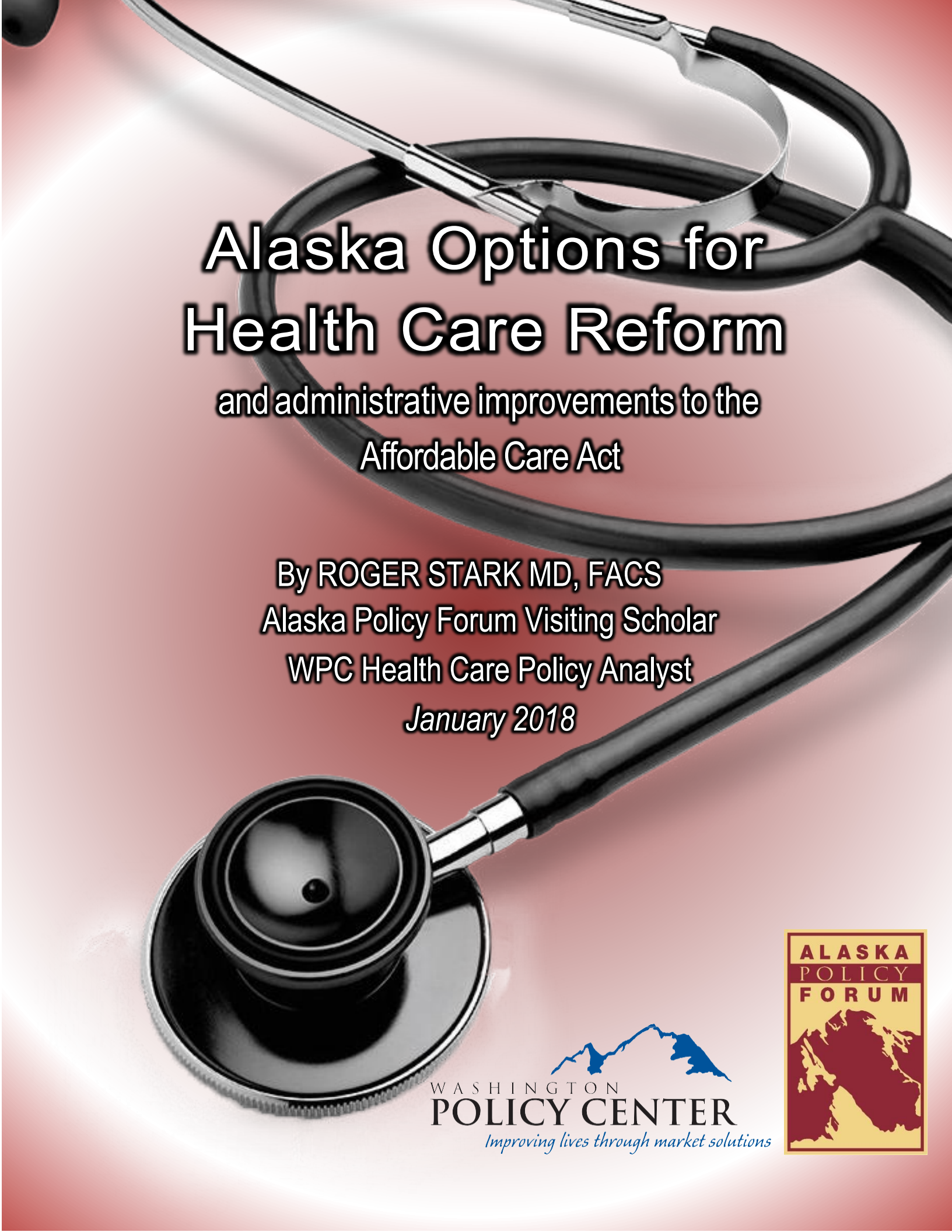

Alaska Options for Health Care Reform

and administrative improvements to the Affordable Care Act

By ROGER STARK MD, FACS
Alaska Policy Forum Visiting Scholar
WPC Health Care Policy Analyst

January 2018

WASHINGTON POLICY CENTER
Improving lives through market solutions

ALASKA POLICY FORUM

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Our vision is an Alaska that continuously grows prosperity by maximizing individual opportunities and freedom.

MISSION

Our mission is to empower and educate Alaskans and policymakers by promoting policies that grow freedom for all.

BACKGROUND

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Nothing appearing in this document is to be construed as an attempt to aid or hinder the passage of any bill before any legislative body.

Policy Brief

Alaska Options for Health Care Reform and administrative improvements to the Affordable Care Act

By Roger Stark, MD, FACS

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and WPC Health Care Policy Analyst

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Key Findings

1. The Affordable Care Act (ACA), also known as Obamacare, has not come close to reaching its supporter's promises of providing universal health insurance coverage and decreasing ever-rising health care costs.
2. Because legal specifics were not defined in the normal Conference Committee process, the law gives the Administration and the Secretary of the Department of Health and Human Services (HHS) sweeping control over the implementation and the oversight of the ACA. The law states vaguely that the "Secretary shall…" over 1,400 times.
3. The U.S. House passed a health care reform bill in May 2017. Leadership stated this was the first of three phases.
4. Phase two is to be administrative changes to the ACA that the HHS Secretary can unilaterally accomplish. Phase three would hopefully be bipartisan, long-term solutions for the country's health care system problems that Congress would pass.
5. The ACA contains two broad areas that are open to administrative improvements. These are Section 1332 state waivers and Section 1115A Medicaid waivers.
6. The Administration also has the ability to withdraw the cost-reduction subsidies in the health insurance exchanges, expand the use of "hardship" cases to allow more people an opt-out of the individual mandate, increase the time period of short-term limited-duration insurance, and potentially increase the use of catastrophic health insurance plans.
7. If Congress is unwilling to reform the health care system, the executive branch should step up and use the administrative authority provided by Congress to achieve meaningful reform.
8. In addition to administrative changes to the ACA, Alaska can enact its own health care reform, regardless of federal actions.

Policy Brief

Alaska Options for Health Care Reform and administrative improvements to the Affordable Care Act

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"We have to pass the bill so you can find out what is in it."
-Nancy Pelosi (D-CA) Former Speaker of the House of Representatives [1]

"I've got a pen and a phone – and I can use that pen to sign executive orders and take executive actions [without Congress]."
-Former President Barack Obama [2]

Introduction

The controversial Affordable Care Act (ACA), also known as Obamacare, has helped some people. The tragedy is that it has not come close to reaching its supporter's promised goal of providing universal health insurance coverage and decreasing ever-rising health care costs. The complex law has not improved health care quality and has not provided patients with more health care choices. It has, unfortunately, forced millions of people to lose coverage they liked, and to seek new health insurance while imposing a huge financial and regulatory burden on the vast majority of Americans.[3]

The ACA has only insured 20 million of the 50 million people who were without health insurance when it became law. Nationally, half of these newly insured were forced into the substandard Medicaid entitlement program. In Alaska, 74 percent of the newly insured found themselves pushed into Medicaid.

Obamacare has raised insurance premiums for virtually everyone in the country outside of the free Medicaid entitlement. Health care spending was 17 percent of the economy when the ACA became law. By 2021, with the ACA in place, estimates show that the country will spend 21 percent of the annual economy on health care.

The ACA has limited patients' insurance options, has generated over 20,000 pages of new federal regulations, has not improved health quality, and has not decreased waste, fraud, and abuse in the medical system.

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1 March 9, 2010, National Association of Counties meeting, Washington, D.C., at https://www.youtube.com/watch?v=hV-05TLiiLU.

2 January 14, 2014, White House press conference, Washington, D.C., at https://www.youtube.com/watch?v=N_skPgxH178.

3 "Update on the status of the Affordable Care Act," by Roger Stark, MD, Policy Brief, Washington Policy Center, December, 2016, at http://www.washingtonpolicy.org/library/doclib/PB-Affordable-Care-Act.pdf.

"Lack of transparency is a huge political advantage. And basically, call it the stupidity of the American voter or whatever, but basically that was really, really critical to get the thing [ACA] passed…"

- Jonathan Gruber, Architect of the Affordable Care Act [4]

Background

In 2009, the United States was recovering from the worst recession since the Great Depression. The American public was overwhelmingly concerned about jobs and the economy.[5] However, the Democratic Congress and the newly-elected Democratic president forced through health care reform legislation with the U.S. House passing its bill that summer and the U.S. Senate taking an 11th hour vote on its bill on Christmas Eve. No Republican voted for either bill.

In a normal legislative process, both bills (which were considerably different) would have gone to a special Conference Committee. Members of both houses would then have negotiated a single piece of compromise legislation that would go back to both houses for approval and, if passed, be sent to the president.

Instead, in early 2010, Massachusetts held a special election to fill the seat of Senator Ted Kennedy (D-MA) who had recently died. Voters elected Scott Brown (R-MA) and the Democrats lost their super-majority of 60 votes in the U.S. Senate. A Conference Committee health care bill would then not pass in the Senate. Consequently, the U.S. House simply adopted the Senate health care reform bill and the country was stuck with the deeply flawed Patient Protection and Affordable Care Act (ACA).[6]

The ACA as signed into law was therefore never intended to be the definitive health care reform legislation. It is a very complex, 2,700-page law that in many places is vague and non-specific. Never in the history of the United States has such a broad piece of social legislation become law with only one party's support.

Because legal specifics were not defined in the normal Conference Committee process, the law gives the Administration and the Secretary of the Department of Health and Human Services (HHS) sweeping control over the implementation and the oversight of the ACA. The law states vaguely that the "Secretary shall…" over 1,400 times.[7]

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4 October, 2013, Health care panel discussion, University of Pennsylvania, at https://www.youtube.com/watch?v=G790p0LcgbI.

5 "Economy, jobs trump all other policy priorities in 2009," Pew Research Center, January 22, 2009, at http://www.people-press.org/2009/01/22/economy-jobs-trump-all-other-policy-priorities-in-2009/.

6 "The Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, March 23, 2010, at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

7 "Here's what the White House can do to dismantle Obamacare even if Congress doesn't go along," by Bertha Coombs, CNBC, March 17, 2017, at https://www.cnbc.com/2017/03/17/heres-what-hhss-tom-price-can-do-to-dismantle-obamcare.html?view=story&%24DEVICE%24=native-android-mobile.

Voters change party control of Congress and the Presidency

In 2016, in part due to the unpopularity of the ACA, voters gave Republicans control of the presidency and both houses of Congress. The U.S. House passed a partial repeal of the ACA and a health care reform bill in May, 2017.[8] Leadership stated this was the first of three phases.[9] Phase two is to be executive-order changes to the ACA that the Trump Administration can make on their own. Phase three would hopefully be bipartisan, long-term solutions for the country's health care system problems.

Phase two involves changes in the ACA according to the 1,400 "Secretary shall…" provisions and potential Administrative alterations that Democrats wrote into the original law. With Congress being slow to pass its own health care reform legislation, Phase Two takes on more importance.

This Policy Brief outlines changes that state officials can make on their own, without federal input. It also analyzes potential federal administrative changes and recommends patient-oriented solutions that are possible within the context of the existing law.

The 1,400 "Secretary shall" provisions

The specific measures directing the Secretary to take administrative action can be grouped a number of different ways. Many of them deal with the implementation of the ACA and were taken between 2010 when the bill became law and 2014 when the actual benefits began. These measures were handled by Secretary Sebelius and Secretary Burwell, both appointed by President Obama. Because of the vagueness of the wording of the law, these Secretaries and HHS federal career staff shouldered a great deal of the responsibility for the implementation of the ACA.

The current Secretary of HHS, appointed by President Trump, now has responsibility for the oversight of the ACA. The law contains hundreds of Secretary-directives that require the Secretary to insure the smooth running of the ACA. The overwhelming majority of these measures are very specific and allow virtually no leeway in changing the law.

The ACA does contain two broad areas that are open to Administrative interpretation. These are Section 1332 state waivers and Section 1115A Medicaid waivers. Under these two sections, the current Administration can make significant changes in the implementation of the ACA without action by Congress.

8 "H.R. 162a8 – American Health Care Act of 2017," 115th Congress, CONGRESS.GOV, at https://www.congress.gov/bill/115th-congress/house-bill/1628.

9 "The three phases of repeal and replace," Speaker Paul Ryan press release, March 7, 2017, at https://www.speaker.gov/general/three-phases-repeal-and-replace.

Section 1332 state waivers [10]

The current administration has encouraged states to apply for 1332 waivers, which give states flexibility in innovating state designs.[11] It believes these waivers can relieve states of the most harmful effects of the ACA, including the onerous premium price increases and the regulatory burden. The law states that "the Secretary shall determine the scope of a waiver" . . . "within the limits of the authority of the Secretary."

States can file for a 1332 waiver after January 1, 2017 and HHS has six months in which to approve or disapprove them. Waivers last for five years, but can be renewed. Waiver requirements for state plans are that they must:

- Remain cost neutral overall.
- Not add to the federal deficit.
- Provide for public input.
- Offer health insurance at least as comprehensive as the exchanges.
- Offer plans that cost the same as exchange plans.
- Provide health insurance for the same number of people as the ACA.
- A state legislature must pass a law to request the waiver.

According to the ACA, the "Secretary shall determine" the amount of money each state receives based on the amount the state would have received in federal subsidies through the health insurance exchange. States are able to opt-out of the waiver even after the waiver is approved.

As of July 31, 2017, 22 states have considered 1332 waiver legislation.[12] Alaska and Hawaii have had waivers approved by the HHS Secretary. Four other states have completed the 1332 waiver application process to date.[13] Minnesota and Iowa have plans under review. California withdrew its application and Vermont's application is currently on hold.

Hawaii's waiver was approved during the Obama Administration. It aligns the ACA with a 1974 state law that requires employers to offer more generous health insurance than required in the federal law. Alaska's waiver will establish a state reinsurance pool. Minnesota and Iowa are

10 "The Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, pages 85-86, Marc 23, 2010, at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

11 "Secretary Price statement on release of state innovation waiver checklist," U.S. Department of Health and Human Services Press Office, HHS.gov, May 16, 2017, at https://www.hhs.gov/about/news/2017/05/16/state-innovation-waiver-checklist-release.html.

12 "State roles using 1332 waivers," by Richard Cauchi, National Conference of State Legislatures, July 20, 2017, at http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx.

13 "Section 1332 state innovation waivers: current status and potential changes," by Jennifer Tolbert and Karen Pollitz, The Kaiser Family Foundation, July 6, 2017, at http://www.kff.org/health-reform/issue-brief/section-1332-state-innovation-waivers-current-status-and-potential-changes/. Update: Iowa withdrew its 1332 waiver request on October 23, 2017.

requesting waivers to establish state high-risk pools. In addition, Iowa asked for a change in its health care exchange so it can offer only one basic insurance plan and the state is seeking a change in subsidy consideration so subsidies are based on age as well as income.

California withdrew its request. Its waiver would have allowed undocumented immigrants to purchase health insurance on the exchange without subsidies. Employers in Vermont have been able to offer employee health insurance without using a State Health Option Plan (SHOP) portal as allowed in the ACA. Although it is officially on hold, the Vermont waiver currently allows the state to continue this practice.

Seven states have passed legislation to investigate 1332 waivers. This is not binding legislation and does not mean these states will necessarily apply for a waiver. Nine state legislatures considered 1332 waiver bills, but did not pass legislation.

Because of ever-increasing health insurance premium prices and the decreasing number of participating insurance companies, more states will undoubtedly apply for 1332 waivers. HHS has encouraged innovation and flexibility in waiver requests and the Department says it is prepared to be flexible in the acceptance process.

Potential revisions of the ACA using 1332 waivers include a redefinition of the "essential" health benefits the federal government requires in every insurance plan, expanded access to health savings accounts and high deductible insurance plans, ending the premium tax credit, and a greater use of state-based high-risk pools for high-cost patients.

1115A waivers

The Medicaid entitlement program began in 1965 as a government health insurance safety-net for children of low-income families and the disabled. It has grown into one of the largest insurance plans in the world and is one of the largest budget items for the federal and state governments.[14] Last year, total spending on Medicaid was $545 billion and is projected to increase to $700 billion by 2020. Although some individuals have successfully accessed health care through Medicaid, independent research shows that, in general, having Medicaid health insurance provides patients with no better medical outcomes than being uninsured.

The federal government has allowed states to obtain Medicaid waivers since the beginning of the program. These waivers must follow strict guidelines, must be budget neutral, and are subject to federal oversight. In the past 50 years, the federal government has granted over 500 Medicaid waivers nationally. Alaska has four approved 1915c waivers but no 1115A waivers.[15]

14 "Medicare and Medicaid at fifty," by Roger Stark, MD, Policy Note, Washington Policy Center, September, 2015, at http://www.washingtonpolicy.org/library/doclib/Stark-Medicare-and-Medicaid- at-50.pdf.

15 "State waiver list," federal Medicaid entitlement program, Medicaid.gov, August, 2017, at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

The ACA expanded Medicaid to any able-bodied person 18 years of age to 64 years of age who earns less than 138 percent of the federal poverty level, or about $16,000 per year. The ACA also expanded the use of 1115 Medicaid waivers by providing billions of federal taxpayer dollars for innovative, pilot projects. In order to be approved, these plans must reduce costs and improve health quality in the Medicaid program for the state making the application.[16]

Submission of waivers is an ongoing process, but as of January 2018, 35 states have had 43 ACA-Medicaid waivers approved.[17] The waivers have differences, but fall into five broad categories:

- Delivery system changes (most of these go from a fee-for-service model to a managed-care or health maintenance organization model.)
- Modifications of a state's long-term care system.
- Creative ways of expanding Medicaid or reallocating funds.
- Changes in behavioral and mental health funding.
- Other – changes specific to individual aspects of the Medicaid program.

In 2016, the Alaska state legislature passed Senate Bill 74. Among other things, this bill directed state officials to submit a 1115A waiver application to the federal government for development of a "data-driven, integrated behavioral health system."[18] This waiver application recently completed the public testimony phase but has yet to be submitted as of January 2018.

Alaska could potentially use 1115A waivers to prioritize the use of Medicaid dollars to the truly needy and disabled, impose a work or community service requirement where applicable, charge a small premium, require drug tests and/or monthly income verification and eligibility, incentivize healthy behaviors, replace the current matching grant with a capped grant, and ultimately limit how long a person can be enrolled. Combining 1332 and 1115 waivers would also open up possibilities for broad-based health care reform at the state level.

Cost-sharing reduction subsidies

The Affordable Care Act has three revenue-neutral provisions for market stabilization in the exchanges.[19] Reinsurance and risk corridors began in 2014, ran for three years, and, by law, ended in 2016. Reinsurance covered high-cost people and was paid for by an excise tax on all insurance premiums. Risk corridors limited losses and gains for insurance companies within the exchanges by having the federal government redistribute money from profitable companies to companies losing money.

16 "The Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, pages 271-277, March 23, 2010, at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

17 "Approved Section 1115 Medicaid Waivers, as of January 12, 2018," at files.kff.org/attachment/Which-States-Have-Approved-and-Pending-Section-1115-Medicaid-Waivers-Approved.

18 "State of Alaska's Medicaid Section 1115 Behavioral Health Demonstration Draft Application," November, 2017 at http://dhss.alaska.gov/HealthyAlaska/Documents/AK1115_Draft_Application-11-2017.pdf

19 "Explaining health care reform: risk adjustment, reinsurance, and risk corridors," by C. Cox, A. Semanskee, G. Claxton, and L. Levitt, The Kaiser Family Foundation, August 17, 2016, at http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and- risk-corridors/.

Risk adjustment began in 2014 and is set to continue indefinitely. Risk adjustment redistributes funds from insurance plans that have low-risk patients to plans with high-risk patients.

The ACA also provides subsidies for low-income individuals above and beyond the standard exchange subsidies.[20] These so-called cost-sharing reduction subsidies were never funded by Congress, specifically due to inaction in the U.S. House of Representatives. The Obama Administration then unilaterally instructed the Treasury Department to pay out these funds, which are renewed on a monthly basis.

The U.S. House of Representatives, led by its Republican leadership, sued the Obama Administration and won. Congressional leaders successfully argued that it was illegal for the Obama Administration to pay out money from the U.S. Treasury without authorization from Congress. The Administration appealed and the case now sits in a federal appellate court.

In October of 2017, the Trump Administration discontinued the cost-sharing reduction payments. However, Members of Congress are currently debating restarting the subsidies because of concern, or fear, of totally destabilizing the health care exchanges and individual insurance markets.

However, even with the cost-sharing reduction subsidies in place, the exchanges continue to attract a greater number of older and sicker people and comparatively fewer young and healthy individuals. The exchanges are on a downward path to financial collapse regardless of whether the federal subsidies are in place.

Essential health benefits (EHB)

The ACA states that every health insurance plan must contain ten well-defined essential health benefits.[21] These benefits were determined by bureaucrats who do not necessarily understand the needs of any specific patient. For example, an unmarried man does not need an obstetrical coverage "essential benefit," yet he is forced to pay a higher premium for it.

Like other types of insurance, health insurance should be designed to mitigate overall risk. Through the use of catastrophic health insurance plans, many, if not all, of these mandated essential health benefits could be covered at potentially a much lower premium price. An interpretation of EHBs by the HHS Secretary and development of plans by insurance companies could make this happen. Coupled with health savings accounts, these plans could satisfy the health insurance needs of many Americans at much lower costs.

20 "The Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, pages 102-106, March 23, 2010, at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

21 "The Patient Protection and Affordable Care Act," Public Law 111-148, 111th Congress, pages 45-50, March 23, 2010, at https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

Short-term, limited-duration health insurance

In December 2016 the Obama Administration issued what was thought to be the final definition and regulations regarding short-term, limited-duration health insurance.[22] These policies are designed for people between jobs or for individuals transitioning from one health insurance plan to another.

The plans do not contain all of the essential health benefits required in the ACA, but could potentially offer affordable major medical or catastrophic coverage. The Obama Administration set the limit for use of a short-term plan at three months.

The Trump Administration has extended the three-month coverage limit to one year. The Administration could extend the time duration of short- term plans indefinitely, and thereby give people more choices in the health insurance marketplace.

Navigators, Certified Application Counselors, and advertising

The ACA provides millions of dollars in grant money to hire government employees who help enrollees find the most appropriate health insurance plan within the exchanges.[23] There are several categories of helpers, including navigators and certified application counselors. All of these new government employees essentially duplicate the function of private insurance brokers and compete with them for clients.

Insurance brokers and online services have a long-standing relationship with the American public and offer real benefits to customers. In September 2017, HHS announced reduced funding for these navigators and counselors. Further reductions could be made so the government is no longer hiring employees to compete for business against its own citizens.

Like any business, health insurance companies allocate money for advertising. The ACA supplies additional money for enhanced advertising. It is always problematic when the government requires citizens to pay taxes, and then uses that money to promote itself. While HHS reduced these advertising funds in August 2017, HHS should simply discontinue this taxpayer-funded advertising.

Specific measures Alaska can implement

In addition to administrative changes the Secretary of Health and Human Services can make to the ACA, Alaska can enact its own health care reform, regardless of federal actions. Here is a list of policy options available to Alaska policymakers:

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22 "Regulations regarding short-term limited-duration insurance, excepted benefits, and lifetime/annual limits," by Danielle Capilla, United Benefit Advisors, December 27, 2016, at http://blog.ubabenefits.com/regulations-regarding-short-term-limited-duration-insurance-excepted-benefits-and-lifetime/annual-limits.

23 "What are the differences between navigators, certified application counselors, and others assisting consumers in making health insurance decisions in the ACA's health insurance marketplaces?," by Michael Meulemans, healthinsurance.org, February 18, 2016, at https://www.healthinsurance.org/faqs/what-are-the-differences-between-navigators-certified-application-counselors-and-others-assisting-consumers-in-making-health-insurance-decisions-in-the-acas-health-insurance-marketplaces/.

1. **Aggressively pursue new 1332 and 1115A waivers.**

   Under these two sections, states can request, and the current Administration can approve, significant changes in the implementation of the ACA without action by Congress.

2. **Pass state legislation to limit state contributions to the Medicaid expansion.**

   The ACA enticed states to expand Medicaid by offering federal taxpayer funds to cover 100 percent of the expansion costs for three years. By 2020, the states are required to pay 10 percent of the costs. The federal government now has a $20 trillion debt and there is a high likelihood that states will be required to pay more than 10 percent of the Medicaid expansion cost in the future. State legislatures can pass laws that limit the amount of state responsibility to 10 percent or to a fixed amount of expansion costs.

3. **Repeal Certificate of Need laws.**

   Research now shows that state Certificate of Need (CON) laws do not decrease health care costs, but that they do limit patient choices by banning investment and construction of new health care facilities. In fact, some research demonstrates that CON laws are associated with per capita higher healthcare spending.[24] With 20 health care services currently requiring a CON in Alaska, there is room for reform.

4. **Expand and promote the use of private association health plans.**

   The U.S. Department of Labor has proposed expanding access to association health plans, which allow small private groups and individuals to join together to purchase health insurance in the same way large groups do.[25] Large private group plans are regulated by the federal ERISA law and therefore avoid many of the worst features of the ACA.

5. **Cap or freeze Medicaid enrollment.**

   Medicaid, as originally intended by Congress, should be targeted to help the most vulnerable patients, while encouraging patients with the means to gain access to affordable private health insurance coverage.

6. **Eliminate or decrease waste, fraud, and abuse in the Medicaid program.**

   A high percent of Medicaid costs do not increase care or access for enrollees. The massive bureaucratic nature of the program makes it a target for cheating and financial crime.

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24 "Certificate of Need Laws Alaska State Profile,"George Mason University Mercatus Center at https://www.mercatus.org/system/files/alaska_state_profile.pdf.

25 "U.S. Department of Labor Press Release," January 4, 2018 at https://www.dol.gov/newsroom/releases/ebsa/ebsa20180104.

7. Expand and promote telemedicine.

While Alaska has made improvements to telemedicine in recent years, there are many opportunities for expansion. Telemedicine and similar online services can reduce cost and increase patient access to health care.[26] This is especially true for people living in remote areas.

8. Reduce reimbursement rates for Medicaid to those of Medicare.

Alaska is one of only two states which reimburses Medicaid at higher rates than Medicare. Alaska could submit a state plan amendment which puts all recipients of both of these government-funded health care systems on a level playing field.

9. Protect direct primary care.

For a fixed amount of money per month, patients can access primary care around the clock without the hassle and overhead of third-party payers. Direct primary care can increase access to doctors for all socio-economic groups. Alaska should protect direct primary care from state regulatory insurance laws and consider integrating it into the state's Medicaid system.

10. Encourage Price Transparency

Using third-party payers has created a system in which patients are unaware of actual health care costs, and providers have little incentive to disclose them. Alaska can encourage price transparency to create better health care consumers.

11. Implement Right to Shop for state employees

Incentivizing public employees to shop for value in health care lowers state costs and improves patient options. Incentives can vary, i.e. cash or mileage.

12. Reduce maintenance of certification requirements.

Maintenance of certification via unregulated specialty boards imposes costly fees and testing that can drive up health care costs, while doing nothing to improve care. Relaxing barriers to medical practice will increase access to health care for patients.

13. Reduce number of Medicaid Optional services

Alaska currently offers many optional Medicaid services that are not available to senior citizens on Medicare. Altering Medicaid to only cover the federal mandatory benefits would reduce costs significantly.

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26 "The Department of Veterans Affairs Health Case Study," by Christopher Wasden, August 1, 2014, at http://www.himss.org/department-veterans-affairs-mhealth-case-study?ItemNumber=30310

Policy analysis

In spite of the 20 million "newly" insured, Obamacare has been a clear policy failure. Except for the enrollees in the Medicaid entitlement program, virtually every person with health insurance in the United States has experienced a loss of choice and a significant increase in insurance premiums.

Millions have lost insurance plans they liked, lost access to their doctors, and have seen their deductibles go up. Access to health care is a growing problem, especially in the Medicaid and Medicare entitlement programs. Just having health insurance on paper is no longer a guarantee of getting necessary health care services in a timely fashion.

There is wide agreement that the health care system was dysfunctional before the ACA became law. Going back to the situation as it existed before 2010 is not a solution. Going forward, the country has two choices at this point: 1) impose more government control at an ever-increasing cost to taxpayers or 2) move toward more patient control, affordability, and choice.

Policymakers could increase government control by further expanding Medicaid, allowing non-seniors to buy into Medicare, offering a public, socialized option in the individual market and placing more regulations on the employer-paid market. With these maneuvers, a mandatory single-payer, government-run health care system, like that in Canada, could soon become a reality in the United States.

Alternatively, policymakers could move toward giving patients more control and re-establishing the private relationship between patients and doctors, while reducing government-directed interference. Congress seems unable to pass ACA reform legislation at this time. Former President Obama bypassed Congress and used administrative fiat liberally. The Trump Administration could do the same, but instead move policy in the direction of empowering patients, rather than government regulators.

Policy recommendations

Patients are the most important part of the health care system and they should be in charge of their own health care. There is nothing inherently different about health care as a service than any other economic activity.

Health care providers should be paid for their work, and to the extent possible prices for health services should be set, not by government, but by economic efficiency and the natural movement of supply and demand in the market.

There are practical steps that would put patients in charge of their health coverage without complete repeal of the ACA:

1. Reform the ACA through Administration and incremental legislative actions.
    - promote greater use by the states of 1332 and 1115 waivers.

- provide patient-centered alternatives, such as health savings accounts and catastrophic health insurance plans, to the essential health benefits in the ACA.
- extend the use of short-term, limited-duration health insurance plans.
- allow the purchase of health insurance across state lines.
- allow greater use of private association health plans to give small employers and individuals the same insurance price and benefit advantages of large employers.[27]
- permanently withdraw the cost-sharing reduction subsidies and allow the exchanges to collapse sooner rather than later. Because of adverse selection, the exchanges are currently in a financial death spiral. More taxpayer money will not improve the long-term outlook of the exchanges.
- repeal the Obamacare taxes.

2. Promote price transparency, so patients become true consumers of health care and know the real cost of the services they are receiving.
3. Change the tax code and allow equal treatment for individuals and families, so they can benefit from the same tax deductions that employers now receive for providing employee health benefits.
4. Enact meaningful reform of Medicaid and Medicare entitlements and make them true, targeted, safety-net programs, as they were originally designed.[28]

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27 "Association health plans and small business health insurance exchanges in the Affordable Care Act," by Roger Stark, MD, Policy Note, Washington Policy Center, August, 2015, at https://www.washingtonpolicy.org/library/docLib/Stark-Association-Health-Plans-and-Small-Business-Health-Insurance-Exchanges-in-the-Affordable-Care-Act.pdf

28 "Medicare and Medicaid at fifty," by Roger Stark, MD, Policy Note, Washington Policy Center, September, 2015, at https://www.washingtonpolicy.org/library/doclib/Stark-Medicare-and-Medicaid-at-50.pdf

Conclusion

In spite of the 20 million "newly" insured, Obamacare has been a clear policy failure. Except for the enrollees in the Medicaid entitlement, virtually every person with health insurance in the U.S. has experienced a significant increase in insurance premiums. Millions have lost insurance plans they liked, lost access to their doctors, and have seen their deductibles go up.

The bright promises made by the Obama Administration to the American people when the ACA passed have not turned out to be true.

Yet Congress has been politically unable to pass meaningful reform of the ACA. The current "fixes" for Obamacare essentially all involve more taxpayer money to "stabilize" the failing health insurance exchanges and the Medicaid expansion, while continuing the government-control of our health care system.

The goal of any reform should be to give patients the greatest control of their own health care, just as citizens control other essential aspects of their lives. Patients, acting as health care consumers, would demand more transparency in pricing and, just as happens in other areas of life, would promote competition, and improve quality and service. As a result, natural competition in a normal-functioning health care market would drive costs down and increase access to quality health care for all Americans.

If Congress does not act to reform and improve the U.S. health care system, the executive branch should act and use the legal administrative authority given to it by Congress to achieve meaningful reform. Similarly, state policymakers should aggressively pursue practical measures that are allowed outside of the ACA that can increase access and health care choices for patients.

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Nothing here should be construed as an attempt to aid or hinder the passage of any legislation before any legislative body.

If you have any comments or questions about this study, please contact us at:

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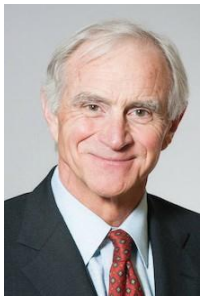

About the Author

Dr. Roger Stark is the health care policy analyst at Washington Policy Center and a retired physician. He is the author of two books including *The Patient-Centered Solution: Our Health Care Crisis, How It Happened, and How We Can Fix It*. He has also authored numerous in-depth studies on health care policy for WPC, including *The Impact of the Affordable Care Act in Washington State, A Review of the Medicaid Program: Its Impact in Washington State and Efforts at Reform in Other States, What Works and What Doesn't: A Review of Health Care Reform in the States*, and *Health Care Reform that Works: An Update on Health Savings Accounts*. Over a 12-month period in 2013 and 2014, Dr. Stark testified before three different Congressional committees in Washington DC regarding the Affordable Care Act. Dr. Stark graduated from the University of Nebraska's College of Medicine and he completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He has served on the hospital's governing board. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. He currently serves on the Board of the Washington Liability Reform Coalition and is an active member of the Woodinville Rotary. He and his wife live on the Eastside and have children and grandchildren in the area.

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