CHOICES FOR ALL PROJECT

Introduction to the Choices for All Project

Healthcare Reforms for the Future

Lanhee J. Chen, PhD, Tom Church, and Daniel L. Heil

There is near-universal agreement that the US healthcare system currently fails to deliver affordable and high-quality care for all Americans. But the consensus ends there. Politicians and health-policy experts can't agree on how to improve the system.

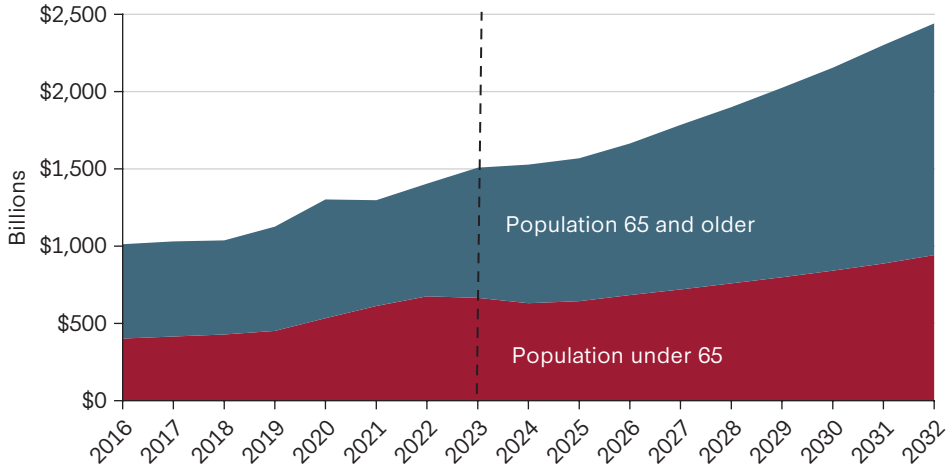
Why is our system so broken? Why have past reforms failed? Is there a better way forward?

THE PROBLEM: MISSING PRICES

Recent legislative remedies have embraced the notion that healthcare is *different* from other markets. Advocates of "Medicare for All" and the public option argue that providing up-front prices for health services is not useful because shopping is impossible when people are in pain, uninsured, or at the emergency room. Prices and competition are unnecessary, they argue, when providing a "human right" such as healthcare. Indeed, purchasing healthcare isn't like buying a car or a television. But the rules of supply and demand apply to healthcare just as they do in every other market. And centralized healthcare suffers from the same issues as all other centralized economic activity: it distorts prices so that they no longer convey useful information about value or cost. In the process, it takes choices away from patients and limits them to government-approved coverage.

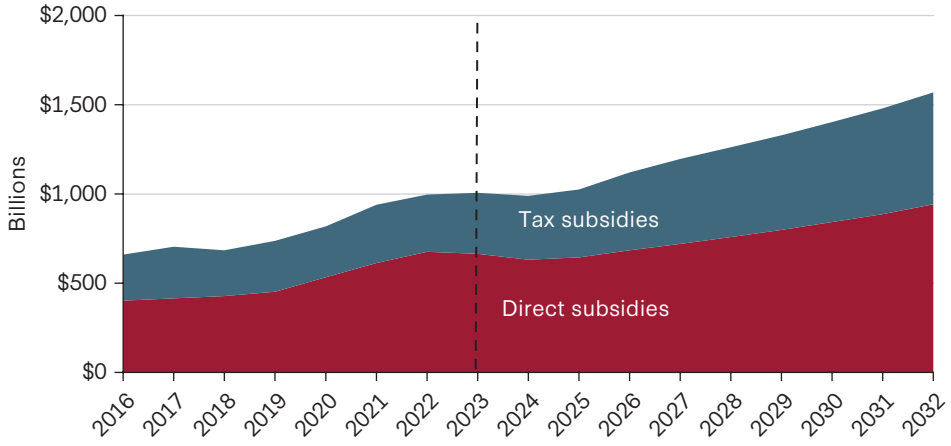
We can already see this fact in America's healthcare system. Myriad federal and state regulations affect medical care's price, quality, and availability. Nurses and physician assistants are prohibited from operating up to the scope of their training in many states. Insurers are limited in the way they can design and offer plans that would better meet the needs of consumers and expand their choices. Permissions to build and operate specialized facilities that would compete with existing institutions are denied or unnecessarily difficult to achieve.

FIGURE 1 Direct federal subsidies for healthcare (2016 to 2032)



Note: Data are derived from Congressional Budget Office data.

FIGURE 2 Healthcare subsidies for population under 65 (2016 to 2032)



Note: Data are derived from table 2 of Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65" (various years).

The regulations are paired with expensive government subsidies. As shown in figure 1, the federal government spends over $1.5 trillion a year in direct healthcare subsidies, largely through Medicare, Medicaid, and the Affordable Care Act (ACA).[1] Over the next decade, that total will rise by over 60 percent.[2]

Currently, almost half of the direct subsidies go to those under sixty-five years of age. As figure 2 shows, hundreds of billions more go to tax subsidies for employer-sponsored insurance (ESI)—but not for most out-of-pocket (OOP) spending. Much of that assistance is poorly targeted, going to households in the top half of the income distribution.

The long-term effects of these regulations and subsidies aren't immediately apparent, but they lead to enormous distortions of the healthcare market, which are erroneously blamed on a "free market" healthcare system that doesn't exist, because regulations prevent it from existing.

If the "free market" isn't the root cause, then what explains the system's failings?

There are, of course, many reasons, but none loom as large as the dominance of third-party payments for healthcare services. The government pays. Insurers pay. But patients are generally shielded from the full cost of their care. Consumers lack both the information and the incentives to make smart spending decisions. Providers often perform higher-cost or additional procedures because they know that patients are largely shielded from out-of-pocket costs, and they practice defensive medicine because of America's overactive litigation environment. And there is little demand for fixing the regulations reducing the supply of providers, hospitals, and medicines, which ultimately increases prices.

Prices, in fact, rarely make an appearance in conversations between providers and patients. And even then, the quoted prices rarely match what is actually paid by insurers or the government. That makes healthcare one of only a handful of markets in which prices are visible only after consumption—or not all.

Missing prices aren't a market phenomenon. They are, instead, a consequence of countless government interventions. The tax code rewards high-premium "Cadillac" workplace plans. Medicaid bans nearly all cost sharing among recipients. The ACA contains numerous rules and subsidies to limit out-of-pocket spending and prevent prices from conveying information, further distorting healthcare markets.

Those who call for single-payer systems tend to go even further. They think prices are the problem and argue that anyone who needs care has no choice but to accept whatever prices doctors or hospitals want to charge. As a result, only large purchasers like the federal government can put downward pressure on costs, through either price regulations or single-payer systems.

But single-payer care already exists in the United States in the form of Medicaid, care administered by the US Department of Veterans Affairs (VA), and, to some extent, Medicare. And these systems come with inevitable trade-offs among cost, quality, and access. Arbitrary cost ceilings lead to rationing, less access to new drugs or treatments, and longer wait times. The reality is that savings in single-payer systems are illusory: they can't achieve the same level of price savings and increases to quality that come from competition and prices driven by individual buying decisions.

In short, preventing patients from seeing meaningful prices—whether through regulations, tax subsidies, or single-payer systems—doesn't mean patients don't bear the costs of their medical decisions. Quite the opposite. The costs are just hidden in higher premiums and taxes, reduced quality, or limited access.

THE ANSWER: CHOICES FOR ALL

We believe the answer lies with patients. By providing patients with meaningful prices and genuine choices, they will make informed healthcare decisions that lower costs while preserving quality and access.

Healthcare is not fundamentally different from other markets. It has some difficult challenges, some unique and some not, but all can be solved in a way that puts downward pressure on existing prices using the same market forces that exist with every other good or service that people pay for. It is possible for everyday Americans to pay attention to prices and make informed decisions about most of the care they require. This is not hypothetical. This revolution is already happening across direct primary care, outpatient care facilities, health savings accounts, and more. These decisions represent enough of all medical spending to begin driving major changes to every aspect of the market.

The key is to put more decisions in the hands of patients. That means introducing meaningful prices into the system. It means fewer supply-side regulations that limit the supply of hospitals or providers. And it means finding new, innovative ways to deliver insurance and medical care that better meet the demands of patients.

PAST LESSONS: THE PROMISES AND FAILURES OF COMPREHENSIVE HEALTHCARE REFORMS

Our conclusion is not new. Countless healthcare proposals have begun with a similar premise of putting prices first. Guided by this conclusion, other plans have proposed radical, comprehensive changes to the American healthcare system. They featured good ideas that would have offered long-term improvements to this system.

Too often, however, the plans were narrowly focused on immediately reducing federal costs and failed to account for the short-term effects on coverage or care. Such solutions insisted on immediate, universal, and heavy-handed changes to the nation's healthcare system. Tax preferences for workplace plans would be reduced or eliminated. Existing federal subsidies—from Medicaid to the ACA—would be replaced with new programs that would ensure recipients had skin in the game. Health spending accounts paired with catastrophic health insurance plans would become the standard—and sometimes only—insurance that employers or others could offer.

Unsurprisingly, these past proposals failed to overcome significant political opposition. The result was that good ideas went unheeded, and America's healthcare system drifted further away from prices and toward more federal control.

The healthcare debate over the last decade reflects the danger in this approach. The focus from advocates of market-based healthcare has been almost exclusively on chipping or doing

away with the ACA at the expense of other dimensions of our healthcare system. There is no question that the ACA has fallen far short of its authors' objectives. It covers fewer people than projected, and it has increased premiums in the individual and small-group markets. But while these shortcomings demand changes, the ACA was never the primary culprit for our healthcare woes. As we have seen over the last decade, the repeated preoccupation with repealing the ACA is politically perilous and has made it more challenging to enact needed reforms in other parts of the system.

THE FUTURE: AN ALTERNATIVE APPROACH TO PATIENT-DRIVEN HEALTHCARE REFORM

Rather than offering comprehensive reforms that seek to upend the current system, policymakers need commonsense proposals that give consumers incentives and the tools to make decisions based on prices.

These reforms should not eliminate existing options—politicians should be able to honestly promise that "if you like your healthcare plan, you can keep it." Instead, new choices should be created that offer clear benefits to consumers while improving their incentives to think deeply about the kind of medical care that they purchase. This does not mean that reforms can be costless or will not face political opposition. Inevitably, every reform will hurt someone's bottom line. But wherever possible, we need reforms that expand the choices available to consumers. In other words, successful healthcare reforms should offer consumers carrots, not cudgels.

The Choices for All Project seeks to do just that. The plan offers various healthcare reforms that would jump-start competition, help to furnish meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for many Americans under the age of sixty-five. We aim to improve incentives for consumers, providers, and payers. Over the long term, these reforms would lower overall costs, offer more choices in our healthcare system, and provide effective health coverage for those who cannot afford necessary medical care.

Our goals are as follows:

- Empower individuals to take more control of their healthcare decisions.
- Encourage personal saving for healthcare expenditures to protect against unexpected or catastrophic costs.
- Protect vulnerable populations while supporting individuals on their path toward self-sufficiency.
- Create competitive markets for healthcare services and insurance coverage that offer tailored products capable of meeting diverse preferences and needs.

- Reduce the growth of healthcare costs by promoting price transparency and reducing the reliance on third-party payment.
- Expand the supply of medical care.
- Promote long-term spending and deficit reductions (although not insisting on deficit neutrality in the first year of operation).
- Reduce long-term dependency on the government by providing better options for individuals and families.

To achieve these goals, we propose reforms that would put more control in the hands of those who currently have employer-based coverage; promote universal savings accounts specifically for healthcare expenses; encourage states to rescind regulations that reduce available coverage options and increase prices; and promote experimentation within state Medicaid policies to give recipients more control over their healthcare.

Brief summaries of our major reforms are below, with more details provided in the other essays in this series.

THE REFORMS

CREATE INDIVIDUAL HEALTH ACCOUNTS (IHAs)

We propose the creation of individual health accounts (IHAs), which are tax-advantaged savings accounts for healthcare expenses. IHAs would remove restrictive rules, giving consumers more opportunity to save for their future healthcare needs. They would be available to legal residents who have qualified health insurance (qualified plans would include traditional ESI, catastrophic insurance, ACA exchange plans, and Medicaid coverage). Annual tax-preferred contribution limits to IHAs would be based on family size, and to encourage consumers to choose lower-premium insurance plans, a family's contribution limit would be lowered by the amount of its tax-preferred premium payments. Those with low-premium catastrophic plans could contribute the most, while enrollees with higher-end "Cadillac" plans may not be able to contribute at all. Withdrawals for healthcare spending would not be taxed. All other withdrawals would be considered taxable income and taxed at ordinary rates, but there would be no additional penalty for nonqualified withdrawals.

EXPAND TAX DEDUCTIBILITY OF OUT-OF-POCKET PAYMENTS

Extending tax deductibility to all out-of-pocket (OOP) payments would reduce the backward incentives that are embedded in the nation's tax code. The deductibility would be "above the line," meaning OOP payments would reduce a tax filer's adjusted gross income. This would mirror the income tax treatment of ESI premiums and ensure taxpayers would

not need to itemize their deductions to receive the tax savings. This proposal would not perfectly level the tax treatment between premiums and OOP payments, as premiums are also excluded from payroll taxes, but the difference in tax treatments would be lessened.

ALLOW STATES TO REFORM ACA MARKETPLACE PLANS AND RELATED REGULATIONS

Our proposal would offer states additional flexibility in shaping their individual and small-group healthcare markets. Expanded waivers would be conditional upon states developing detailed plans that would guarantee coverage for individuals with high expected health costs. One particularly valuable option would allow states to create pilot programs that would allow ACA recipients to choose low-cost catastrophic plans—so-called copper plans—instead of the standard ACA plans, with the remaining subsidy balance deposited into an IHA. The total subsidy would remain unchanged, but this would give ACA recipients more control over their healthcare choices.

SUPPORT GREATER STATE EXPERIMENTATION WITHIN MEDICAID PROGRAMS

Like our proposed ACA reforms, this aspect of our plan would allow state policymakers additional flexibility in reforming their state Medicaid plans. The ultimate aims of this reform would be to give Medicaid recipients more control over their medical spending by providing them with partially funded IHAs and to use supply-side competitive pressure from managed care organizations to lower overall spending. This reform can likely be accomplished through existing authority granted by Section 1115 Medicaid demonstration waivers. Under this reform, states would be permitted to use Medicaid funds to contribute to state-administered IHA plans for low-income families. States that contribute funds would be permitted to increase cost-sharing requirements for Medicaid recipients on a dollar-for-dollar basis. Cost-sharing amounts would be limited to the funds contributed to IHA plans. State contributions to IHAs would ultimately belong to the recipients, but (unlike with private IHA plans) states could limit withdrawal options to prevent individuals from immediately withdrawing money after it has been deposited.

EXPAND THE SUPPLY OF HEALTHCARE PRACTITIONERS

Countless state and federal rules reduce the supply of doctors and nurses. Through scope-of-practice rules, about half of states prevent nurse practitioners and advanced registered nurse practitioners from practicing up to their level of competence and training. This often leads to longer wait times and more expensive medical care. Complicated federal and state rules regarding telemedicine make it difficult for doctors to see patients remotely from other states. Many of these rules were waived during the COVID-19 pandemic without negative consequences, demonstrating how unnecessary they are. Removing or liberalizing these rules would give patients more choice in choosing medical providers while driving down medical prices.

ELIMINATE LONG-TERM SHORTAGES IN PRIMARY-CARE PROVIDERS

The projected number of primary-care physicians in the United States falls far short of the amount needed for the foreseeable future. Increasing federal spending on residency programs will help alleviate some of the shortage. To further address this shortage, policymakers should lower burdensome requirements on foreign-trained doctors with appropriate credentials and work histories. A special visa status for healthcare providers going to underserved areas or population centers with large concentrations of immigrants would be an innovative way to handle the existing shortage. Similar visa expansions should be made for other medical providers, such as nurses or physician assistants.

REMOVE RESTRICTIONS ON NEW AND EXPANDED HEALTHCARE FACILITIES

Many states still have certificate-of-need (CON) laws that prevent entrepreneurs from building new hospitals or medical facilities. These rules were intended to prevent wasteful medical spending fifty years ago but are now used instead to shield existing facilities from competition. Similarly, ACA rules have banned the development of new physician-owned hospitals. The result of these rules is fewer healthcare facilities, particularly in rural areas. Eliminating these regulations would expand the supply of healthcare in underserved areas and promote competition that would drive down medical prices.

INCREASE AVAILABLE INSURANCE OPTIONS IN LARGE-GROUP MARKETS

Improving the number of available health insurance options available in the large-group market begins by allowing large-group coverage to be sold through association health plans at the state level. Association health plans are just like traditional health insurance plans, except instead of being tied to an employer, they are offered by and tailored to people within the same industry or profession. Multiple employers would be able to join together to offer medical benefits. In addition, self-employed workers in similar industries could participate. One can picture insurance for rideshare service employees, restaurant employees, or whole construction industries.

INCREASE DIRECT PRIMARY CARE ENROLLMENT

Direct primary care (DPC) agreements are a new model of providing primary care to patients with a low-cost monthly subscription cost. DPC can be thought of as "affordable" concierge care that expands choice and access for consumers. Unfortunately, federal tax rules make it difficult for patients to use pretax dollars to pay for the services. Allowing payments to DPC providers to count as deductible medical expenses would help to make them more widespread. They could also become a relatively cheap supplement to state Medicaid enrollment.

THE PATH FORWARD

The reforms presented above would lead to lower-cost, better-quality, more accessible healthcare and more choices for millions of Americans. They represent federal and state tax and regulatory options that could be implemented piecemeal or all together. Ultimately, they

would encourage healthcare prices to become much more visible, allowing patients to shop when they are able. Price competition leads to lower costs, better quality, and more choices in every industry. Healthcare is no different.

The other essays in this series handle each reform in turn, explaining how the current system works—and fails—before turning to more detailed solutions.

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NOTES

1. This total doesn't include healthcare for veterans, the military, or federal civilian workers.

2. For more information, see Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65: CBO and JCT's May 2022 Baseline Projections" (May 2022), https://www.cbo.gov/system/files?file=2022-06/51298-2022-06-healthinsurance.pdf.

ESSAYS IN THE CHOICES FOR ALL PROJECT

There is near-universal agreement that the US healthcare system fails to deliver affordable and high-quality care for all Americans. The Choices for All Project examines why our system is so broken and offers reforms that would improve incentives for consumers and expand the supply of healthcare. The reforms would lead to lower-cost, better-quality, more accessible healthcare, and more choices for millions of Americans.

1. CREATE INDIVIDUAL HEALTH ACCOUNTS (IHAS)

Our healthcare system discourages patients from taking control of their healthcare futures. To fix that, the federal government should offer individual health accounts (IHAs). These accounts would serve as a more flexible alternative to health savings accounts (HSAs), allowing for larger contributions when paired with lower-premium health plans. IHAs would empower and encourage individuals and families to save for both routine and unexpected healthcare costs and would promote price discovery.

2. EXPAND THE TAX DEDUCTIBILITY OF OUT-OF-POCKET PAYMENTS

The "original sin" of healthcare policy—the federal tax preference for employer-sponsored insurance (ESI) premiums—produced the third-party payment system that wreaks havoc on consumer incentives. But the politically popular tax break isn't going anywhere. Rather than limiting the existing tax break, Congress should extend tax deductibility to all out-of-pocket (OOP) medical spending. This change would reduce the backward incentives embedded in the nation's tax code without raising anyone's taxes.

3. EXPAND THE AVAILABLE SUPPLY OF HEALTHCARE

Cumbersome regulations burden the supply of both medical care and health insurance. Restrictions on the supply of healthcare have led to longer wait times, reduced availability of services, and increased costs. Unnecessary insurance regulations have prevented innovative insurance models that can lower costs and expand access. This essay summarizes reforms that could remove these unnecessary barriers to expand the supply of healthcare.

4. EMPOWER MEDICAID RECIPIENTS AND ACA PARTICIPANTS

Medicaid and the Affordable Care Act (ACA) continue to fail patients. Long wait times and uneven health outcomes are the norm for many Medicaid recipients, while narrow networks and limited plan options are standard for ACA participants. To fix these issues, this essay offers reforms that would give states more flexibility in pursuing policies that would give enrollees more control over the money that is spent on their behalf.

5. THE BUDGET EFFECTS OF PROPOSALS IN THE CHOICES FOR ALL PROJECT

The Choices for All Project offers targeted, incentive-based improvements to our healthcare system, rather than a one-size-fits-all fix. The reforms, however, are not costless. They will require either short-term deficit spending or offsetting budget cuts. This essay discusses the budget effects of the proposed reforms and offers options to offset the deficit effects should policymakers find it necessary.

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ABOUT THE AUTHORS

LANHEE J. CHEN, PHD

Lanhee J. Chen, PhD, is the David and Diane Steffy Fellow in American Public Policy Studies at the Hoover Institution and the director of domestic policy studies in the Public Policy Program at Stanford University. He has advised four presidential campaigns and previously served as a member of the Social Security Advisory Board and at the US Department of Health and Human Services.

TOM CHURCH

Tom Church is a policy fellow at the Hoover Institution whose work focuses on healthcare policy, entitlement reform, income inequality, poverty, and the federal budget. He holds a master's degree in public policy with honors from Pepperdine University.

DANIEL L. HEIL

Daniel L. Heil is a policy fellow at the Hoover Institution whose work focuses on the federal budget, healthcare, tax policy, and antipoverty programs. Heil served as Florida governor Jeb Bush's economic policy adviser, counseling him on these issues, during the 2016 presidential campaign. He holds a master's degree in public policy from Pepperdine University.

The Choices for All Project: Healthcare Reforms for the Future

There is near-universal agreement that the US healthcare system fails to deliver affordable, accessible, and high-quality care for many Americans. Fixing our system requires putting more decisions in the hands of patients. That means introducing meaningful prices into the system, reducing supply-side regulations that limit the supply of medical care, and finding innovative ways to deliver insurance and medical care that better meet the demands of patients. The Choices for All Project offers healthcare reforms that would jump-start competition, encourage meaningful and transparent prices to patients, and bring consumer sovereignty to the healthcare market for millions of working-age Americans.

Hoover Institution, Stanford University
434 Galvez Mall
Stanford, CA 94305-6003
650-723-1754

Hoover Institution in Washington
1399 New York Avenue NW, Suite 500
Washington, DC 20005
202-760-3200

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