The Dignity of Private vs. Public Insurance

Grace-Marie Turner[1]

There is no question that Americans are frustrated with our current health care system. Millions remain uninsured, and coverage and care cost too much. People are hurting, and they feel powerless against this system.

But political leaders tell us we should be happy about progress in the current system as the nation's uninsured rate has reached an all-time low.[2] However, there is a big problem beneath the headlines, starting with the disparity between uninsured rates for minorities and whites. The most recent data from 2019 showed that only 9% of whites were uninsured compared to 15% of blacks.[3]

And there are large disparities in the health status and health outcomes for black Americans compared to white Americans, according to the Office of Health Policy at the Department of Health and Human Services (HHS).[4] Chronic disease burden, morbidity, and mortality are all significantly higher among young adult black Americans than the U.S. population as a whole.[5] According to the U.S. Census Bureau, black Americans' life expectancy in 2020 was 3.6 years shorter than non-Latino white Americans.[6]

There also are big disparities in types of coverage. Pacific Research Institute President and CEO Sally Pipes explains in her chapter for this book that 52% of black Americans had private health insurance in 2019 compared to 74% of white Americans. And 37% of blacks were enrolled in Medicaid—the joint federal-state health insurance program for the poor—or other public insurance compared to only 19% of whites.[7]

The Biden administration boasts that 1.1 million fewer Americans were without health insurance in 2021 than in 2020. But what they don't tell us is that the number of people with *private* health coverage fell while enrollment in public programs, especially Medicaid, soared. Democrats in Congress used COVID to expand the welfare state, to the detriment of people who prefer and deserve the dignity of private health insurance.

"All told, more than half of Medicaid's beneficiaries are racial and ethnic minorities,[8] subject to the long waits, poor quality of care, and devastating outcomes endemic to government-run programs. If we want to improve health outcomes among black Americans, we'll have to start here," Pipes writes.

Mortality of black babies is another tragic disparity. Infant mortality is 10.8 per 1,000 live births for black mothers compared to 4.6 per 1,000 for whites.[9] More than half of all births in the U.S. are covered under Medicaid, and black women are disproportionately likely to be enrolled in this program for lower-income Americans. Black women are less likely to receive prenatal care and therefore to experience maternal complications and are more likely to give birth to infants with low birthweight and congenital malformations.[10] The problems with Medicaid, especially the difficulty in accessing coordinated care, is a problem that manifests in these tragic disparities.

Access to mental health care among African Americans also is an important problem. The Office of Minority Health at HHS reports that black adults are more likely than white adults to report "persistent symptoms of emotional distress."[11]

"Black adults living below the poverty line are more than twice as likely to report serious psychological distress than those with more financial security," government data show. Despite the needs, only one in three black adults with mental illness receives treatment.[12]

This chapter will offer policy recommendations to address these inequities. But rather than the typical failed prescription of recommending new government programs, we believe that policies need to be directed at lifting all people up and creating a health sector that is efficient, dynamic, and relies on the power of consumer power and competition to drive transformative change.

Promises Not Kept

While politicians have made many promises to black Americans and others, the reality is that the government "solutions" often relegate them to failing public programs. Medicaid recipients struggle to find physicians who can afford to take the program's low payment rates, and patients can find it especially difficult to get appointments with specialists to treat more serious health problems. Studies have shown there is little if any difference in outcomes between patients who are on Medicaid and those who are uninsured.[13] That is an insult to those who rely on the program and often have no other alternative.

Despite these failures, the Left isn't giving up and believes that all of these problems could be solved if the government were to control all of the health sector. They are proposing an alternative that would provide coverage for everyone, with no premiums, copayments, or deductibles—a new universal system run by the federal government.

As I will document, a government-run system would have many if not more of the problems we experience today because it would put even more health care decisions under control of government. Americans deserve better.

It is true that the United States does not have a properly functioning market in the health sector. It does not respond to the needs of consumers and their demands for lower costs and abundant choices as they are accustomed to receiving in other sectors of the economy. Too many people are priced out of the market for health insurance—they don't qualify for subsidies or public programs and can't afford private insurance. The costs of premiums can be prohibitive, and even those with policies say they face deductibles that are so high they might as well be uninsured.

Instead of being relegated to failing government programs, Americans deserve the "freedom to flourish," as Center for Urban Renewal and Education (CURE) founder and president Star Parker insists. All Americans, especially black Americans, deserve the dignity of private health insurance and a choice of physicians and care arrangements. That means offering coverage that gives them more options of plans that meet their needs. Creation and expansion of government programs is not the answer.

Opinion Polling Swings

The political dangers of the U.S. slipping into a national government controlled health system are very real. The Kaiser Family Foundation[14] regularly asks Americans about health policy issues as part of its Health Tracking Poll series. Its 2019 comprehensive survey found that 56% of Americans support a "national health plan, sometimes called Medicare for All" and an even larger 71% support the idea when told that it would "guarantee health insurance as a right for all Americans."

But then come the details. When the surveyors focused on the costs of this single-payer system, support for Medicare for All dropped below 40%. Support fell even further to 37% when they learned the plan would eliminate private health insurance and require people to pay more in taxes. And when they learned that some medical treatments and tests could be delayed, support dropped even further, to 26%.

More recent focus group testing has found that soaring inflation in our economy makes calls for more health spending and expansion of government programs "seem reckless, not compassionate."[15]

Political philosopher Thomas Sowell gets it right: "It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medications somehow think that we can afford to pay for doctors, hospitals, medications and a government bureaucracy to administer 'universal health care.'"[16]

Too Much Government

Wharton School Professor Mark Pauly, in a paper published by the American Enterprise Institute, has important findings about the controlling role that the federal government already plays in our health sector today.[17] Pauly details how the federal government shapes a much larger share of spending than the portion it finances directly. He finds the share of "government-affected" spending in 2016 totaled nearly 80%—"not leaving much in the unfettered, market-based category."

The federal government finances nearly 55% of all "explicit and implicit" health spending, he reports—including Medicare, the federal share of Medicaid, Affordable Care Act (ACA) subsidies, and tax preferences for employer-sponsored health insurance, etc. The federal government controls even more of our health care through regulations and mandates it imposes on titularly private plans.

We are close to having the majority of Americans dependent on government for their health care and coverage. Liberals have gained government control over the health sector with step-by-step changes over nearly 60 years, never missing an opportunity to expand an existing government program and using the slimmest of political majorities to create new ones.

The passage of the Inflation Reduction Act (IRA) in 2022 is an example. It means that Washington will exert even more control over health care for millions more people and lead to greater dependency on taxpayer subsidies for health insurance.

Star Parker and the CURE team pushed back hard against passage of the IRA, arguing that the law would "plunge low-income Americans deeper into government dependency, undermine individual freedom, harm small business owners and individual contractors, substantially increase the national debt, and exacerbate already growing inflation."[18]

Star points out there are better options. "Following passage of welfare reform, child poverty fell, dependency shrunk, and millions of Americans moved from welfare to the dignity of work." Freeing people from dependency on government enriches opportunities for success.

The Left promises "free" health care with Medicare for All[19] and its derivative big-government, taxpayer-funded solutions. But we know nothing is free. Having an insurance card doesn't equal access to actual care. Putting everyone on one big federal plan would mean people would lose their employer health plans. Medicaid, Medicare and Medicare Advantage would go away, and 330 million Americans would be competing for care from a shrinking number of physicians working for ever lower payment rates, with many being forced to close their doors.

While there are a few incentives in taxpayer-supported programs to moderate costs, at some point the expenses of these wasteful and inefficient programs must be addressed. In other countries with government-run healthcare systems, it's done through rationing of care, underfunding public institutions, and restricting purchases of the latest medicines and technologies.

The Congressional Budget Office (CBO) found that using Medicare payment rates for the entire U.S. health sector would substantially reduce income for physicians, hospitals, and virtually all others in the health sector.

CBO found this would likely "reduce the amount of care supplied and could also reduce the quality of care." It says that "decreases in payment rates lead to a lower supply" and "fewer people might decide to enter the medical profession in the future. The number of hospitals and other health care facilities might also decline as a result of closures, and there might be less investment in new and existing facilities."

According to CBO, the government's low payment rates "could lead to a shortage of providers, longer wait times, and changes in the quality of care, especially if patient demand increased substantially."[20]

Their Disguised Agenda

While Medicare for All is their moniker, the Left sees Medic*aid* as a platform upon which to build their government-run health care system.

Nearly 90 million Americans now are enrolled in this federal-state program designed for the poor. Medicaid is arguably the worst of U.S. public programs. It dramatically underpays doctors and hospitals and thereby restricts access to coordinated, quality care for patients.

Instead of reforming and improving government-funded health programs like Medicaid, the current Congress has pumped more taxpayer dollars into expanding enrollment.

COVID provided the opening for Congress to expand Medicaid dramatically and to enhance and expand ACA subsidies for two years. The federal government bribed states into expanding Medicaid enrollment by paying a bigger share of costs, and once people were enrolled, states were forced to keep them enrolled even if recipients no longer met program qualifications.

In the midst of COVID, Congress also lifted the cap on income eligibility for ACA subsidies and made premium subsidies richer. The Inflation Reduction Act of 2022 extended the expansion for three more years. These COVID expansions are a regressive use of taxpayer dollars since much of the benefit accrues to higher-income people.[21]

Most of those who will benefit from the added ACA subsidies are in the upper two income quintiles, many of whom drop private coverage to take advantage of the taxpayer subsidies. For example, a family of four with a 60-year-old head of household earning $265,000 could end up eligible for more than $7,800 or more a year in ACA subsidies, according to an analysis by Brian Blase, president of the Paragon Health Institute.[22]

With taxpayers footing most of the bill, there are few incentives for insurance companies to moderate costs. Premiums for insurance in the individual market increased by 143% over six years to 2019, and deductibles also have skyrocketed. The average annual premium plus deductible for a family of four with an ACA plan was about $25,000 in 2021. And that is for coverage with extremely narrow physician networks and often limited access to the best hospitals.

“Between 2000 and 2021 alone, premiums for individual coverage increased 213%, and premiums for family coverage increased 245%—much greater than the 60% increase in overall prices during this period,” Brian Blase explains.[23] Government spending has been a primary contributor to health cost inflation. All of this pumps more taxpayer dollars into the health care system, further inflating premium and health costs for everyone. This makes it increasingly difficult for people to keep and afford private coverage and the choices of quality care it generally provides.

Galen Senior Fellow Doug Badger explains[24] that many people will lose their private coverage as a result of the Inflation Reduction Act. Small businesses can’t compete with government. Businesses with fewer than 50 employees aren’t subject to the Affordable Care Act’s employer mandate, and many will drop insurance coverage they currently offer to their employees and instead send employees to the government exchanges. That means millions more people will have policies through government programs where politicians and government bureaucrats, not doctors and patients, are making medical decisions.

Public coverage is inferior to private coverage because it pays doctors and hospitals less, making access to care more difficult. Providers and facilities throughout the health sector also are forced to respond to legislative and regulatory demands rather than to the needs and preferences of patients. Too many patients on public programs find that having an insurance card doesn't mean having access to care.

Small Business in the Crosshairs

Small businesses that have borne the brunt of cruel COVID closures lack the bargaining power of big companies to negotiate lower health insurance rates. New and bigger government programs fuel inflation and make it harder for these businesses to make ends meet, especially those that want to provide health insurance for their employees and need to offer benefits to attract good workers.

CURE president Star Parker stresses that "Health is essential to productive citizenship." Black entrepreneurs are especially challenged. Blacks comprise approximately 14% of the U.S. population, but only 2.3% of owners of employer firms. According to a Brookings Institute report, the latest Census data show there were 3.12 million black-owned businesses in the United States, generating $206 billion in annual revenue and supporting 3.56 million U.S. jobs.[25]

Many want to offer health insurance to their employees and want to use the benefit to attract new employees in a tight labor market, but the costs of coverage and the enormous bureaucracy of running an employer-sponsored health program deplete the time and resources of most small businesses.

Wall Street Journal editorial writer and author Jason Riley got it right in his 2014 book, *Please Stop Helping Us: How Liberals Make It Harder for Blacks to Succeed*.[26]

CURE emphasizes the need to "provide our most vulnerable communities with the care they need."[27] Government policies can provide this strong safety net, but it needs to stop creating lifelong dependency on government programs and robbing people of the opportunity to be independent and succeed.

Shared Goals

While there are different views on how to reach that goal of a fair, affordable, quality health care system in the United States, there are important shared values:

- Everyone should be able to get health coverage to access the health care they need.
- Coverage and care should be affordable.
- We must guard the quality of care.
- People should be able to see the physicians and other providers of their choice.
- And most important, we must work together to protect the most vulnerable and marginalized communities.

So What Should We Do?

We have fresh ideas to allow people to obtain a wider variety of health insurance offerings, and that involves giving states more authority over approving policies that meet the needs of their citizens—not the dictates of Washington bureaucrats.

Health care is too local and personal for a Washington-driven, one-size-fits-all approach to work. Health care costs and spending are escalating, dependence on government programs is at an all-time high, and individuals and families have less control of their health care decisions.

The only way to help black Americans obtain better, more affordable, more reliable, quality health coverage is to reform the health sector so consumers, rather than bureaucrats, are in charge.

A system that devolves power and control away from Washington to communities and ultimately to doctors and patients will better serve all Americans, including black Americans. Their needs are not being met in a system run by remote bureaucrats that are detached from their communities.

Texas state legislator Tan Parker writes in *Making America Health Care Great:*

> No policy area in America is more complex or more personal than healthcare. Protecting the health and wellbeing of our families is a top priority for us all. As Americans, we are blessed with the greatest medical practitioners and innovative technologies in the world, but hidebound government programs and endless bureaucratic red tape hinder the innovative solutions desperately needed to make sure everyone can access the health care they need and have insurance coverage that is affordable.[28]

CURE has as one of its core pillars promoting "policies that give people freedom to flourish."[29] Star Parker stresses that "Americans deserve to make their own decisions about their health and healthcare."

Star is right. Eighty percent (80%) of voters say that individual Americans should be allowed to purchase any health insurance product approved by their state's health insurance commissioner. A Scott Rasmussen national survey found that 9% think they should not, and 12% are not sure.[30]

The survey also found that 45% of voters think that allowing each state to set its own health insurance guidelines would lower the cost of healthcare in America; 27% think it would not lower the cost, and 27% are not sure.

Rather than dramatically expanding the role of government through "Medicare for All" or other new or expanded taxpayer-supported programs, policymakers should focus on creating a functional health sector, emphasizing improved health outcomes for everyone. We should start by devoting resources to address the specific needs of those who are uninsured, focusing on those in marginalized communities and the most vulnerable. But these policies should lift people up, not force them into reliance on inadequate government programs.

We are offering better ideas that rely on market forces and consumer power, but we need a different political environment for those ideas to advance.

The goal must be to return power to doctors and patients. That is our task now and will be for many years to come. For starters, we just need politicians to stop making it worse.

The patient-centered plan supported by scores of health policy experts in the market-based community is called Health Care Choices.[31] It is built around changes to help patients have the dignity of private insurance in a system that is responsive to their needs.

States have decades of experience in regulating health insurance markets and can better assure citizens that policies offered balance the needs and resources of each state. Under our plan, states also would be able to set up new, better-funded risk mitigation programs, such as reinsurance, that help those with the greatest medical needs to get the care they need. Regulatory barriers would be removed that keep plans from specializing in treating those with chronic conditions. And people with chronic illness would be better able to manage their health care spending in accounts they own and control.

One Woman's Frustrations

The problems with government-run health care are not limited to Medicaid. A woman from Colorado recounted her story about the difficulty of getting the care she needs in the highly regulated Obamacare exchange marketplace:[32]

"Janet" reported to us that when she was diagnosed with Hepatitis C in 1999, she enrolled in Colorado's high-risk pool.

"My premiums in 2010 were $275/month with a total out of pocket of $2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question," she said. "My $600,000 transplant was covered 100% with a $2,500 out of pocket maximum!"

When Obamacare went into effect, Colorado's high-risk pool was shut down. "I was forced into the regular marketplace." Her premiums rose to $450 right away, and eventually she was paying $1,100 a month with a deductible of $6,300.

But her anti-rejection meds weren't covered along with the cost of other necessary care. She now is spending $19,500 a year just in out of pocket costs before her insurance kicks in.

Too many families report their ACA plans do not provide them access to hospitals that specialize in the cancer care they need, the surgeries they require, or the medicines they must have.

Like Janet, they have "coverage" under the ACA but access to care is often inferior to the state high-risk pool or other coverage they had before. We must do better for those who are most vulnerable and most need quality care.

Transformation to Lift People Up

"The only effective way to resolve persistent problems in health care is to leverage the power of personal choice and market competition," writes health policy expert Nina Schaefer of The Heritage Foundation.[33]

"Congress should take the steps needed to transform the health care system away from a government micromanaged public utility model, as advocated by the Left, and instead embrace a patient-centered health care agenda that puts individuals and families, not the government, in control of health care decisions and subjects the health care sector to the discipline of market competition."

There is an enormous amount of energy pent up in our economy among those who have transformative ideas for change in our health sector. But even the most entrepreneurial companies crash into barriers created by a government, which controls far too much of the spending and sets virtually all of the rules in our health sector. This government monopoly must end if we are to get to a system centered around doctors and patients with incentives for providers, hospitals, and manufacturers to compete on price and value and satisfy the needs of consumers.

Consumers gain control over resources and therefore choices in a system that supports "defined contributions" in private and public health plans. [34] Like school choice, patients can take the money devoted in public or private programs to support their coverage and give consumers a chance to obtain insurance that better supports their needs. Our Health Care Choices proposal also provides better support than the ACA or Medicaid for those who need assistance because of age, disability, or economic conditions by providing dedicated resources to states to provide for their care.

Defined contributions mean consumers can control and direct resources to the health care arrangements that suit them best.

The defined contribution model works in both private and public coverage. Being on Medicaid, CHIP, or Obamacare exchange programs should not lock people into a lifetime of dependence on poorly performing, government-run health care programs. Americans, regardless of income status, should benefit from the innovations of the private sector.

"Congress should allow beneficiaries to apply the dollars that otherwise would have been spent on their care through the traditional Medicaid program to a private coverage option of their choice," Schaefer writes.[35] States have some flexibility to do this now by requesting mother-may-I waivers from Washington, "but Congress should remove burdensome requirements that act as barriers to making it more widely available to enrollees," Schaefer says.

Several administrations, both Republican and Democrat, have permitted states to have more flexible programs and policies. Congress should make these options more readily available without the need for administrative waivers.[36]

And choices should be extended to seniors on Medicare as well. While more than half of seniors have voluntarily enrolled in private Medicare Advantage plans, other options would be available if they could direct the value of their Medicare subsidies to other private coverage of their choice, such as Direct Primary Care where people have a private physician on call to coordinate their care.

A patient-centered system would put more focus on the needs and special health problems faced by black Americans.

Specialized Solutions

In a patient-centered system, providers would organize care to better serve patients rather than being forced to follow Washington's detailed policy prescriptions. We would see more innovative options:

Kidney disease: Those with end-stage renal disease must submit three times a week to dialysis to cleanse their blood, which means regular hours-long visits to clinics and hospitals to undergo the procedure.

Innovation in this sector has lagged far behind the rest of medical technology largely because the federal government pays the lion's share of dialysis costs through Medicare. There are experiments with home dialysis, for example, but it is not widely available. The U.S. falls far behind other developed countries in access to home dialysis, with only 12.6% of U.S. patients using this treatment. And this is another disparity: Black and Hispanic people have even lower rates of use of home dialysis.[37]

Even still, dialysis is a stopgap measure that fails to fix a chronic problem. Dialysis clinics that profit from the government payments have for decades shirked responsibility to help patients get on kidney transplant lists to receive organs from living donors that would eliminate the need for the life-altering dialysis treatments.

A patient-centered system would empower patients by giving them more options for treatment and would encourage the industry to innovate to be more responsive to their needs.

New and better medicines: The Inflation Reduction Act that Congress passed in August of 2022 will have a seriously detrimental impact on future pharmaceutical innovation. The law's supporters cheered that it allows the federal government to "negotiate" Medicare drug prices with pharmaceutical companies. But this is just another name for price controls, which Europe has painfully learned dries up investments in research.

This will impact black Americans disproportionately because they have higher than average rates of chronic disease. They *were* poised to benefit the most from breakthrough treatments for conditions like diabetes, heart disease, and cancer that were in the research pipeline. Work on many of those drugs was ended because of Washington's threat of onerous price controls.

Members of Congress who care about patients more than politics should make it a priority to end these price controls that will undermine the vibrant U.S. biopharmaceutical industry. Policymakers should focus instead on market-oriented reforms. To lower drug costs for consumers, Congress should, for example, allow rebates to go directly to consumers at the pharmacy counter rather than to the back pockets of Prescription Benefit Managers (PBMs) and provide new incentives for patients to adhere to their medication instructions. In addition, a key reason prices for medications are so high is because other developed countries do not pay their fair share of research and development costs. That's a trade issue that a new president should tackle.

Access to physicians: Medical professionals are experiencing significant burnout after COVID, and there are thousands of unfilled openings in hospitals and nursing homes throughout the country. But even without COVID, the paperwork burden can be crushing.

"In countless surveys and studies, and across specialties, physicians consistently cite the time and energy they must devote to filling out forms and other administrative tasks near or at the top of their list of grievances.," according to an editorial in the *Medical Economics Journal*. "The mantra repeatedly heard throughout the profession is, 'This isn't why I went into medicine.'

"The problem is worsened by electronic health records (EHR), now used by close to 90% of office-based physicians," the editorial continued. "Once seen as a way to streamline documentation data sharing, EHRs instead have become enormous time-sucks. A December 2016 study in *Annals of Internal Medicine* found that physicians in outpatient settings spent about 27% of their day on direct clinical face time with patients, but 49% on EHRs and desk work. Many also worked up to two hours every evening on EHR-related tasks."[38]

Reducing that burden could allow doctors to spend more time with patients and see more patients, particularly those covered by programs like Medicaid, who must wait longer and have fewer options for care than those with private insurance. Reducing the administrative burden could be a way to effectively increase the supply of medical care and in the process give doctors more time to boost trust among patients, who have historically distrusted the medical establishment.

To achieve these goals, we would redirect resources to the states and give them more flexibility to approve health plans and coverage options that better meet the needs of their citizens who are empowered by having control over the resources that finance their care. This will lead to more flexible, affordable health care and coverage arrangements and to more focused assistance to those who most need help.

Health care is too local and personal for a one-size-fits-all approach to work. Washington has created hundreds of thousands of pages of rules and regulations in a clumsy and misguided effort to run our health care system. This has driven up costs, reduced choices, and made it harder for sick people to get care—all while giving a blank check from taxpayers to health insurers, hospitals, and other big health care businesses.

Health reform should be about your care and your coverage with you and your doctor in control of your health care decisions.

The consumer focus we see in other sectors of our economy also can work in health care to produce many more options for care and coverage. States should be free to approve plans that meet the needs of consumers, not just Washington's cookie-cutter policies.

The Left's proposals expand government power over health care and make doctors and patients pawns in the system. Instead, our ideas would **expand access to better private coverage**, with many more options of affordable plans that meet the needs of Americans.

We see some hopeful pockets of change:[39]

Patient-focused health reform is gaining momentum in the states.[40] For example, Texas enacted "Healthy Families, Healthy Texas"[41] as an alternative to Medicaid expansion. This bipartisan package of reforms focuses on improving access, outcomes, and affordability of care and coverage.

Oklahoma also provides a friendly climate for the hugely successful Surgery Center of Oklahoma.[42] It is a state-of-the-art multispecialty facility in Oklahoma City, owned and operated by approximately forty of the top surgeons and anesthesiologists in the state. They offer surgery care at one competitively low price.[43] For example, the nearby Oklahoma University Medical Center billed $20,456 for the open repair of a fracture; the procedure costs an estimated $4,855 at Surgery Center of Oklahoma.

"We can offer these prices because we are completely physician-owned and managed. We control every aspect of the facility, from real estate costs to the most efficient use of staff, to the elimination of wasteful operating room practices that non-profit hospitals have no incentive to curb. We are truly committed to providing the best quality care at the lowest possible price," according to founders Dr. Keith Smith and Dr. Steven Lantier.

This surgery center was created before Washington imposed a ban on creation of any new physician-owned hospitals. A 2018 White House Report on Choice and Competition[44] recommended that Congress lift the ban to allow creation and expansion of these hospitals to give patients more choice and give big community hospitals much-needed competition.[45]

Dr. Brian Miller practices hospital medicine at the Johns Hopkins Hospital and also is an academic health policy researcher at the American Enterprise Institute. In 2021 testimony before the Senate Judiciary Committee, he reported that "Physician-owned hospitals (POHs) represent a powerful lever through which policymakers can promote market entry. Currently, new POHs are statutorily excluded from participation in the Medicare program, a policy with both a long history and recent legislative efforts aimed at its repeal in 2017 and 2019.[46]

Washington needs to shift its focus to proposals that will unleash this kind of innovation and energy that are pent up in our health sector. One way is to lift the ban Washington imposed on

creation of new physician-owned hospitals like the Surgery Center of Oklahoma to put doctors rather than politicians in charge of health care.

Evidence the Consumer-Choice Model Works

My colleague Doug Badger and I described the Medicare Part D program's success:[47]

The federal government's largest prescription drug program is Medicare Part D. The program has made prescription medicines more affordable for millions of seniors, offering them broad coverage choices while holding down costs for taxpayers.

Part D, established in 2003 through the Medicare Modernization Act, has led to more than 9 out of 10 seniors having drug coverage, and they are paying less than predicted for their coverage. Their premiums average $33.50 in 2018, less than CBO said they would average in 2006, the program's first year.[48]

Part D has consistently come in under budget. Under the initial 10-year budget projections, Part D was expected to cost $770 billion. Actual cost after 10 years: $421 billion. That's 45 percent less than expected.

That underestimates the value of Part D. Innovative new medicines reduce the need for hospital stays and physician visits. A 2016 study found that Part D actually resulted in net Medicare savings of $679 billion over its first nine years.

Instead of building on this island of success in the sea of red ink in other government programs, Congress has chipped away at the unique features that have produced Part D's success—a judicious use of regulation, genuine market competition, transparency, and consumer choice.

In the Medicare Prescription Drug Benefit Program, plans compete for enrollment based on the premiums and coverage design. Unlike Obamacare, which has caused insurers to abandon individual health insurance markets and leave consumers with few choices, Part D offers seniors a broad array of options. As a result, plans have a big incentive to negotiate the lowest price they can get to make their premiums attractive.

While Congress has made changes that have made the program less consumer-centric, the basic structure of the program should be a model for future reform.

Our Vision for the Right Kind of Health Reform

- Everyone who wants health coverage could get **a plan they can afford**.
- People would have **many more options** of coverage that fit their needs and pocketbooks.
- **Coverage would be secure** so people don't lose insurance if they lose or change jobs.

- For those with low incomes and the greatest health care needs, there is **a strong safety net**.

Americans are in no mood for another disruptive, massive overhaul of our health sector. We must begin with targeted reforms that empower patients, free doctors and nurses, and unleash entrepreneurial energy.

Here are some of the specific policy ideas to create more choices of health coverage in a market with genuine competition:

- **Health plans should be able to specialize** (instead of being required to be all things to all patients). Patients, especially those with chronic disease, should have a plan that provides continuity of care with medical professionals who specialize in their condition and disease.

- Allow **Medicaid recipients the dignity** of using the value of their subsidy to get private insurance. Most recipients find it extremely difficult to find physicians, especially specialists, who can afford to take the program's paltry payment rates. Recipients wind up in hospital emergency rooms to get even routine care—at a much higher cost to taxpayers, who foot the bill and at the expense of continuity of care for patients.

- Make **Health Savings Accounts** more flexible so anyone can use them in conjunction with more versatile plans, including plans that specialize in treating chronic conditions to help people like Janet that struggle to get the care they need in narrow-network plans.

- **Provide stronger consumer protections.** Advancing more patient-centered health care models will require additional tools and resources to support patients. For example, individuals need better information on prices, quality, and choices. Patients also should be able to reap the benefits from their cost-saving decisions and be protected from contract decisions outside of their control. Congress and the states should facilitate meaningful price transparency initiatives, permit patients to share in premium savings with insurance plans, and revisit flawed surprise-billing legislation.

- Give states the option of facilitating **private exchanges** in which health plans compete to offer affordable insurance rather than having only the ACA exchange monopoly that limits choices and inflates prices.[49]

- Codify the administrative rule that allows employers to offer, and employees to use, **tax-free dollars to buy insurance** they may prefer outside the workplace. This should be expanded to include allowing pooling of employer or other contributions from each spouse to buy one family policy.

- Give **small businesses** the option of joining together through Association Health Plans to get better prices on health insurance for their workers like larger companies do.

- Insist that hospitals and insurers follow the law in making their **prices transparent**.[50]

- Make **telehealth** a permanent option so patients have easier and better access to doctors.

- Provide incentives for states to **lift regulations** that restrict competition and increase costs, such as certificate-of-need laws.

- Repeal the moratorium on new or expanded **physician-owned hospitals** to broaden access to quality, innovative, patient-centered care.

- Crack down on **anti-competitive practices** in the health sector where excessive consolidation limits competition and increases prices. As a start, the FTC and Justice Department should routinely report to Congress the extent and effects of hospital consolidation on restraining competition.

- Clarify that the Stark law is **not intended to limit innovative** payment arrangements, care coordination, and patient engagement.

- **Remove restrictions** on physicians that discourage them from entering into private arrangements with their Medicare patients for direct primary care and other private options.

- Any reform plan must **protect life and protect the conscience rights of health care providers** to practice medicine without violating their values and beliefs. An important guarantee is making sure that funding for health programs has Hyde Amendment protections to assure no federal dollars will be spent to fund abortions.

Drug Costs

- Don't buy the line that the government can "negotiate" lower drug cost in Medicare. Private plans compete fiercely in Part D to offer the lowest prices and the best selection of drugs. **Government "negotiation" is just a fancy word for price controls** that lead to shortages, drug rationing, and fewer new and better drugs. The Inflation 'Reduction' Act's price-control provisions should be repealed.

- Assure all **drug discounts and rebates** are passed along directly to consumers rather than to the middlemen.

- **Streamline and modernize the FDA** drug approval processes so safe drugs can reach the market faster, reducing what is now an average of 12 years from design to market that costs billions of dollars—costs that get passed along in the price of the product.

- **Force others to pay their fair share of research costs.** Wealthy European countries piggy-back on U.S. consumers who pay more than their share of research costs.

Rectifying this should be a top priority of the next administration negotiating trade deals.

Patients First

Just as physicians must always put their patients first, political leaders should do the same and stop catering to special interests. And stop promising "the government" can fix our health sector. Many of the problems with health care and costs are *because* of big government intervention so we don't need *more* of it.

The solution lies in creating a truly competitive and transparent, patient-centered marketplace and getting rid of Washington's iron grip on health care.[51] The American people don't want another major overhaul of our health sector, but they do need targeted changes to create a patient-centered health sector that unleashes the innovation and energy pent up in our health sector to create a health sector that can be a model and a beacon for the rest of the world.

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