Government-Run Healthcare Will Harm Patients and Eliminate Consumer Choice

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CITIZENS AGAINST GOVERNMENT WASTE

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About CAGW

Citizens Against Government Waste (CAGW) is a private, nonprofit, nonpartisan organization dedicated to educating the American public about waste, mismanagement, and inefficiency in government.

CAGW was founded in 1984 by J. Peter Grace and nationally syndicated columnist Jack Anderson to build public support for implementation of the Grace Commission recommendations and other waste-cutting proposals. Since its inception, CAGW has been at the forefront of the fight for efficiency, economy, and accountability in government.

CAGW has more than 1 million members and supporters nationwide. Since 1984, CAGW and its members have helped save taxpayers more than $1.9 trillion. CAGW publishes special reports, including the *Congressional Pig Book* and *Prime Cuts*, as well as its official newsletter *Government WasteWatch* and blog *The WasteWatcher*, to expose government waste and educate the American people on what they can do to stop the abuse of their hard-earned money. Internet, print, radio, and television news outlets regularly feature CAGW's publications and experts.

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Introduction

Healthcare reform has been a topic of vigorous debate for what seems like an eternity. But as John S. Gordon said, "Perhaps the most astonishing thing about modern medicine is just how very modern it is. More than 90 percent of the medicine being practiced today did not exist in 1950. Two centuries ago, medicine was still an art, not a science at all. As recently as the 1920s, long after the birth of modern medicine, there was usually little the medical profession could do, once disease set in, other than alleviate some of the symptoms and let nature take its course. It was the patient's immune system that cured him – or that didn't."[1]

Citizens Against Government Waste (CAGW) has been at the forefront of the debate over healthcare reform since the group's inception in 1984. As one example of the work CAGW has done, the October 30, 2000, report, "Through the Looking Glass: Price Controls on Drugs: Hazardous to Your Health," noted that many reforms have been "inspired in large part by the supposed success of the Canadian healthcare system and its 'cheap' prescription drugs." Government-run healthcare systems have resulted in "long waiting lists to see specialists, limited medical technology and delays in getting surgery and access to new lifesaving pharmaceuticals."[2]

Despite this evidence of the negative impact of government-run healthcare on patients and taxpayers in Canada and other countries, the calls for Medicare for All and similar nationalized healthcare plans continue unabated. This report highlights why a free market approach to healthcare reform is necessary to ensure individuals have the best care available at a cost they can afford.

History of Employer-Sponsored Health Insurance

A significant breakthrough in medical care came with the use of anesthesia during the 1840s, combined with the growing knowledge of germ theory of disease that began in the 1850s.[3] This helped lead to the discovery of penicillin in 1928 by Dr. Alexander Fleming and the development of antibiotics, which help prevent and cure patients of infectious diseases.[4]

These discoveries led to more sophisticated and expensive care and helped hospitals transition from a place where poor people would go to be treated or die, to a place where everyone could be treated and potentially cured. New treatments also led to increased expenses, which has long been a concern for hospitals across the country. Hospital facilities are expensive to maintain and must stay open, no matter how many patients may be utilizing them. Prior to

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[1] John S. Gordon, "A Short History of American Medical Insurance," *Imprimis*, September 2018, p. 1, https://imprimis.hillsdale.edu/wp-content/uploads/2018/10/Imprimis_Sept_8pgWeb.pdf.
[2] Elizabeth Wright and Gerard Cox, "Through the Looking Glass – A CAGW Special Report, Price Controls on Drugs: Hazardous to Your Health," Citizens Against Government Waste, October 30, 2000, pp. 1-2, https://www.cagw.org/sites/default/files/pdf/CAGW_2000_Price_Controls_on_Drugs.pdf.
[3] Gordon, p. 3.
[4] American Chemical Society, Royal Society of Chemistry, "Discovery and Development of Penicillin," November 19, 1999, https://www.acs.org/content/dam/acsorg/education/whatischemistry/landmarks/flemingpenicillin/the-discovery-and-development-of-penicillin-commemorative-booklet.pdf.

insurance, people used to avoid hospitals because they could come home with a huge expense that they could not afford, forcing many people to delay medical care.

Baylor Hospital in Dallas, Texas, was no different. In 1929, it was close to insolvency. Historically, churches and other charities raised money to keep hospitals afloat. Justin F. Kimbell, who was the hospital's director, decided to try something he had instituted when he was the superintendent of the Dallas Public Schools. He created the Sick Benefit Fund in 1921 to help teachers when they got seriously ill. At that time, teachers had no sick leave in addition to not being paid very well. By contributing $1.00 to the fund each month, teachers were protected and received $5.00 a day when they got seriously ill.[5]

Kimbell, knowing what the Sick Benefit Fund collected and what it paid out per month per teacher for hospitalization, decided to create the Baylor Plan, the first healthcare cooperative. He came up with a figure of 50 cents per month. That amount would provide each teacher with 21 days of hospital care, including the use of the laboratory, operating room, and anesthesia. It was very popular from the beginning, covering about 75 percent of teachers in the Dallas school district. Those that paid in helped to cover the cost for those who got sick and needed care. Soon other employees at a variety of different companies began to sign up for the Baylor Plan.[6]

After the success of the Baylor Plan, other hospitals across the country began to provide a plan that allowed subscribers their choice of which hospital they could use. This process was the model for Blue Cross, which first operated in Sacramento, California. Although called insurance, which usually was used to protect people from a large and unexpected loss, the hospitals covered all costs up to a certain limit. They were primarily designed by hospitals to provide a steady income.[7]

Insurance for physicians started at about the same time but took a different path. Doctors, represented by the American Medical Association (AMA), were generally against health insurance, fearing that it would threaten their income. The AMA lobbied in the states for their own pre-paid plans but wanted indemnity coverage where the physician was paid a certain amount. This provided the physician the ability to balance bill the patient. The AMA plans were called Blue Shield in 1946.[8]

The Blue plans began to spread across the nation and hospitals and doctors worked hard together to prevent state insurance departments from regulating the plans like regular insurance. The Internal Revenue Service (IRS) determined that the Blue companies were nonprofit charitable organizations and exempt from federal taxes (modifications were enacted by Congress

[5] Helen Jerman, "How a Baptist Educator and Businessman's Simple Plan Gave Rise to the Health Insurance Industry," *Baptist News Global*, November 16, 2020, https://baptistnews.com/article/how-a-baptist-educator-and-businessmans-simple-plan-gave-rise-to-the-health-insurance-industry/#.YPRMQsSSmUl.
[6] Ibid.
[7] Gordon, pp. 3-4.
[8] Robert Helms, "Tax Policy and the History of the Health Insurance Industry," American Enterprise Institute, February 29, 2008, p. 4, https://www.aei.org/wp-content/uploads/2011/10/healthconference-helms.pdf.

in 1986). John S. Gordon wrote that if hospital insurance had been regulated like normal insurance, the economics of modern healthcare could have ended up very differently.[9]

Private insurers, who had avoided selling health insurance believing it was too risky, saw the success of the hospital and physician pre-paid plans and started to develop their own commercial products. In order to compete, commercial insurers had to behave like the Blue plans.[10]

To help fight World War II, Congress created the War Production Board, which controlled production of war-related materials and prevented the development of "non-essential" consumer goods so that everything else would be directed to produce armaments. President Franklin D. Roosevelt created the Office of Price Administration and the National War Labor Board, which instituted rationing, price controls, and wage controls. To attract employees under a wage and price controls structure, employers began to provide fringe benefits, primarily pensions and health insurance.[11]

While car, fire, and life insurance were sold directly to the consumer, health insurance, covering groups of people rather than individuals, was provided through employers. Starting in 1913, the IRS began treating employers' offering of accident and health insurance as a nontaxable fringe benefit but with no specific ruling. It was not until 1943 that the IRS ruled that employer contributions to group health insurance were exempt from taxation. But in 1953, the IRS ruled that an employer's contribution to individual health insurance policies was taxable. A year later, Congress reversed the IRS ruling by enacting Section 106 of the Internal Revenue Code of 1954.[12]

In 2019, 68.5 percent of Americans had private health insurance, with 55.4 percent obtaining it through their employer. Medicare coverage was at 18.1 percent; Medicaid/CHIP at 19.8 percent; Military or Tricare at 2.7 percent; Department of Veterans Affairs (VA) healthcare at 2.2 percent; and the remaining 9.2 percent were uninsured.[13]

Health policy economists who believe in personalized, patient-driven healthcare where consumers have the power to pick the type of health plan they want, as opposed to government-controlled healthcare where bureaucrats and politicians decide what the masses shall be entitled to, have long argued that the tax treatment of employer-sponsored healthcare is a major cause of "economic efficiency" in the healthcare marketplace.[14]

Grace-Marie Arnett's 2002 book, *Empowering Health Care Consumers Through Tax Reform*, noted that, "tax policy subsidizes the purchase of health insurance in two ways: first, by allowing the deduction of a limited amount of medical expenses and health insurance premiums

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[9] Gordon, pp. 4-5.
[10] Ibid.
[11] Helms, pp. 6-7.
[12] Congressional Budget Office, "The Tax Treatment of Employment-Based Health Insurance," March 1994, p. 5., https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/1994_03_taxtreatmentofinsurance.pdf.
[13] Congressional Research Service, "U.S. Health Care Coverage and Spending," January 26, 2021, https://fas.org/sgp/crs/misc/IF10830.pdf.
[14] Grace Marie Arnett, *Empowering Health Care Consumers Through Tax Reform*, University of Michigan Press, 2002, p. 9.

from taxable income; and second, by excluding the value of employer-provided insurance from the employee's taxable income for the income tax and Social Security and Medicare payroll taxes. Like wages and other costs, the cost of health insurance to the employer is deductible as a business expense. The tax inclusion in the more important."[15]

Individuals who pay higher marginal tax rates receive greater tax benefits. The tax subsidy lowers the net cost of a given level of insurance, so employees often prefer to spend more dollars on costlier health insurance than on higher wages.[16]

Increased demand for insurance lowers the perceived cost of medical care for consumers, which encourages more medical care at levels above what a consumer may value, leading to increased healthcare costs, which drives up demand for more insurance to protect assets. While the tax exclusion of health insurance directly affects those with employer-sponsored plans, it indirectly affects those who purchase their own health insurance or those without insurance who end up paying more for care. This has created a situation where government officials at both the federal and state level attempt to solve the cost of healthcare by controlling prices. Thus, those who look to the free market for solutions in controlling costs and want to empower consumers that create personalized, patient-driven healthcare, believe the solution is through tax reform.[17]

Private Insurance Versus Government-Run Insurance

The Kaiser Family Foundation (KFF) has been tracking U.S. public opinion on a nationalized healthcare plan for many years. From 1998 to 2004, about 54 percent opposed a national healthcare plan. That changed in 2016 when 50 percent of those surveyed supported national health insurance and that opinion has remained above 50 percent until late in 2020. KFF admitted that it "remains unclear how this issue will play out in the 2020 election and beyond."[18]

Those who have supported national health insurance have encouraged its adoption since the beginning of the twentieth century. Political leaders saw the offer of "free healthcare" as a way to advance and solidify their power. Mandatory healthcare became an issue just before World War I and was led by the Progressive Party. But it was crowded out by the war and a vibrant economy in the 1920s. Calls for national health insurance rose again during the Great Depression and President Harry Truman made it part of his 1948 campaign. But the fear of socialized medicine and communism caused the effort to die.[19]

The most popular proposal for government-run health insurance is Medicare for All, a term first associated with Sen. Jacob Javits (R-N.Y.). The headline for an April 15, 1970, *New York Times* article described his national health plan as, "Medicare for All is Being Asked for by

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[15] Ibid., pp. 10-11.
[16] Ibid., p. 11.
[17] Ibid., pp. 17-19.
[18] Kaiser Family Foundation (KFF), "Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage," October 16, 2020, https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage.
[19] Arnett, p. xxvii.

Javits."[20] In 1971, Sen. Ted Kennedy (D-Mass.) introduced the Health Security Act, a single-payer government-run healthcare plan that was supposed to be paid for through payroll taxes. Neither plan gained traction in the Senate.

The current version of Medicare for All, H.R. 1976, is sponsored by Rep. Pramila Jayapal (D-Wash.), with 117 cosponsors. This legislation would establish a national health insurance program administered by the Department of Health and Human Services (HHS) to cover all U.S. residents, with automatic enrollment upon birth or residency in the country, and provide items and services that are deemed medically necessary or appropriate to maintain health or to diagnose, treat, or rehabilitate a medical condition, including hospital services, prescription drugs, mental health and substance abuse treatment, dental and vision services, and long-term care.[21]

The concept of Medicare for All sounds good to many people, until they learn more about how it would function. Pacific Research Institute President Sally Pipes wrote in a March 2019 column that most people do not realize what is in Medicare for All, which helps to explain why 56 percent of Americans surveyed in the January 2019 KFF poll favored such a plan. When they were told it eliminated private health insurance, support dropped to 37 percent. The only private insurance that would remain is for coverage of benefits that are not provided in Medicare for All, like plastic or laser eye surgery.[22]

Support for government-run healthcare is likely to drop even further due to the government's response to COVID-19. A May 13, 2021 *USA Today* article described a survey conducted in February and March 2021 by the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health (Chan School), which found public confidence in the nation's public healthcare system declined from 43 percent in 2009 to 34 percent in 2021. The Centers for Disease Control and Prevention saw its positive ratings decline from 59 percent in 2009 to 54 percent in 2021. *USA Today* reported, "Health experts say distrust and the politicization of public health measures contributed to Americans' negative view of health institutions."[23]

The survey found that 37 percent reported having "a great deal" or "quite a lot of trust" in the National Institutes of Health. The Food and Drug Administration was also at 37 percent, and HHS was at 33 percent. The co-director of the survey, Chan School Professor of Health Policy and Political Analysis Robert Blendon, Ph.D., said, "When it comes to trust with health

[20] "Medicare for All Is Asked for by Javits," *The New York Times*, April 15, 1970, p. 18, https://www.nytimes.com/1970/04/15/archives/medicare-for-all-is-asked-by-javits.html?searchResultPosition=1.
[21] Medicare for All Act of 2021, H.R. 1976, 117th Congress (2021), https://www.congress.gov/bill/117th-congress/house-bill/1976.
[22] Sally Pipes and Thomas Smith, "Guest Opinion: Americans Like Medicare for All – Until They Realize What's In It," *Deseret News*, March 6, 2019, https://www.deseret.com/2019/3/6/20667639/guest-opinion-americans-like-medicare-for-all-until-they-realize-what-s-in-it.
[23] Adrianna Rodriguez, "Many Americans Don't Trust Their Public Health System During the COVID-19 Pandemic, Survey Shows," *USA Today*, May 13, 2012, https://www.usatoday.com/story/news/health/2021/05/13/cdc-fda-american-opinion-public-health-system-suffers-amid-covid/5054439001.

information, which is the heart of what public health is about, they're much more likely to trust clinical physicians and nurses than public health institutions and agencies."[24]

Supporters of the Medicare for All bill are pushing House Speaker Nancy Pelosi (D-Calif.) for a vote.[25] So far, she has resisted. No doubt Speaker Pelosi has not forgotten what happened when the Democrats passed, and President Obama signed into law, the Patient Protection and Affordable Care Act (ACA) in March 2010 without any Republican support. The Republicans won 63 seats and retook the House majority in November 2010.

Whether the Democrats can move forward with Medicare for All, or President Biden's equally damaging "public option" plan that would be added to the ACA is anyone's guess, based on the slim margins in Congress. However, it is highly likely that whatever the Democratic majority in Congress does will not be to give consumers a healthcare system that is more personalized; provides more choices; allows more control over the type of coverage they want; does not require new taxes; and returns regulatory oversight to the states.

More Government Interference in Healthcare is Not the Answer

The first significant government-run healthcare plans were created in 1965, when Medicare and Medicaid were signed into law. These programs for the elderly and the poor were the foot in the door for nationalized health insurance. One of the many issues with these programs has been inaccurate cost projections. For example, the House Ways and Means Committee predicted that the cost for Medicare would be $9 billion by 1990; its actual cost was $67 billion.[26] While the 2021 Medicare Trustees' report has not yet been released, the 2018, 2019, and 2020 reports all stated that Medicare would become insolvent and be unable to cover its full payment obligations in 2026.[27] The 2021 report may be delayed to the latest release date in the year ever, perhaps because it will reflect the additional costs of the COVID-19 pandemic and may show an earlier date for insolvency. And proponents of Medicare for All never mention the program's precarious and ominous financial status.

Signing the ACA into law in March 2010 became the next giant leap after Medicare and Medicaid in getting Washington, D.C. bureaucrats and politicians further enmeshed into everyone's healthcare. It was supposed to reform health insurance, lower premiums by as much as $2,500 per family per year and reduce the number of uninsured. But health costs went up, not down.[28]

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[24] Ibid.
[25] Caitlin McFall, "Progressives Pressure AOC, other Dems to Force Pelosi's Hand on Medicare for All Vote," *Fox News*, December 31, 2020, https://www.foxnews.com/politics/progressives-aoc-dems-pelosis-medicare-for-all.
[26] *The Washington Time*s, "U.S. Health Plans Have History of Cost Overruns," November 18, 2009. https://www.washingtontimes.com/news/2009/nov/18/health-programs-have-history-of-cost-overruns.
[27] Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds, "2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds," April 22, 2020, p. 6, https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.
[28] J.B. Wogan, *Poltifact*, The Poynter Institute, August 31, 2012, https://www.politifact.com/truth-o-meter/promises/obameter/promise/521/cut-cost-typical-familys-health-insurance-premium-/.

Government-Run Healthcare Will Harm Patients and Eliminate Consumer Choice

Obamacare began operating in 2014 and since 2016, enrollment in Obamacare marketplaces has been steady at just under 11 million annually.[29] There was an increase of about 2 million enrollees in 2021, likely due to the American Rescue Plan Act of 2021 (ARPA), which provided additional subsidies.[30] However, these expanded subsidies only last two years unless Congress makes them permanent. And these increased subsidies go directly to the insurer, not the individual, so there is no incentive to lower costs. [31]

The greatest increase in insuring individuals under the ACA came from Medicaid expansion, under which states receive a 90 percent federal matching rate, as opposed to the minimum rate of 50 percent for the original Medicaid. The insured now include newly eligible adults for the program, the abled-bodied poor. Currently, 38 states and the District of Columbia have adopted expansion, while 12 states have not.[32]

According to Brian Blase, CEO of Blase Policy Strategies, and Aaron Yelowitz, professor of economics at the University of Kentucky, enrollment in Medicaid expansion was much higher than expected and many enrolled have incomes above the program's eligibility threshold. Not surprisingly, they found that states have a significant incentive to participate due to the larger federal match rate "to classify individuals – both those already eligible for Medicaid under previous criteria and those formerly ineligible for Medicaid – as newly eligible. Additionally, healthcare interest groups in the states, such as hospitals and insurers offering Medicaid managed care, generally benefit from maximizing Medicaid enrollment, particularly at the elevated rate. Insurers, in particular, have reaped large profits from the Medicaid expansion – profitability that may be driven by receiving large monthly payments from the government for people who use little, if any, healthcare services."[33] Taxpayers pay for these increased costs, and even with the larger federal reimbursement, states have seen their Medicaid budgets soar.

American Legislative Exchange Council Executive Vice President Jonathan Williams and Research Manager Thomas Savidge wrote in a July 10, 2020, policy paper, "The Impact of Medicaid Expansion on State Budgets," that "Many states that have expanded Medicaid under the Affordable Care Act (ACA), or 'Obamacare,' have experienced unforeseen cost increases due to unexpected enrollment increases, as well as higher per person costs." They noted that the Kansas Policy Institute found that states that expanded Medicaid under the ACA had twice as many abled-bodied adults participate than anticipated; Medicaid costs exceeded per person original estimates by 76 percent, and the higher per-person costs and enrollment led to cost

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[29] Assistant Secretary for Planning and Evaluation (ASPE), Office of Health Policy, "Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates, June 5, 2021,https://aspe.hhs.gov/system/files/pdf/265671/ASPE%20Issue%20Brief-ACA-Related%20Coverage%20by%20State.pdf.

[30] HHS Press Office, "Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline," Health Care Sign Ups Surpass 2 Million During 2021 Special Enrollment Period Ahead of Aug. 15 Deadline," https://www.hhs.gov/about/news/2021/07/14/health-care-sign-ups-surpass-2-million-during-2021-special-enrollment-period-ahead-of-aug-15-deadline.html.

[31] Elizabeth Wright, "Biden's Budget Busting Boondoggle," *The WasteWatcher*, February 25, 2021, https://www.cagw.org/thewastewatcher/bidens-budget-busting-boondoggle.

[32] KFF, "Status of State Action on the Medicaid Expansion Decision," July 9, 2021, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

[33] Brian Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center, November 2019, pp. 3-4, https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v2_2.pdf.

overruns of 157 percent. In addition, Medicaid is consuming larger portions of states' revenues, crowding out other services like public safety, education, and infrastructure.[34]

The Biden administration and congressional Democrats hope the remaining 12 states that have not yet expanded Medicaid will do so by taking advantage of the additional 5 percent to their traditional Medicaid match rate for two years that is provided by ARPA. If the states should take up the offer, it would cost an additional $16.4 billion over two years in federal funds and an estimated $6.8 billion in state funds. This would be in addition to the 6.2 percentage point increase in the match rate that was provided under the Families First Coronavirus Response Act, which will be in place at least until March 2022.[35]

But the 12 states, one of which is Wisconsin, may not be so easily seduced. An April 20, 2021, MacIver Institute policy paper, "Why Medicaid Expansion Is Still A Bad Deal and A Bad Idea," noted that former Wisconsin Governor Scott Walker (R) obtained a federal waiver that already allows the Medicaid expansion population to obtain private insurance through the state's ACA exchange at a much lower cost. The paper noted that the federal government's $28.7 trillion debt makes it unlikely it will keep its promise to provide continued funding; COVID-19-related legislation provides sufficient funding to avoid the need for more federal Medicaid reimbursement; there is no waiting list in Wisconsin, unlike other states; and expansion has not improved patient outcomes, saved money, or improved access.[36]

While Wisconsin Gov. Tony Evers (D) included Medicaid expansion in his 2019-2021 budget, the Wisconsin legislature rejected the proposal "over concerns that accepting the temporary enhanced federal reimbursement rate would put Wisconsin taxpayers on the hook for a large spending increase in the future."[37]

Legislators in other states should take heed. During the fiscal year (FY) 2012 budget negotiations, former President Obama offered to cut the Medicaid expansion rate. When he was chairman of the House Budget Committee, former House Speaker Paul Ryan (R-Wisc.) said that "The fastest thing that's going to go when we're cutting spending in Washington is a 100 or 90 percent match rate for Medicaid … It doesn't matter if Republicans are running Congress or Democrats are running Congress. There's no way we're going to keep those match rates like that."[38] With a national debt now at $28.7 trillion and a spendthrift President and Congress, that day may not be too far off.

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[34] Jonathan Williams and Thomas Savidge, "The Impact of Medicaid Expansion on State Budgets," American Legislative Exchange Council, July 10, 2020, https://www.alec.org/article/the-impact-of-medicaid-expansion-on-state-budgets.
[35] Robin Rudowitz, Bradley Corallo, and Rachel Garfield, "New Incentive for States to Adopt the ACA Medicaid Expansion: Implications for State Spending," KFF, March 17, 2021, https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending.
[36] Lexi Dittrich, "Why Medicaid Expansion is Still a Bad Deal and a Bad Idea," MacIver Institute, April 20, 2021, https://www.maciverinstitute.com/2021/04/why-medicaid-expansion-is-still-a-bad-deal-and-a-bad-idea.
[37] Ibid.
[38] Rick Pearson, "Rep. Paul Ryan Warns Governors on Obama Health Care Plan," *Chicago Tribune*, April 22, 2013, https://www.chicagotribune.com/politics/ct-xpm-2013-04-22-chi-rep-paul-ryan-warns-governors-on-obama-health-care-plan-20130422-story.html.

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Putting Patients and Doctors in Charge, Not the Government

The Health Policy Consensus Group, facilitated by the Galen Institute, is composed of healthcare policy analysts who provide recommendations and analysis on numerous healthcare policy issues. The group has worked together for more than 15 years and includes free market-based think tank experts, taxpayer advocates, academics, and former legislative and executive branch staff. The group meets regularly, discusses ongoing congressional and executive branch activities, formulates new policies, and provides solutions to healthcare problems by using free-market principles.[39]

In the fall of 2020, the Consensus Group released, "Health Care Choices 2020: A Vision for the Future."[40] The proposal was scored in October 2020 by American Action Forum, headed by former Congressional Budget Office Director Douglas Holtz-Eakin, which demonstrated the plan would decrease the cost of premiums in the private individual health insurance market, with Silver Plans seeing the greatest reduction of 18 to 24 percent, and would decrease federal spending by $36 billion from 2022 to 2030.[41] The proposal offers a variety of policies that aim to equalize the tax disparity currently found between people who get their insurance from their employer and those who do not. It expands the use of private care, not government-run care.

Policies include:

- Encouraging the continued use of Health Reimbursement Arrangements (HRA) to allow people to keep their private healthcare coverage and physicians when they change or lose their jobs. This would be accomplished by Congress codifying the Trump administration's HRA rule that allows employers to offer and employees to use tax-free dollars to buy the type of health insurance they want. That way, the plan travels with them.[42] In addition, low-income people could use the value of existing government coverage to enroll in private plans, including employer-sponsored coverage.

- Expanding the use of Health Savings Accounts (HSAs) to allow more Americans partake in managing their healthcare dollars to pay for medical expenses and save for future health expenses by eliminating the rules that bar them. HSAs help to make healthcare expenditures more transparent because patients shop for the best deal on routine expenses. HSAs are valuable tools in driving down costs and more than 22 million Americans already utilize them.

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[39] The Galen Institute, Health Policy Consensus Group, https://galen.org/projects/consensus-group.
[40] Health Policy Consensus Group, "Health Care Choices 20/20: A Vision for the Future," November 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/11/HealthCareChoices2020_Proposal.pdf.
[41] Douglas Holtz-Eakin and Christopher Holt, "Research: The Health Care Choices Proposal," American Action Forum, October 22, 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf.
[42] U.S. Department of Treasury Internal Revenue Service, U.S. Department of Labor Employee Benefits Security Administration, and the U.S. Department of Health and Human Services, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans Final Rule," *The Federal Register,* Vol. 84, No. 119, Fed. Reg. Page 28888, June 20,2019, https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

- Building on the success of the Trump administration use of ACA's Section 1332 State Innovation Waivers that allows states to redirect ACA funds to improve healthcare options for high-cost patients by creating high-risk pools, "invisible risk pools," reinsurance, or other risk adjustment arrangements that provides specialized care for people with chronic illnesses and other pre-existing conditions. Several states adopted these measures and have seen significant decreases in ACA plan premiums, which helps all patients while protecting those with chronic illnesses.[43]

- Providing regulatory relief to the states with formula grants. Instead of sending money directly to insurance companies and imposing the Ten Essential Benefits that force people to obtain insurance they do not need, like a single man having maternity care, the proposal would substitute the funding for Medicaid Expansion and the ACA health insurance premium subsidies and tax credits for formula grants. At least 50 percent of the formula grant would go toward individuals' purchase of private insurance that better fits their needs and 50 percent to low-income people, so they did not have to enroll in a government program assigned to them and instead direct the funding to their choice of private coverage.

- Allowing more regulatory flexibility for the states to reform their health insurance markets and enable the creation of more health insurance choices like codifying the Trump administrations rules on short-term/limited duration insurance policies.[44]

- Providing an alternative to the No Surprise Act (NSA), which was signed into law in late 2020 and addresses surprise billing.[45] Many members of the Health Policy Consensus Group, including CAGW, believe it is a flawed law and Congress will have to reconsider making changes. The NSA, set to be implemented in 2022, utilizes price controls, which will hurt patient access to providers, especially in rural areas. The first set of rules have been promulgated and sent to the Office of Management and Budget for review and more will be forthcoming that will exacerbate the problems inherent to the legislation.[46] The Health Care Choices Plan offers a better

[43] Elizabeth Wright, "How Did Maryland Drop Their Individual Insurance Premiums by 22 Percent?" *The WasteWatcher*, September 27, 2019, https://www.cagw.org/thewastewatcher/how-did-maryland-drop-their-individual-insurance-premiums-22-percent.
[44] HHS News Release: "Trump Administration Delivers on Promise of More Affordable Health Insurance Options," August 1, 2018, https://www.cms.gov/newsroom/press-releases/hhs-news-release-trump-administration-delivers-promise-more-affordable-health-insurance-options.
[45] KFF, "Surprise Medical Bills: New Protections for Consumers Take Effect in 2022," February 4, 2021, https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022.
[46] *The National Law Review*, "Biden Administration Release Part 1 of its Regulations Targeting Surprise Billing," July 7, 2021, https://www.natlawreview.com/article/biden-administration-release-part-1-its-regulations-targeting-surprise-billing.

approach by promoting transparency and truth in advertising that would compel providers and insurers to reach a negotiated price regarding out-of-network treatment without relying on heavy-handed government intervention.[47]

- Making telemedicine regulatory relief permanent and expanding this healthcare delivery system. The value of telemedicine became very clear during the COVID-19 pandemic. The Trump administration and many states dropped the regulatory barriers to telehealth, which enabled patients to limit exposure to COVID-19 as virtual doctor visits increased exponentially. The proposal would have Congress and the states make the regulatory changes permanent, which has also been recommended by other groups.[48] Congress has not acted yet, but many states are moving forward in keeping current flexibilities in place that includes cross-state licensing and payment parity to encourage this new type of healthcare delivery.

- Lowering federal and state barriers that stifle innovation and competition. There are too many burdensome government mandates, like certificate of need laws, that prevent competition, and rules that prevent many providers from practicing at the top of their training and education. The proposal calls for lifting these barriers to encourage competition, lower prices, and increase better quality of care.

Healthcare at a Crossroad

The American healthcare system is at an important inflection point. Calls for a single-payer system like Medicare for All are growing louder, but Americans remain concerned and skeptical over government-run healthcare, especially due to the bungling of the COVID-19 pandemic. Reforms should be bipartisan and not move the country further toward the socialized medicine that has been a disaster in other countries. But S. Con. Res. 14, the Concurrent Budget Resolution on the budget for FY 2022, which was approved on a partisan vote by Democrats in the House and Senate, would allow the committees with jurisdiction over Medicare to lower the age for eligibility and add benefits for hearing, vision, and dental care, which moves the country much closer to full government-run healthcare.[49]

These provisions in the budget resolution ignore other constructive proposals to reform the healthcare system, which should be part of any serious debate. In 2019, the Republican Study Committee (RSC) released, "The RSC Health Care Plan: A Framework for Personalized, Affordable, Care," which adopts many of the same policies found in the Health Care Choices

[47] Doug Badger and Brian Blase, "A Targeted Approach to Surprise Medical Billing," *American Healthcare Choices*, December 6, 2019, https://americanhealthcarechoices.org/need-reform/a-targeted-approach-to-surprise-medical-billing.
[48] Frances Floresca, "Access to Telemedicine Should Be Made Permanent," *The WasteWatcher*, June 28, 2021, https://www.cagw.org/thewastewatcher/access-telemedicine-should-be-permanent.
[49] Concurrent Resolution on the Budget for Fiscal Year 2022, S. Con. Res.14, 117th Congress (2021), https://www.congress.gov/bill/117th-congress/senate-concurrent-resolution/14/text.

Plan. It would protect vulnerable Americans, like those with pre-existing conditions, while offering policies that would provide tax benefit equity, empower individuals through HSAs, reduce mandates, and repackage ACA dollars for state flexibility grants to subsidize private health insurance for low-income adults.[50]

It will be up to the American people to decide what they want. The choice is between more government control and oversight, where bureaucrats and politicians make the final decision on what kind and level of care patients receive, or adopting the provisions found in the Health Care Choices Plan or the RSC plan that would empower individuals to choose the kind of healthcare plan they want and put themselves and their doctors in charge.

[50] Republican Study Committee, "A Framework for Personalized, Affordable Care," October 22, 2019, https://rsc-banks.house.gov/sites/republicanstudycommittee.house.gov/files/FINAL%20RSC%20Health%20Care%20Report.pdf.