

Key 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 (see Scott W. Atlas, “The Limited Value of Life Expectancy Comparisons in Ranking Health Systems,” in *In Excellent Health: Setting the Record Straight on America’s Health Care*, Hoover Press, 2011). Many factors significantly impact overall life expectancy; many have little or nothing to do with quality of health care. For example, the United States ranked near the bottom of the life expectancy tables compiled by the OECD, an international organization whose members include the world’s economically developed nations. Then, in 2007, Ohsfeldt and Schneider standardized countries for all immediate deaths from homicide, suicide, and high-speed motor vehicle accidents (situations where health care is irrelevant). The United States moved to the top of the ranking! Personal lifestyle choices involving nutrition, exercise, obesity, cigarette smoking, and safe sexual practices impact life expectancy. The United States has a greater commitment to caring for vulnerable newborns and senior citizens. Individual decisions to follow doctor recommendations about treatments, follow-up, and 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,

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and other factors separate from the quality of medical care. Differences in technology, disposable income, violence, urbanization, marriage rates, and economic inequality also change life expectancy. Some of these factors bias the statistic against US life expectancy because the United States has 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 eight to ten 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 is the US infant mortality rate worse than that of so many other countries?

- The 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 United States is different from other countries in important ways regarding infant mortality, including the following: (1) the United States adheres strictly to World Health Organization's definition of "live births" and records all births, whereas most other countries do not count high-risk newborns who die early; (2) medical standards differ among countries; for example, the United States uniquely prioritizes a "full-court press" to resuscitate and save even the most premature infants with the least likelihood of survival; and (3) the United States has the highest frequency of preterm births, the dominant risk factor for neonatal mortality (these factors and others are reviewed in detail in Scott W. Atlas, "Infant Mortality as an Indicator of Health and

Health Care,” *In Excellent Health: Setting the Record Straight on America’s Health Care*, Hoover Press, 2011).

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 features 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 they do not want. That is both anticompetitive and anticonsumer. And there is another reason—mandates are typically not very effective and quite complicated to enforce. The decades of experience in the United States with mandates for automobile insurance and even income taxes show that mandates have a 14 percent to 18 percent noncompliance 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 and, equally important, 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

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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, as Hadley showed in 2008, “private insurance premiums are at most 1.7 percent 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 percent higher due to the shift from people without insurance. This impact is very minimal.

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. Since the 1986 Emergency Medical Treatment and Active Labor Act, hospitals cannot turn away any individual seeking medical care—regardless of insurance status or ability to pay. 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 given not only through the emergency room in emergency circumstances; a full 86 percent of free care is given 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 recent Oregon study showed that when uninsured people become insured, they use the emergency room more frequently, not less. This finding 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 percent, that is, a very small amount. This situation will not disappear under my proposal, but it will diminish because (1) more of the poor will have incentives to enroll in coverage (to protect their new assets in HSAs), and (2) 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, that is, 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 copays?

- The new plans would be designed by the insurers, not by my plan or the government, so a variety of arrangements is likely.

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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 copayments that they personally value. As with 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, 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?

- People who want coverage for treatments such as chiropractic care, or acupuncture, or even marriage therapy and massage, that is, any benefits not included in LMCC, are still free to purchase more comprehensive coverage. Just as with 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 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 do not want and would never use. Instead

of mandates, my proposal provides financial incentives to buy low-cost catastrophic coverage. The catastrophic coverage that this reform package encourages is insurance that has already proved to be a good value because consumers have increasingly moved to purchase this type of insurance when it has been available. In addition, my plan will generate more options for individuals. This plan will reduce the cost of medical care, consequently lowering the cost of insurance. Insurers will respond to the new environment where there are 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 feature 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 preexisting 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, especially those who took the personal

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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 percent, 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. Perhaps even more important, 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 \$850 billion 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 (for example, excessive mandates) that caused the cost of coverage to become so expensive. Under my plan, insurance coverage will become far less expensive, so people will be able to afford the insurance and actually choose to pay for it because it represents a good value. In addition, 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, economists generally agree that the employer-employee market trades benefits for wages, which, in the long run, 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 as the counterproductive, perverse incentives in our current system are removed. In my plan, the idea is to generate insurance options that people value and therefore decide to purchase, rather than force people under threat of penalty to buy insurance products that they would not choose to spend their money on.

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

- 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 ultimately supplies products that consumers want to buy; 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 doesn't this plan place price caps on prescription drugs, so patients can afford them?

- Price caps ultimately do not work to provide the desired products at lower prices. In fact, price caps restrict the availability of the product—this is “Econ 101.” In this case, it would do great harm to patients to impose such caps because the number of drugs would become less available, and, even if available, they would be in scarce supply. My reforms would reduce the costs of drugs by virtue of the following: unleashing the power of consumers with control of payments; ridding our system of the regulatory excesses that generate the massive costs and time involved in new drug discovery; streamlining the overly long approval process for lower-cost generic drugs; eliminating the punitive taxes on the pharmaceutical industry that are passed on to consumers; and reversing the Obamacare elements that have contributed to the ongoing consolidation that will further harm consumers. The biggest danger for Americans, particularly senior citizens, who commonly depend on prescription

drugs, is increasing insurer consolidation and even more control by the government over decisions on insurance reimbursement. As proved by history and by those countries with government-centralized health care, more government domination over health care results in less access to the life-saving drugs that government bureaucrats judge to be costly or “unnecessary.” For example, we see this in such systems as the National Health Service in England and in Canada, with their scandalous waiting lists, limitations on innovative drugs and tests, and worse outcomes than here in the United States.

Why pick on obesity?

- Obesity is the most serious public health problem in the United States 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 most cases is well known and in the hands of individuals. My plan does not discriminate against people who are obese; 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?

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- 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 of the HSA to cover the high deductible so that health expenses that are smaller than the deductible are paid by the HSA?

- That's partly true. Money in an HSA could also be used for copays, 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 copays (and those maximums would increase as indexed to the consumer price index). But it might also be valuable to have money in the HSA to pay for 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, an 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 because employers will shift much of the previous payments for tax-preferred benefits to direct wages because of the tax reforms under this plan.

How specifically are the new HSAs liberalized for more uses?

- First, expenditures from new HSAs would be permitted not only for the account holder but also for spouses, children, parents, and siblings—regardless of the tax dependency of those family members on the named account holder. Current law permits expenses only for the account holder, spouse, and tax-dependent children. Second, expenditures for proven over-the-counter medications will be permitted under new HSAs. Current law limits HSA expenditures to prescription drugs and insulin.

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

- It is true that money could be withdrawn from HSAs for noneligible uses. The financial penalty for withdrawals of funds from HSAs will be significant, however—it will be raised to 50 percent from the current 20 percent. More important, 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 have 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 seventy, seniors would be allowed to withdraw from their HSAs without the full 50 percent penalty. Nevertheless, the HSA is not intended to be a retirement account for expenditures other than health care. In new Medicare HSAs, a 20 percent penalty would be in place for non-health-care withdrawals, starting once the owner of the HSA became seventy 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 nonemergency medical care would be simple.

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We know that Americans find it straightforward to shop for computers and other far more complicated items. Under my plan, price transparency and competition create even more visible information for consumers. And remember, most 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 (that is, 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 is a fundamental cause of rising costs. I want to put the consideration of value and price back into the consumer’s purchasing decisions, just as value and price are considered in every other good and service. My plan reforms health insurance back to the way it was intended to function, that is, 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”?

- My definition of “high deductible” is based on 75 percent 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, 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 is the specific amount of \$6,850 chosen for the maximum tax exclusion?

- Although like all such thresholds, the selection of such a number is somewhat arbitrary, this number was chosen for a few reasons: (1) it matches the currently allowed annual out-of-pocket expenses under the ACA; (2) it matches the proposed maximum for deductible HSA annual contribution; and (3) it approximates the average annual employer-based health benefit.

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 on 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

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spent because it could be saved and then 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 because of subsequent increased demand?

- Generally, high demand for goods does lead to price increases. However, increasing demand for the insurance itself 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 (for example, age and certain behaviors); and cost shifting caused by underpayment by public insurance. We need 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 feature overwhelmingly benefits the upper-income earners, that is, the people who enjoy the biggest value from the present tax deduction. The existing tax preference gives a disproportionate

benefit to the wealthy because of 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, the ACA institutes a new “Cadillac tax”—a 40 percent 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. In addition, 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

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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 and therefore reduce wages?

- No—this six-point health reform plan will reduce the medical care costs by more than the lost value of the old tax exclusion for health benefits to consumers. The proposed tax reform herein is a cut in a tax expenditure program (see *Fiscal Year 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 Twenty-First 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 will become available for consumers. This plan will expand choices for beneficiaries, so beneficiaries can decide whether 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 long-term viability 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, reduce costs, and eliminate the increasing problem of seniors of finding doctors and hospitals who accept Medicare. For those over age thirty-five today, though, traditional Medicare will still be an option when they become 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. Still, 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.
 - While everyone over age thirty-five today will still have the option of traditional Medicare, eventually traditional Medicare coverage would be 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 (as happens today with Medicare

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Advantage), new Medicare beneficiaries would receive 100 percent of the rebates, in cash returns to their HSAs, if they selected insurance with lower premiums than the benchmark.

- The plan would eliminate the current anticonsumer conflict of interest of the federal government that allows government restrictions on access to medical care. Today, with its role as the insurer via traditional Medicare, the government has the power to restrict access to care and artificially set prices of medical services. This ability 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. With the new plan, the Medicare patient will have the power to choose from 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 mainly enroll 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 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 cause 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 (for more on these plans, see Robert E. Moffit, "Saving the American Dream: Comparing Medicare Reforms Plans" [Heritage Foundation Backgrounder No. 2675, April 4, 2012], <http://www.heritage.org/research/reports/2012/04/saving-the-american-dream-comparing-medicare-reform-plans>). 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 would make payments 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 a 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, that is, the Medicare beneficiaries themselves. Under the new Medicare plan, the beneficiaries will have far more choices at competitive prices. Today, overly bloated requirements of coverage that many beneficiaries do not want are causing excessively high premiums and out-of-pocket costs, including the coverage requirements of traditional Medicare. Because beneficiaries would receive rebates into their HSAs if they chose cheaper insurance, they would now have incentives to consider carefully what coverage they chose. Remember, enrollees still have the choice of buying insurance with more extensive coverage.

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Equally important, 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 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 (nonetheless, 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 in 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 whom I have seen for years under Medicare? Seniors have complicated medical problems, so it is very important to have continuity of care.

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- No—in fact, my plan will reduce the problem of 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, that is, 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 whom seniors need most, will no longer drop Medicare acceptance.

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

- My plan is 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 allowable 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. Nevertheless, lower out-of-pocket maximums

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will likely also be available among the many choices of insurance plans open to seniors in the new Medicare program.

Under the Atlas plan for Medicare, would seniors be at risk of losing coverage for preexisting 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) in the current Medicare program. All participating insurance plans would retain current Medicare rules.

What would happen to the complicated rules wherein some doctors accept Medicare assignment and others do not?

- Those rules would be abolished. Under this new plan, Medicare beneficiaries would be allowed to purchase medical care with cash, insurance, or any other means of payment agreeable to them and 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, twelve years for it to have increased by two years, and so forth. And it would only affect those currently age fifty or younger. For example, under the current system, people currently age fifty become eligible for Medicare in fifteen years (in the year 2030). Under my plan, the age of eligibility would increase by thirty months after fifteen years from the implementation of the rule change; therefore, individuals now age fifty would become eligible for Medicare at age

67.5. In the year 2045, that is, in thirty years, the age of eligibility would be seventy. 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 copays, 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 reversible up to the amount of the transfer. This feature 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, that is, money to be used for health care expenses. Lastly, children or other family members will be able to use their HSAs to help pay HSA-eligible expenses. And don't forget that health care itself will cost less.

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.

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- 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, the HSA 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 cannot have other health insurance that would cover the cost of services during your Medicare MSA plan's yearly deductible.
 - ◆ Many 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 nonqualified expenses, the money becomes taxable, and a 50 percent penalty is charged regardless of the age of the beneficiary.
 - ◆ If you name a beneficiary for your MSA account who is not your spouse, the money in the account after your death is taxable and added to that person's income 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 sixty-five for HSA spending on certain insurance premiums (that is, can reimburse themselves for the money that Social Security withholds to pay Medicare Part B and can

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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, nonprescription medication.
- New Medicare HSA contributions are open to employers, family members, and individuals.
- New Medicare HSA contributions are allowed even for individuals receiving Social Security benefits.
- Once age seventy, seniors would be allowed to withdraw from their HSAs without the full 50 percent penalty. In new Medicare HSAs, a 20 percent penalty would be in place for non-health-care withdrawals once the owner of the HSA became seventy years old.
- On the 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 senior citizens, with both taxpayer money and administrative oversight by the government. Remember, the reality of current Medicare is that about 75 percent of beneficiaries already supplement or fully replace traditional Medicare with private insurance. Only about 9 percent of beneficiaries have Medicare alone, and another 15 percent 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 book. 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 proved both here in the United States (for example, the Veterans Health Administration system or Medicaid) and around the globe, where patients in government-centralized systems experience unconscionable waits for care and worse outcomes than care obtained via private insurance. Do not forget another fact—the private insurance of current Medicare Advantage plans outscored traditional Medicare on nine of eleven measures of health care quality in a recent direct comparison (see 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 of an inherent conflict of interest—being not only the insurer but also 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. In a voucher system, a set amount of money (typically indexed in some way to something that changes over time, such as the consumer price index) is sent to the beneficiary. Then, the beneficiary is basically on his or her own to use it in the purchase of private coverage. My 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 vouchers.

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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 percent of the savings to the beneficiary by way of more benefits, and the remaining 25 percent goes to the government. In my plan, the entire amount of the savings—100 percent—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 percent of HSAs belonging to new Medicaid enrollees in order to receive any federal money to support their Medicaid programs. Today, about 57 percent of Medicaid funding comes from the federal government, even though Medicaid is a state-run program, so this condition will be a strong incentive. The second requirement for states to receive federal money for Medicaid is that at least 50 percent of beneficiaries must enroll in limited-mandate private coverage. Under this plan, Medicaid agencies would no longer have direct authority over insurance plans because the plans are private. Agency offices would now assist beneficiaries in finding and enrolling in private plans.

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 a period of ten to twenty years, I envision that traditional Medicaid will be gradually phased out for most 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 do not 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 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.

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Increasing the Supply of Medical Care and Ensuring Innovation

Is it realistic to propose streamlined training programs for physicians?

- Yes—innovative, shortened training programs already exist. For example, the NYU School of Medicine has begun offering a streamlined three-year medical degree program. The 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 United States for education and opportunity, not for entitlements. Moreover, foreign-born people are more likely than US-born people to start a company, according to Fairlie's 2012 study. And according to the Kauffman Foundation, about 44 percent 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 reduce the current level of national health expenditures, and consumers will save on the cost of insurance and the cost of health care. Nonetheless, 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 published literature and previous estimates of the JCT and the CBO, as indicated in Tables Q&A.1 and Q&A.2 below.

TABLE Q&A.1 Impact of Atlas Plan 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
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 of taxes on devices and brand-name drugs	\$196B*	Reform #6: Supply increases

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TABLE Q&A.1. (continued)

Specific Reform	Estimated Savings (Loss) over Decade	Reform Category (See Plan)
Increased 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		

¹ Estimated 5 percent savings per year from current projections on total private premiums paid, based on half of the 63 percent of privately insured who were not already in high-deductible plans switching, estimated 10 percent overall price drop in high-deductible plans from reduced mandates and more competition among insurers, and estimated 10 percent lower premiums for all existing and future high-deductible health plans extrapolating from one-half of other competition-induced health care price decreases. Data from US Department 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 S. P. Keehan et al., "National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends," *Health Affairs* 2015 [34]: 1407–17, <http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2015.0600>).

² Estimated from extrapolating extra savings from HSAs on expenditures with high-deductible plans of 5.5 percent to 14.1 percent (see Haviland, 2011); overall estimate of a 5 percent expected additional savings in all health expenditures for non-senior citizens because of widespread HSA enrollment.

³ Estimated from transparency impact on reductions in spending for outpatient services assuming 19 percent reduction (see S-J Wu et al., "Price Transparency for MRIs Increased Use of Less Costly Providers and Triggered Provider Competition," *Health Affairs* 33 [2014]: 1391–98, <http://content.healthaffairs.org/content/33/8/1391.abstract>; and J. C. Robinson et al., "Reference-Based Benefit Design Changes Consumers' Choices and Employers' Payments for Ambulatory Surgery," *Health Affairs* 34 [2015]: 415–22, <http://content.healthaffairs.org/content/34/3/415.abstract>); projected outpatient spending in employer-sponsored insurance (see Haviland, 2011, and A. M. Haviland et al., "Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save \$57 Billion Annually," *Health Affairs* 31, no. 5 [2012]: 1009–15, <http://content.healthaffairs.org/content/31/5/1009.full>).

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

⁵ Estimated 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 Estimated for new money into HSAs and accumulated savings resulting from consumer incentives and high-deductible plans for nondisabled, non-senior-adult enrollees into Medicaid.

⁷ Estimated from Parente, 2013, and others.

⁸ Estimated to save 20 percent of total annual associated costs of medical liability (see M. M. Mello et al., "National Costs of the Medical Liability System," *Health Affairs* 29 [2010]: 1569–77).

Notes: *Approximations based on CBO/JCT estimates over one decade of implementation; **other amounts derived from the 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 resulting from response to health reforms.

TABLE Q&A.2. Impact of Atlas Plan on Government Spending, Over Decade (approximations)

Specific Reform	Estimated Change over Decade	Reform Category (See Plan)
Eliminate ACA 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		

Note: *Approximations based on CBO/JCT estimates over one decade of implementation.