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Turning Ideas Into Policy

The reform agenda described here is already deregulating markets and liberating innovators. Congress needs to complete the job and clear away the barriers blocking these changes from coming to full fruition.

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What Trump Has Done to Change Health Care and How It's Helped Battle COVID-19

Our health-care system is experiencing rapid, powerful change, far more consequential than is generally recognized. Although these changes are welcomed by many in the health-policy community (see our assessment a year ago), even those who applaud them have been surprised at their speed and impact.

What follows is a brief overview of what the Trump administration has done to reform the health-care system — in some cases, with the compliant help of Congress.

The vision behind the Trump reforms can be found in Reforming America's Healthcare System Through Choice and Competition. This 124-page Health and Human Services document from 2018 argues that the most serious problems in health care arise because of government failure, not market failure.

In pursuing its vision, the administration has aggressively pursued its options under current law. We now need Congress to make the revolution complete.

Virtual Medicine.

The ability to deliver medical care remotely is growing by leaps and bounds. It promises to lower medical costs, increase quality, and reduce the time and travel cost of patient care. For example, most people in hospital emergency rooms don't really need to be there. With a phone or a computer and an app or two, many of them could be examined and triaged in their own homes.

The benefits of telehealth have been known for a long time. Yet as we entered 2020, it was illegal (by act of Congress) for Medicare doctors to consult with their patients by phone or email, except in rare circumstances. Even non-Medicare patients were constrained. For example, it wasn't clear if visual communication by Zoom or FaceTime satisfied the federal government's privacy regulations. While some state governments were clearing away barriers, progress was incremental and uneven.

Two things made radical change possible: COVID-19 and the Trump administration. Sweeping away the regulatory barriers to telehealth was not a

simple act. There are roughly 7,500 procedures that Medicare pays doctors to do. The Centers for Medicare & Medicaid Services (CMS) had to sort through those and determine which were candidates for virtual medicine and which were not. There were also the questions of whether a virtual visit would pay doctors the same as an office visit, and whether an audio visit would pay the same as an audio/visual visit.

Fortunately, CMS had already been sorting through those problems in the first three years of the Trump administration, for example allowing Medicare patients to use telehealth to determine if an office visit was necessary and allowing patients to send medical pictures to their physicians electronically. CMS also allowed great leeway for telehealth in the Medicare Advantage program. So when COVID struck, the administration was ready. Congress was only too willing to let the administration do what it had wanted to do all along. State governments also got on board, not only loosening prior restrictions but also, in many cases, allowing doctors to practice across state lines.

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The take-up by doctors and patients has been nothing short of breathtaking. According to CMS, between mid-March and mid-June of this year, more than 9 million Medicare beneficiaries alone received a telehealth service — including more than one in five beneficiaries who live in rural areas and almost one in three beneficiaries who live in cities. Remarkably, the elderly are the least computer-literate segment of the American population.

Once home monitoring devices become more widely available, telehealth is likely to expand further. An earache, a sore throat, low oxygen in the blood, and much more — all are opportunities for remote diagnosis and monitoring. Telehealth is even expanding to physical therapy and dentistry. Doctors at the Mayo Clinic can treat stroke victims at rural hospitals anywhere in the country. We are just beginning to imagine the possibilities.

What's needed: What the Trump administration has done administratively could be undone by a less sympathetic future administration. And the changes allowed by Congress and many state governments are tied to the coronavirus threat. When the virus emergency goes away, the freedom to enjoy the benefits of telemedicine will also go away, unless Congress acts. Fortunately, there seems to be bipartisan support in Congress for making these changes part of permanent law.

Round-the-Clock Primary Care.

Concierge doctors used to be available only to the rich. Today "direct primary care" is far more affordable. Atlas MD, in Wichita, Kan., for example, provides all primary care along with 24/7 phone and email access. They offer discounts on lab tests and generic drugs for less than what Medicaid pays. The cost: $50 a month for a middle-aged adult and $10 a month for a child.

A number of employers are creating access to direct primary care (DPC) as an employee benefit. However, employers have not been able to put tax-free dollars into an account and let employees use the money to select a direct-pay doctor of their own choosing.

The Trump administration has made a major step

forward with an IRS rule (expected to be finalized later this year) that will allow Health Reimbursement Arrangements (HRAs) to be used for this purpose. This is a huge improvement in employee benefit options, but much more could be done.

About 26 million Americans have a Health Savings Account (HSA), and under current law these accounts cannot be used to pay monthly fees to direct-primary-care providers. Also, employees who have an HSA are not allowed to also have an HRA.

The administration wants to extend the DPC option to Medicare by paying a fixed monthly fee to a physician or physician group instead of the traditional fee-for-service payments. In return, the physicians would provide virtually all primary care. The fees would range from $90 to $120 a month, depending on the patient's age and medical complexity. Unfortunately, most DPC doctors would like to avoid joining Medicare and being subject to its cumbersome regulations.

What's needed: Congress needs to codify the steps the administration has already taken. Legislation should also permit HSA funds to be used for DPC monthly payments and to make it easier for seniors to have access to DPC doctors who are not participating in Medicare.

Patient Power.

There is mounting evidence that patients suffering from diabetes, heart disease, and other chronic illnesses can (with training and the right support) manage a lot of their own care as well as — or better than — traditional doctor therapy can. And if they are going to manage their own care, they can do an even better job if they are also managing the money that pays for that care.

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HSAs are a natural vehicle. However, current law's requirement of an across-the-board deductible makes HSAs incompatible with smart insurance design for chronic care. For example, an employer might want to make insulin available for free to diabetic employees in order to encourage its use. However, the same employer might ask noncompliant employees who show up in emergency rooms to pay for that care out of their own account.

Guidance issued last year by the Trump administration is a major step in the right direction. People who use HSAs are now exempt from the high-deductible requirement for the purchase of drugs for 13 chronic conditions. This means that the employer or insurer will be able to provide first-dollar coverage for drug therapy without running afoul of HSA regulations.

What's needed: The new guidance (which appears to have bipartisan support in Congress) needs to be codified. A more radical step would be to completely divorce HSAs from a deductible requirement — allowing them to wrap around any third-party insurance plan and allowing HSAs to be used to pay for premiums as well as out-of-pocket expenses. A bill introduced by Senators Ted Cruz (R., Texas) and Mike Braun (R., Ind.), for example, would decouple HSAs from any deductible and also allow the accounts to be used for direct primary care.

Centers of Excellence for Chronic Care.

In the Obamacare exchanges, insurance plans

are not allowed to specialize. They are required to offer a full range of services to all enrollees. Yet if health plans are not allowed to focus and get good at meeting *some* patient needs, they are likely to be mediocre when they try to meet *all* patient needs.

Instead of expecting every health plan to be all things to all patients, we should encourage specialization. We need "focused factories" for such chronic conditions as cancer care, diabetic care, and heart disease. To make the market work better, medical records need to travel with the patient from plan to plan, and health plans need to be able to ask health questions at the point of enrollment.

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In Medicare generally, beneficiaries with two or more chronic conditions represent 94 percent of expenditures, and beneficiaries with six or more conditions account for more than 50 percent. So better chronic care not only promises health benefits but may also put a large dent in Medicare spending.

In contrast to the rest of the health-care system, Medicare Advantage Chronic Condition Special Needs Plans (C-SNPs) can specialize in 15 chronic conditions. These plans can exclude applicants who don't have the condition. They can also ask health questions and request medical records.

The Trump administration has been acting aggressively to expand Medicare Advantage (MA) (up 37 percent since 2016), and under the Bipartisan Budget Act of 2018, it is allowing C-SNPs to provide supplemental non-health benefits that may improve health outcomes. For example, a special-needs plan can pay for home air cleaners and carpet shampooing to reduce irritants that may trigger asthma attacks. It can provide healthy food to someone with heart disease. It can provide transportation to a doctor's appointment, or to a diabetes-education program or a nutritionist for someone with diabetes.

Currently, 1.2 million MA enrollees (6 percent) are in C-SNPs. The initial growth has been in the most competitive markets, and enrollment can be expected to expand in other areas in time.

What's needed: Congress needs to apply the same type of reforms to the Obamacare exchanges. For example, Cancer Treatment Centers of America (CTCA) should be able enter an exchange and restrict its enrollment to patients who have cancer. CTCA should also be able to transact with other health plans — say, accepting all the other plans' cancer patients in return for a fee, provided the patients are willing to move.

Insurance Tailored to Individual and Family Needs.

Obamacare insurance is one-size-fits-all. It comes with a full package of required benefits, and at a heavy price — a very high premium, a high deductible, and typically a very narrow network of providers. Why can't people have different options? Before there was Obamacare, they did.

The Trump administration has made it easier to get other options, including short-term, limited-duration health insurance. These plans, which are not governed by Obamacare regulations, are designed for healthy people with a temporary need — say, to bridge a gap between school and work, or a move from job to job. Since they exclude applicants with chronic conditions, many

of these plans limit coverage for prescription drugs as well as substance abuse and other conditions.

These limitations have prompted critics to dismiss the plans as "junk insurance." In fact, they meet the needs of the people who enroll in them — typically for a premium that is up to one-half the cost of Obamacare, and with broader networks. Remember: People with a chronic condition can enroll in an Obamacare plan — even if those plans often fall short for people who need chronic care.

Traditionally, short-term plans had a twelve-month duration. The Obama administration reduced that to three months, with no renewals. Then the Trump administration reversed that ruling — allowing plans of twelve months' duration with the opportunity to renew for two more years. The Trump administration's rule also allows the sale of riders on these policies — long used in other forms of insurance — that entitle the policyholder to convert to a replacement plan without new medical underwriting at the end of the three-year period.

By stringing these two types of insurance together, people can potentially have a long-term relationship with a "short term" insurer. And since, states permitting, this is a largely unregulated market, we could see the emergence of different types of insurance, designed to meet different types of needs. Whereas today the typical short-term plan has features that would be of interest only to someone who wants insurance temporarily, in the future we might see a proliferation of the standard Blue Cross plans that were popular before there was Obamacare.

We could also see the emergence of insurance better suited to the needs of young, healthy families with low incomes and very few assets. Obamacare forces these families to buy coverage that covers the million-dollar event, but it comes with, say, a $14,000 family deductible. That may be great for hospitals, but it is viewed as almost worthless by many of these families.

What's needed: Since the Trump administration's rules governing short-term insurance markets are purely administrative, they could be revoked by another administration. That's why Congress needs to make them part of permanent law.

Better Care for People with Pre-existing Conditions.

According to its supporters, a primary benefit of Obamacare is protecting people who enter the individual market with a pre-existing condition. Yet people who leave an employer plan and shop for insurance in the individual market today will face three unpleasant surprises: Higher premiums, higher out-of-pocket costs, and more limited access to care than what a typical employer plan provides.

The Affordable Care Act triggered a race to the bottom, as health plans have been trying to attract the healthy and avoid the sick.

Under Obamacare, premiums in the individual market have doubled. Deductibles are three times the level of an average employer plan. And increasingly, enrollees are being denied access to the best doctors and the best hospitals.

The Affordable Care Act triggered a race to the bottom, as health plans have been trying to attract the healthy and avoid the sick. The most successful Obamacare insurers are Medicaid contractors. The plans that have survived in the

exchanges look like Medicaid's managed care with a high deductible. The networks include only those providers who will accept Medicaid fees coupled with all the hassle of managed-care bureaucracy.

To deal with these problems, President Trump's administration has taken aggressive steps to give states the authority to reform their individual markets. The most important reform is risk mitigation (including reinsurance) — setting aside funds for the care of the sickest, most costly enrollees. This ensures that money is there to take care of the sick, without forcing the healthy to pay exorbitant premiums.

These reforms have already led to lower costs in seven states, where premiums fell by nearly 7.5 percent while rising in the other 44 states **(including D.C.)** by more than 3 percent. In Maryland in 2018, premiums that had been expected to rise 30 percent actually fell by 13 percent thanks to state reforms.

Health care is the only important market where buyers cannot find out the prices of services before they buy.

What's needed: Much more could be done. Before Obamacare, people could buy insurance at any time of the year — instead of being confined to a six-week period in which they buy insurance that doesn't take effect until the following January. They could also switch plans at any time if they felt they were being mistreated. With a proper risk-mitigation system, enrollment could be year-round.

People with health problems would also benefit if health plans could specialize in chronic care, as described above. In general, states should be given broad authority to reform their private individual markets, with one important proviso: Conditions must get better for people who have health problems. "Better" means lower premiums, lower deductibles, and broader networks of providers.

Congress should build on the initial success of the waivers by converting Obamacare's subsidies into grants to the states with wide discretion to reform their individual insurance markets. A proposal to do just that is supported by dozens of free-market-oriented leaders across the country.

Price Transparency.

Health care is the only important market where buyers cannot find out the price of services before they buy. This seems to be the result of third-party payment (insurance companies, employers, and government). In medical markets where patients pay out of pocket, buyers always know the price in advance of purchases, and price and quality competition is normal. Cosmetic surgery and LASIK surgery are examples. In addition, when Canadians come to the United States for knee and hip replacements (to avoid long waits in their own country), they are almost always given package prices, covering all elements of their procedure — by American hospitals! In the third-party-payer sphere, by contrast, providers usually don't compete for patients based on price. When they don't compete on price, they don't compete on quality either.

A number of employers, including some state governments, have experimented with price transparency in an effort to reduce the cost of care. One method is to set a price that the employer is willing to pay for a service and then encourage employees to shop aggressively — knowing that at any higher price, the employee will have to pay the difference. When Safeway did this, employees saved 27 percent on laboratory tests and 13 percent on imaging tests.

Pursuant to an executive order signed last year by President Trump, hospitals are now required to post their prices for common procedures in a consumer-friendly manner, and that requirement has been upheld in the courts.

What's needed: As with other Trump executive orders, this one needs to be codified by Congress to prevent a future president from undoing it in response to special-interest pressures. Congress also should create the opportunity for patients who save money by choosing less expensive options to pocket the savings in their HSAs.

Personal and Portable Health Insurance.

As of January 2020, employers can use Health Reimbursement Arrangements (HRAs) to provide tax-free funds that employees can use to buy their own health insurance. This is health insurance that employees can take with them as they travel from job to job and in and out of the labor market. That is especially important at a time of labor-market uncertainty, when millions of Americans are lacking job security.

This opportunity, made possible by a Trump-administration executive order, is a major change from the Obama regulations, which threatened to fine employers as much as $100 per employee per day for letting employees own their own insurance.

The administration estimates this new rule will benefit more than 11 million workers and their families. But it could help many times that number if states cleaned up their individual markets to make individual insurance a more attractive option.

What's needed: Since the Trump executive order was a radical reversal of an Obama executive order, everything could easily be reversed again by a new administration. Congress needs to codify the current rules and expand them. For example, HRA funds can now be used only to purchase Obamacare-compliant plans. This is unduly and unnecessarily restrictive. Millions of people are turning down individual insurance and choosing to be uninsured because the premiums and deductibles in the individual market are too high and the networks of providers are too narrow.

Employees should be able to use their HRA funds to purchase the full range of insurance plans available to individuals and families, including short-term plans described above.

Conclusion.

The reform agenda described here is already deregulating markets and liberating innovators: doctors trying new ways of delivering care, states trying new ways of healing broken private markets, and patients seeking better care at lower prices. These advances were made possible by removing government obstacles to lower-cost, higher-quality, more-accessible health care and allowing markets to work. Congress needs to complete the job and clear away the barriers blocking these changes from coming to full fruition.

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