;
  - Traditional Medicare would be gradually phased out entirely, so that ultimately all Medicare beneficiaries would have the advantages of private insurance, with better access to doctors, hospitals, drug treatments, and advanced medical technology;
  - Instead of sharing rebates with the government after choosing cheaper insurance (today, in Medicare Advantage), new Medicare beneficiaries would receive 100% of the rebates, in cash returns to their HSAs, if they selected insurance with lower premiums than the benchmark;
  - A removal of the current anti-consumer conflict-of-interest of the federal government that allows government restrictions on access to medical care. Today, with the government in the role of the insurer via traditional Medicare, the government has the power to restrict access to care and artificially set prices of medical services. This has already caused a reduction in doctor

acceptance of Medicare, and trends show further reductions. Under my plan, traditional Medicare is eliminated, so the government will support beneficiaries with money to buy insurance instead of dictating benefits and prices as an insurer. In the new Medicare, the government will stay out of the way of impeding consumer choice and access to care. Now, the Medicare patient will have the power to the same wide array and state-of-the-art excellence of medical care as everyone else.

How will the Atlas reforms of Medicare deal with risk pools and adverse selection, where some insurers will enroll mainly low-risk, healthier seniors and create far more expensive insurance for those with chronic diseases?

- A risk pool is the basic foundation of health insurance, so that enrollees with lower health care costs offset enrollees with higher health care costs in a large group of enrollees in a given health plan. It is used to spread risk among groups of people enrolled in health plans, in order to allow insurers to manage their ability to pay claims and provide benefits. Insurance markets could be destabilized by a phenomenon called "adverse selection" where sicker individuals enroll in certain plans in a disproportionate number. This causes higher premiums, which in turn causes younger, healthier people to leave the plan, creating a cycle ultimately leading to collapse. Risk pooling is necessary to prevent such spirals. One possible risk pool mechanism would be a risk-adjustment program similar to those proposed by both the Wyden-Ryan plan and the Heritage Foundation's proposal (see Moffit's *Saving the American Dream: Comparing Medicare Reform Plans*, 2012 for further details). Participating insurers would be required to establish a national risk pool in order to sell to Medicare beneficiaries. Insurers with higher shares of low-cost enrollees would contribute to a fund that will make payment to insurers with larger shares of high-cost enrollees. Medicare administrators would monitor the enrollment data of participating health plans and require cross-subsidies to compensate for plans with disproportionate enrollment of high risk beneficiaries. I believe the actual premium changes and calculations of cross-subsidies should be performed by the insurers themselves, rather than the government.

How will the coverage of new Medicare insurance plans be determined?

- The coverage and benefits of the new insurance plans will ultimately be determined by the individuals selecting the plans, i.e., the Medicare beneficiaries themselves. In the new Medicare, the beneficiaries will have far more choices at competitive prices. Today, overly bloated requirements of coverage that many beneficiaries don't want are causing excessively high premiums and out-of-pocket costs, including the coverage requirements of traditional Medicare. Since beneficiaries would receive rebates into their HSAs if they choose cheaper insurance, they would now have incentives to consider carefully what coverage they choose. Remember, enrollees still have the choice of buying insurance with more extensive coverage. Importantly, as a result of the new competition in place, insurance and medical care itself would cost less under the new reforms to the health care system.

Won't seniors be at greater risk if the government is not the insurer? Who will protect seniors?

- My plan ensures that seniors will be protected the same way that they are now—by the existing Center for Drug and Health Plan Choice, a federal oversight agency that resides within the Centers for Medicare and Medicaid Services. This Center would have authority to approve insurance plans that meet standards, just like it does today for Medicare Advantage plans and drug benefit plans competing in today's Part D (however, it would not have authority to standardize benefits of plans or determine rates). Moreover, the state-based regulatory agencies that currently enforce rules for health insurance and consumer protection against fraud and misleading advertising will also remain in place. This reform plan does nothing to expose seniors to more risk or danger.

What about low income seniors?

- Just like today, America's safety net for low income senior citizens would remain in place for the so-called "dual eligible." Medicaid assistance would add to their federal Medicare subsidies. The difference is that under the reforms to both Medicaid and Medicare of this proposal, the choices, the access, and the quality

of health care for low income seniors would be strengthened and expanded.

Will I lose my current doctor who I have seen for years under Medicare? Seniors have complicated medical problems, so it's very important to have continuity of care.

- No—in fact, my plan will reduce the problem finding doctors that has already begun. Today, more and more doctors are refusing to see Medicare patients. Traditional Medicare pays doctors less than cost. In my plan, more Medicare patients will be allowed to buy private insurance identical to non-Medicare patients, i.e., coverage that pays doctors appropriate amounts for care. The plan eliminates the main reason for doctors dropping Medicare. And the same applies to hospitals. Under this plan, the best hospitals and specialists, the doctors who seniors need most, will no longer drop Medicare acceptance.

How would beneficiary income be used to determine new Medicare benefits under the Atlas plan?

- Similar to current income adjustments in today's Medicare Part B and Part D, but with some differences. Today, adjusted gross incomes over $85,000 for individuals and $170,000 for joint filers result in higher monthly premiums up to a certain point, with no complete phase-out of taxpayer subsidies. Under my plan, the same phase-in of premiums adjustments would occur (subsidies from taxpayers would decrease for those with incomes above these thresholds), but in addition, I suggest that the highest income earners (those with adjusted gross incomes greater than $1,000,000 for individuals) would receive no subsidies at all.

Will there be a cap on annual out-of-pocket expenses in the new Medicare insurance plans?

- Yes—the maximum allowed out-of-pocket annual expenses for seniors will be matched to the maximum allowable contribution to HSAs. For 2016, that cap will equal $6,850 for self-only coverage and $13,700 for self-and-family coverage, including the deductible. However, it is likely that lower out-of-pocket maximums will also be available among the many choices of

insurance plans that will be available to seniors in the new Medicare program.

Under the Atlas plan for Medicare, would seniors be at risk for losing coverage for pre-existing conditions, and would the "oldest old" of Medicare beneficiaries pay far higher rates?

- No—nothing would change from the current status of community rating (where premiums would be based on the pool of enrollees, not the individual) and guaranteed issue (where existing health problems would not prevent the individual from obtaining insurance) from current Medicare. All participating insurance plans would retain current Medicare rules.

What would happen to the complicated rules when some doctors accept Medicare assignment and others don't?

- Those rules would be abolished. Under this plan, Medicare beneficiaries would be allowed to purchase medical care with cash, insurance, or any other means of payment agreed to by them with their doctors. And health care providers could accept any means of payment without the current restrictions that interfere with doctor access for Medicare beneficiaries.

How quickly would the age of eligibility for Medicare increase?

- Two months per year—so, it would take six years for the eligibility age to have increased by one year; 12 years for it to have increased by two years; etc. And it would only affect those currently age 50 or younger. For example, for someone currently age 50, in 15 years (in the year 2030) he would have become eligible in the old system. In my plan, his age of eligibility would have increased by 30 months after 15 years from the implementation of the rule change; therefore, he would become eligible for Medicare at age 67.5. In the year 2045, i.e., in 30 years, the age of eligibility would be 70. Any subsequent changes in eligibility age would be related to the increases in US life expectancy.

Will prescription drugs and cancer screening be covered in the new Medicare plans accepted for competitive bidding?

- Yes—all Medicare insurance plans will include prescription drug coverage, including limited-mandate catastrophic plans. As they do today, plans will likely require co-pays, although more choices of coverage and benefits will be available to beneficiaries. All plans will cover the most important cancer screening tests for no out-of-pocket charges, regardless of the deductible.

Given that seniors have much larger health care usage and costs than other age groups, aren't HSAs going to be too small to have any practical value?

- No—under my plan, seniors will have a special allowance to transfer funds from any tax-sheltered retirement account into their HSA, without any tax penalty and reversibly up to the amount of the transfer. This will allow at least some seniors who need a backstop and choose to do so to leverage their new purchasing power for medical care. In addition, seniors who choose coverage that costs less than the benchmark average will receive a rebate into their HSA, i.e., money to be used for health care expenses.

How do HSA rules under the Atlas Medicare plan differ from current HSA rules for Medicare beneficiaries?

- Under today's Medicare, HSAs are restricted in several ways, many of which are highly complicated and indeed arcane.
    - Current HSAs and Medicare:
        - To qualify for an HSA, you cannot be enrolled in Medicare
        - Beginning with the first month you enroll in Medicare Part A and/or Part B, you can no longer contribute any money to an HSA (you may still withdraw money for eligible expenditures)
        - If you apply for or accept Social Security benefits, even if you continue working, you cannot contribute to an HSA (because once you accept Social Security benefits, you will be automatically enrolled into Medicare Parts A and B). Note that you may decline Medicare Part B if you continue to work for a large employer, but you cannot decline

Medicare Part A. Also note that you must stop contributing to your existing HSA six months before you apply for Social Security, or you will owe a tax penalty, because Medicare Part A is retroactive for six months prior to the Social Security application.

  - If your spouse is the designated beneficiary, it will be treated as the spouse's HSA at your death; if not, the account stops being an HSA and its balance becomes taxable to the beneficiary or the estate

- Current "Medicare Advantage MSAs" (tax-exempt "Archer" medical savings accounts set up with a financial institution into which the Medicare program can deposit money for qualified medical expenses):
  - These accounts are uncommon and offered on a state-by-state basis
  - Eligibility requires Medicare enrollment *and* enrollment into a high-deductible Medicare Advantage health plan that meets Medicare guidelines
  - Unlike HSAs, which allow deposits from anyone (yourself, your employer, other family members), neither you nor your employer, if any, are allowed to deposit any money into Medicare MSAs. Only Medicare can deposit money into your MSA.
  - The deposits into Medicare MSAs are generally significantly less than the deductible of the accompanying high deductible plan, typically less than half.
  - In general, you can't have other health insurance that would cover the cost of services during your Medicare MSA Plan's yearly deductible.
  - A long list of people are excluded from Medicare MSA eligibility, including those who have health coverage that would cover the Medicare MSA Plan deductible, including benefits from an employer or union group health plan; Medicaid enrollees; those who relocate outside the service area of the plan; and others.

  - If you withdraw money for non-qualified expenses, the money becomes taxable and there is a 50% penalty, regardless of the age of the beneficiary
  - If you name a beneficiary for your MSA account who isn't your spouse, the money in it after your death is taxable counted to that person when he or she files that year's income tax return.

- Under my New Medicare proposal, the following rules would be in place:
  - All Medicare enrollees are eligible for New Medicare HSAs, regardless of enrollment into any or all Medicare coverage
  - No specific deductible is required on an accompanying insurance plan to contribute to a New Medicare HSA. The only requirement for contributing is having catastrophic coverage, regardless of any level of deductible.
  - Instead of the confusing, complex allowance for those over age 65 for HSA spending on certain insurance premiums (i.e., can reimburse themselves for the money that Social Security withholds to pay Medicare Part B; and can make tax-free HSA withdrawals to pay Medicare Part D and Medicare Advantage premiums. but not Medigap premiums), new HSAs will permit tax-free spending for all premiums of all high deductible plans
  - New Medicare HSA contribution limits are significantly higher than current HSA limits and current Medicare MSA limits, and they match all other non-Medicare HSA limits
  - New Medicare HSA uses are broadened to match all other non-Medicare HSA uses, including for example non-prescription medication
  - New Medicare HSA contributions are allowed by employers, family members, and individuals
  - New Medicare HSA contributions are allowed even if receiving Social Security benefits
  - Once age 70, seniors would be allowed to withdraw from their HSAs without the full 50% penalty. In New Medicare HSAs, a 20% penalty would be in place for non-health care withdrawals, once the owner of the HSA became 70 years old.

- Upon death of the senior, New Medicare HSA balances are allowed to be bequeathed to the tax-free HSA of surviving spouses or family members

Isn't the Atlas plan really just "privatization" of Medicare into a voucher plan?

- Regarding privatization—this plan preserves the federal government benefit of health insurance for the elderly, with both taxpayer money and administrative oversight by the government. Remember, the reality of current Medicare is that about 75% of beneficiaries already supplement or fully replace traditional Medicare with private insurance. Only about 9% of beneficiaries have Medicare alone and another 15% or so have both Medicaid and Medicare. The private insurance that will be offered in this new Medicare will have numerous advantages for beneficiaries over the current insurance options, as described elsewhere in this document. Remember also that we already know that the best access to care and the best outcomes from care come from private insurance, not government insurance. This has been proven both here in the US (e.g., the VA system or Medicaid) and around the globe, where government-centralized systems have unconscionable waits for care and worse outcomes than care obtained via private insurance. Don't forget another fact—the private insurance of current Medicare Advantage plans outscored traditional Medicare on 9 of 11 measures of health care quality in a direct comparison by Brennan and Shepard in 2010 and reviewed in the *New England Journal of Medicine* by Guram and Moffit in 2012. The bottom line is that this reform plan removes government from a position with an inherent conflict of interest—not only being the insurer, but being the dominant insurer, with direct or indirect control over nearly all prices and access to care. This fundamental change will increase the availability and quality of medical care and reduce its costs for seniors.

- Regarding vouchers—no, this is not a voucher plan. A voucher system would be a system in which a set amount of money (typically indexed in some way to something that changes over time, like the consumer price index [CPI]) is sent to the beneficiary. Then, the beneficiary is basically on his or her own to use it in the purchase of private coverage. This proposal involves premium support, whereby Medicare would pay a certain amount

(determined by the Medicare benchmark calculation, rather than indexed to anything other than the market price for private insurance by way of competing plans submitted for bid) to a Medicare-approved health plan. In this proposal, seniors are not fending for themselves with a voucher.

Under the Atlas plan, if a beneficiary selects coverage with premiums that are lower than the new Medicare benchmark payment, the beneficiary would receive a rebate. Is that the same as the rebate offered today under Medicare Advantage?

- Not exactly—the proposed plan is more advantageous for consumers. Under current Medicare Advantage, if the selected plan is less than the government's benchmark payment, the plan by law returns 75% of the savings to the beneficiary by way of more benefits, and the remaining 25% goes to the government. In my plan, the entire amount of the savings—100%—goes directly to the consumer in cash, as a deposit to the consumer's HSA; the government would receive nothing.

Overhauling Medicaid to Eliminate the Two-Tiered System

How will the poor get started with HSAs to get into the Atlas health care plan?

- All states will be required to open HSAs for all of their Medicaid enrollees. In addition, states must seed-fund at least 50% of HSAs belonging to new Medicaid enrollees in order to receive any federal money to support their Medicaid programs. Today, about 57% of Medicaid funding comes from the federal government, even though Medicaid is a state-run program, so this will be a strong incentive. The second requirement for states to receive federal money for Medicaid is that at least 50% of beneficiaries must enroll into limited-mandate private coverage.

Would current holders of traditional Medicaid suddenly lose their insurance?

- No—they would have the new option of switching to new Medicaid (private high deductible insurance with money going into their own HSA immediately); in this plan, over 10 to 20 years,

I envision that traditional Medicaid will be gradually phased out for the vast majority of Medicaid holders by their own choices. Medicaid will then have been fully transformed into a private insurance premium support program.

Why would doctors suddenly accept new Medicaid patients when they don't accept them now?

- In current traditional Medicaid, the payments for medical services are very low, even below cost in many cases. Under the new plan, doctors and hospitals would receive payments from the same private insurance (or HSAs) as from any other non-Medicaid patient; in the new Medicaid, doctors and hospitals would not even know who was a Medicaid patient and who was not.

What new incentives for healthy lifestyles and preventive care would exist under new Medicaid?

- New Medicaid patients would have the same doctors as private patients. Medicaid patients would receive counsel and the offer of the same screening tests and wellness information to them as all privately insured patients. In addition, new Medicaid enrollees would have new assets to protect, as their HSA balances are built up. The existence of these new assets would provide an incentive for long-term protection. Remember, the rationale for insurance is to cover possible loss of assets; this is also one of the main rationales for receiving preventive care and living a healthy lifestyle.

Increasing the Supply of Medical Care and Ensuring Innovation

Is it realistic to propose streamlined training programs for MD's?

- Yes—innovative, shortened training programs already exist. For example, NYU School of Medicine has begun offering a streamlined 3-year MD program. Texas Tech University School of Medicine and others are also offering accelerated programs.

Why would you call for loosening of immigration limits? Don't immigrants take jobs from American citizens and cost taxpayers money through our public schools and our entitlement programs?

- The immigration reforms suggested in this plan specifically target highly educated, entrepreneurial immigrants who would be here legally. These people are extremely important contributors to American innovation and job creation in our society—they come to the US for education and opportunity, not for entitlements. Moreover, foreign-born people are more likely than US-born to start a company, according to Fairlie's 2012 study. And according to the Kauffman Foundation, about 44% of engineering and technology companies founded between 2006 and 2012 had at least one founder who was born abroad. Our health care system would benefit by way of important advances, new jobs, and more tax revenues from the efforts of highly educated people.

What Is the Total Cost of the Atlas Health Plan?

My plan will undoubtedly save a significant amount from the current level of national health expenditures, and consumers will save on the cost of insurance and the cost of health care. However, it is difficult at best to separate and project over the long term the extremely complex and overlapping impacts of health system reforms. Moreover, in the context of cheaper medical care that will clearly result from these reforms, I have not included any of the other positive economic impacts, such as the anticipated rise in employee wages or job growth as a consequence of the reforms outlined in this plan. Given those limitations, I estimate the financial impacts from this plan over the first decade using reasonable approximations based on literature and previous estimates of the JCT and CBO, as indicated in the following *Tables*:

Impact on Private Savings and Costs, Over Decade (approximations)

Specific Reform	Estimated Savings (Loss) Over Decade	Reform Category (see Plan)
Remove penalties on uninsured people and employers	$210B*	Reform #1: Private insurance expansion
Remove excise tax on health insurance premiums	$87B*	Reform #1: Private insurance expansion
Premiums from shift to lower cost, limited-mandate coverage[1]	$940B**	Reform #1: Private insurance expansion
Expanded HSA enrollment and limits[2]	$350B**	Reform #2: Universal liberalized HSAs
Transparency to consumers[3]	$880B**	Reform #2: Universal liberalized HSAs
Expanded utilization of wellness and lifestyle programs[4]	$120B**	Reform #2: Universal liberalized HSAs
Reduced income exclusion	($550B*)	Reform #3: Tax reforms

continued on next page

[1] est. 5% savings per year from current projections on total private premiums paid, based on half of the 63% of privately insured who were not already in high deductible plans switching, and est. 10% overall price drop in high deductible plans from reduced mandates and more competition among insurers; and est. 10% lower premiums for all existing and future HDHPs extrapolating from one-half of other competition-induced health care price decreases; data from US Dept. of Health/CDC/National Center for Health Statistics, June 2015 (see Table 10 in Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2014); and CMS (see Exhibit 2 in Keehan, 2015)

[2] est. from extrapolating extra savings from HSAs on expenditures with high deductible plans of 5.5–14.1% (see Haviland, 2011); overall estimate of a 5% expected additional savings in all health expenditures for non-elderly due to widespread HSA enrollment

[3] est. from transparency impact on reductions in spending for outpatient services assuming 19% reduction (see Wu, 2014; Robinson, 2015); projected outpatient spending in employer-sponsored insurance (see Haviland, 2011; Haviland, 2012)

[4] est. from impact of multiple wellness programs on health spending, based on $200/year/employee savings and 50% employee participation (see Health & Economic Implications of Worksite Wellness Programs, American Institute for Preventive Medicine, 2010; also Bureau of Labor Statistics)

Specific Reform	Estimated Savings (Loss) Over Decade	Reform Category (see Plan)
High deductible option and new, expanded HSAs[5]	$400B**	Reform #4: Medicare modernization
Gradually phased-in increase in age of eligibility	($64B*)	Reform #4: Medicare modernization
High deductible option and new, expanded HSAs[6]	$50B**	Reform #5: Medicaid overhaul
Repeal taxes on devices and brand-name drugs	$196B*	Reform #6: Supply increases
Increase supply of retail clinics[7]	$20B**	Reform #6: Supply increases
Medical liability reforms[8]	$110B**	Reform #6: Supply increases
OVERALL NET PRIVATE SAVINGS*: $2,749,000,000,000 (~$2.75T), over decade**		
Notes: * approximations based on CBO/JCT estimates over one decade of implementation; ** other amounts derived from literature, using conservative estimates and given expected price transparency and increase in higher deductibles with HSAs (see footnotes); *** not including anticipated rise in wages to employees due to response to health reforms		

[5] est. for new money into HSAs, reduced payments of premiums for supplemental insurance, rebates to enrollees choosing low premium plans, and savings for out-of-pocket Medicare health expenses

[6] est. for new money into HSAs and accumulated savings due to consumer incentives and high deductible plans for non-disabled, non-elderly adult enrollees into Medicaid

[7] est. from Parente, 2013 and others

[8] est. to save 20% of total annual associated costs of medical liability (see Mello, 2010)

Impact on Government Spending, Over Decade (approximations)

Specific Reform	Estimated Change Over Decade	Reform Category (see Plan)
Eliminate Obamacare exchange subsidies	$822B* Spending reduction	Reform #1: Private insurance expansion
Premium support with competitive bidding	$275B* Spending reduction	Reform #4: Medicare modernization
Fixed federal grants to states, capped by CPI-U annual increases	$450B* Spending reduction	Reform #5: Medicaid overhaul
OVERALL Government Spending Reduction: $1,547,000,000,000 (~$1.5T) less, over decade		
Notes: * approximations based on CBO/JCT estimates over one decade of implementation		

Notes and References

[1] SP Keehan, GA Cuckler, AM Sisko et al. National health expenditure projections, 2014–2024: Spending growth faster than recent trends; *Health Affairs* 2015;34:1407–1417; http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2015.0600

[2] Dept. of Health and Human Services; Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report; May 2015

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Scott W. Atlas, MD, is the David and Joan Traitel Senior Fellow at Stanford University's Hoover Institution and a member of Hoover Institution's Working Group on Health Care Policy. He investigates the impact of government and the private sector on access, quality, pricing, and innovation in health care; he is a frequent policy adviser to government leaders in those areas. Dr. Atlas's most recent books include *Reforming America's Health Care System* (Hoover Institution Press, 2010) and *In Excellent Health: Setting the Record Straight on America's Health Care System* (Hoover Institution Press, 2011). Dr. Atlas has been interviewed by or has published in a variety of media, including BBC Radio, the *PBS NewsHour*, the *Wall Street Journal*, *Forbes Magazine*, CNN, *USA Today*, Fox News, London's *Financial Times*, Brazil's *Correio Braziliense*, Italy's *Corriere della Sera*, and Argentina's *Diario La Nacion*. Dr. Atlas also advises entrepreneurs and companies in the life sciences, medical technology, and health information technology sectors.

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Time is of the essence. America's aging population will increasingly require medical care at an unprecedented level. Although extraordinary advances in technology offer great promise, the current trajectory of the health system, particularly under Obamacare, threatens both the sustainability of the system and the innovation essential to reaching its full potential.

It is time for a fundamentally different approach. Instead of framing reforms with the traditional trade-off, that is, "take away benefits, or raise taxes," this plan centers on a different paradigm: restoring the appropriate incentives to increase the quality of health care and simultaneously reduce its costs. The six-point plan instills market-based competition, empowers consumers, and reduces the federal government's authority over health care. It restores the originally intended purpose of health insurance (to protect against the risk of significant and unexpected health care costs), enhances the affordability of twenty-first-century medical care, and ensures continued innovation. Private and federal government health expenditures will conservatively decrease by trillions of dollars during the decade, and access to high quality health care will significantly improve. Perhaps most important, the reforms in this plan reflect the principles held by the American people about what they value and expect from health care in terms of access, choice, and quality.

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