CHAPTER FOUR
IMPROVING HEALTH CARE COVERAGE

1. Policy Recommendation: Repeal the state public option to increase health care affordability and choice

More than half of Washington residents, 52% or 3.8 million people, receive health care coverage through their employer or their spouse's employer.[1] Employer-based coverage in the private market is popular and most people want this coverage to continue.

A further 1.3 million residents are enrolled in the state Medicare entitlement program for the elderly, with annual public spending of about $12.6 billion.[2]

The Medicaid entitlement was originally intended as a safety-net program for the poor, yet today fully 25% of the state population, or 1.8 million Washingtonians, have been put into the program, for a further annual cost of $12 billion. The poverty rate in Washington is only 11%.[3]

About 220,000 people have individual coverage through

1 "Health insurance coverage of the total population," State Health Facts, Washington state, Kaiser Family Foundation, 2017, at https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

2 Total number of Medicare beneficiaries," State Health Facts, Washington state, Kaiser Family Foundation, 2018, https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

3 "Washington percent of population in poverty, 1969-2017," Population in Poverty, Washington Data and Research, Office of Financial Management, last modified May 21, 2019, at https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/social-economic-conditions/population-poverty. The figure includes children enrolled in the state Children's Health Insurance Program (CHIP), which is funded through Medicaid.

Washington's subsidized Obamacare exchange, and a further 108,000 people have individual coverage in the free market.[4] The uninsured rate in Washington is 5.5%, or about 400,000 people.[5]

Restricting patient choice – the state public option plan

The Washington legislature recent passed the country's first public option health plan, which will be administered through the Washington State Health Benefit Exchange.

The public option is a government-subsidized health plan designed to compete against private insurance in the individual and small group markets. The plan will be offered to any one earning up to 500 percent of the federal poverty level. For a family of four, that is an income of $129,000 a year in 2019, a level of about twice the average working family wage in the state.

Obviously, this is not a social safety-net program; it is intended an incremental step toward imposing a single-payer, socialized health care system. The public option plan is designed to include the following; reduced deductibles, more services before the deductible is paid,

predictable cost sharing, more government subsidies, a limit on

4 "Washington's health insurance marketplace: history and news of the state's exchange," by Louise Morris, Health insurance and health reform authority, Health Insurance.org, May 20, 2019, at https://www.healthinsurance.org/washington-state-health-insurance-exchange/, and "Data Note: Changes in enrollment in the individual health insurance market through early 2019," by Rachel Fehr, Cynthia Cox and Larry Levitt, Kaiser Family Foundation, August 21, 2019, at https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/.

5 "After a three year decline, Washington's uninsured rates shows no change in 2017," by Wei Yen and Thea Mounts, Research Brief No. 89, Washington State Health Research Project, Office of Financial Management, December 2018, at https://www.ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief089.pdf.

cost sharing to 10 percent of an enrollee's yearly income, and a limit on increase in premium rates.

Public option plan is government-defined and directed

Beginning in 2025, all plans in the state exchange must be standardized. The standardized plans would cut payments to doctors and hospitals to match federal Medicare rates. (Medicare payments average 30 percent less than what private insurance pays.) Private insurance companies manage the plan under the direction of the Insurance Commissioner. In other words, plan services and payments are limited and defined by the government.

The real cost of the program is to federal taxpayers. The Obamacare exchanges are in a death spiral because of adverse selection. Young, healthy individuals are not participating because they do not want or need all of the government mandated benefits. The higher costs leaves older and sicker people in the state exchanges.

The premium subsidies in the public option plans will be much higher than in the standard Obamacare exchange plans, placing a much higher tax burden on federal taxpayers. Of course, federal taxpayers are state taxpayers, so ultimately the tax burden will wind up on Washingtonians.

Private plans can't compete against government subsidies

It is impossible for private citizens to compete against the government. For example, Medicare devastated the thriving private health insurance market for seniors. The public option, once up and running, will have the same effect on the individual and small group health insurance markets in Washington state. As private choices fade, employers may even discontinue employee health benefits,

which will increase the government-reach into our health care.

The public option is designed as an incremental move toward a single-payer, government-controlled health care system for the state and the country.

Lawmakers should repeal Washington state's public option law to allow greater choices, competition and affordability in the private market, so employers and families can select the price and level of coverage that best fit their needs.

2. Policy Recommendation: Avoid imposing a socialized single-payer system

The Affordable Care Act (ACA), also known as Obamacare, was enacted in 2010. It is a highly complex law that has made our current health care delivery system more costly and confusing. In comparison, a socialized single-payer system is attractive to many people because of its perceived simplicity – the U.S. government would direct health services for all Americans.

Problems with the Canadian system

Canada has had a single-payer system for over 30 years and its hard experiences are revealing. Canadians are proud of the idea that every citizen has health insurance, at least in theory. From a cultural identity standpoint, the principle of universal coverage is a priority for the country. National pride in the broad idea also makes it easier for the citizens to overlook the many problems they experience in the system.

Perceived as "free," the demand for health care far outweighs the supply of care. All industrialized countries face the same age demographic problem, whereby the younger, working age group is getting smaller, while the older, non-working group is

getting larger in proportion to the total population. Financing for a single-payer socialized system is pay-as-you-go – there is no long-term trust fund, only monthly taxes paid by workers. This aging demographic imbalance guarantees a looming financial disaster in Canadian health care funding in the future.

Using waiting lists to ration health care

The long waiting times in a single-payer system are not in the patient's best interest and would not be acceptable for the vast majority of Americans. Health care rationing through waiting lists happens when supply is overwhelmed by demand. The question is whether government bureaucrats should have the authority to pick and choose what medical procedures patients receive and who should actually receive those treatments, while others, usually older, sicker patients, are forced to wait for care.

A single-payer system discourages innovation. There is virtually no money in the system to encourage investment in new life-saving medicines and medical devices. Lack of innovation guarantees that under single-payer few new treatments would be discovered, with little or no improvement in quality of life or life expectancy, particularly for the medically vulnerable and the elderly.

Further politicizing health care services

Under a single-payer system, health care spending must compete with all other government activity and political interests for funding. This makes health care very political and subject to change with every new budget. It also forces each health care sector, for example hospitals and doctors, to compete with each other for limited public money.

No government bureaucrat is more concerned about a person's health than that person is. Patients, as health care consumers, should be allowed to be informed about, to review the prices of,

and to gain access to the best health care services available in a fair, open, and free marketplace.

As the real-world examples of Canada and the failures of the U.S. Veterans Administration hospital system show, a single-payer system does none of these things, leaving patients at the mercy of a distant, bureaucratic and heavily politicized health care system.

3. Policy Recommendation: Do not use other countries as a model for U.S. health care

The United States has a complex health care delivery system composed of private and government-funded insurance plans. Half of all Americans receive their health insurance from their employer or their spouse's employer. Over forty percent of Americans receive their health insurance from the government. The remainder are either uninsured or obtain health insurance through the private individual market. The current political debate concerns how large a role the government should play in our health care delivery system.

The United States spends far more money per-person on health care than other industrialized countries. Last year, overall medical spending in the U.S. totaled $3.5 trillion or 18 percent of the national gross domestic product.

Other countries devote fewer resources to health care

Because other countries spend less on health care, they are often promoted as useful models for the U.S. However, looking to other countries to solve our health care delivery system problems is not practical or reasonable. Most other countries are smaller than the U.S., have a more homogenous population and have lower rates of immigration and diversity. What the people of one country favor may not be applicable or acceptable to people living in a different society.

One fact does remain, though. In all other industrialized countries, the demand for health care is much greater than the money politicians budget to pay for it. The results of this supply/demand mismatch are chronic shortages followed by strict rationing of health care. The rationing can take many forms – from long waits, to denying the elderly access to certain procedures, to allowing individuals with political influence to receive priority attention from providers.

As noted, Canada uses waiting lists to ration care. In 2018, waiting times for specialty care averaged 20 weeks. Canada actually has a two-tiered system; socialized services in the country, and travel to the U.S. for privately-funded care.

Great Britain enacted a government system in 1948, the National Health Service, to give every citizen cradle-to-grave coverage. About ten percent of the population has private insurance and many physicians combine government-paid work with private practice. In 2018, 250,000 citizens waited more than six months for needed treatments within the NHS, while 36,000 British waited nine months or more.

Using choice to hold down costs

Switzerland has a comparatively large private health care sector and patients are responsible for 30 percent of their own health care costs. Consequently, a certain degree of consumer choice exists in Switzerland and the country has been fairly successful in holding down costs. Unfortunately, as officials increase the number of benefit mandates imposed on insurance plans, health care costs rise.

Singapore has a multi-tiered system with different levels of care depending on the patient's ability and willingness to pay more. This is similar to the system in the U.S. before Medicare and Medicaid, when competition controlled costs and private hospitals

and doctors treated paying patients and charity hospitals and residents-in-training cared for indigent patients.

Although the overall systems vary, the common factor for all other countries is government-mandated health insurance. Even those countries that have a component of "private" health care continue to mandate that every citizen have government-approved health insurance.

The free market and consumer choice offer the best solution

Politicians push for "universal health coverage," but the critical point is to use the best mechanism to allow the greatest number of Americans access to affordable health care. Simply having health coverage in theory in no way guarantees timely access to actual care. The American experience with the Veterans Administration hospital system, a government-run, single-payer health care program, reveals unacceptable waiting times and huge inefficiencies.

Just like all other economic activities, the free market offers the best solution to provide the greatest access to health care and to control costs. People freely making their own health care decisions and using their own health care dollars would give Americans the best chance to utilize their right to access health care, with tax-funded safety-net health programs provided for those who can't afford it.

4. Policy Recommendation: Promote structural reforms at the state level, free of federal government restrictions

States can enact their own health care reform, regardless of federal actions, that would increase access to health care while decreasing costs. Here is a list of policy options available to state

policymakers under current federal law:

1. Request pursue 1332 and 1115A waivers. Under these two sections, states can request, and the Administration can approve, significant changes in the implementation of the ACA without action by Congress.
2. Pass state legislation to limit state taxpayers' contribution to the Medicaid expansion. States can opt-out of costly Medicaid expansion under the ACA, freeing resources that can be used for state-level health programs.
3. Repeal Certificate of Need laws. Research now shows that state Certificate of Need rules do not lower costs, but that they do limit patient choices by banning investment and construction of new health care facilities.
4. Enact legal reform to reduce wasteful medical expenses. Legal fees and defensive medicine (ordering unneeded tests) add tremendously to health care cost, without increasing patient choices or quality of care.
5. Cut state mandates on health care services. Each mandate adds to the cost of health insurance and, while catering to politically-connected special interest groups, often reduces choices for patients. Legislatures should repeal most of their state-imposed health insurance mandates.
6. Expand and promote the use of association health plans. Association health plans allow small groups to join together to purchase health insurance in the same way large groups do. Large group plans are regulated by the federal ERISA law and therefore avoid many of the worst features of the ACA.
7. Promote telemedicine. Telemedicine and similar online services reduce cost and increase patient access to health care, especially for people living in rural areas.

8. 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.
9. Encourage home health care in Medicaid. Costs are less and patient satisfaction is higher with home health care. It reduces government involvement in care and respects the supportive family relationships of patients.
10. Cap Medicaid enrollment. Congress originally intended Medicaid to be targeted to help the most vulnerable patients, while encouraging well-off patients to buy affordable private health insurance coverage.
11. Reduce restrictive licensing laws. States should cut barriers to medical practice to increase access to skilled health care services for patients.
12. Encourage direct primary care. For a fixed amount per month, patients can access primary care without waiting. Direct primary care increases access to doctors for all patients, regardless of income. Legislatures should encourage direct primary care and protect doctors from state regulatory insurance laws.

Lawmakers should enact deep structural reforms like these to promote innovation in the health care market, attract talented medical professionals, and increase access and lower costs for patients.

5. Policy Recommendation: Focus illegal drug enforcement on dealers and suppliers

The 50-year fight against illegal drugs has cost taxpayers over one trillion dollars and yet has been of limited effectiveness. The drug crisis in the United States continues, and a different approach is needed.

When considering the current opioid crisis, focusing punishment on prescription drug manufacturers and doctors is misplaced. Data from the government Center for Disease Control confirm that the alarming increase in opioid deaths over the past ten years is from illicit fentanyl and heroin, not legally-available medications.

Any market transaction depends on the supply of a product or service and the demand for that product or service. The illegal drug trade is no different. For a war on drugs to be successful, it must reduce both the supply and the demand for drugs.

Drug abuse as a treatable disease

One key strategy is to treat drug abuse as a treatable disease, just like many cases of mental illness. Advocates of this viewpoint support more money for treatment and prevention, rather than money for police activity. To date, law enforcement has accounted for 75 percent of the money spent on the war on drugs.

Many who view drug abuse as a disease would like to see less enforcement against the drug user and more emphasis on prosecuting major suppliers and manufacturers of illegal drugs. This is not to be confused with the legalization of all drugs.

Incarceration of the user is extremely expensive for taxpayers and provides no real treatment or long-term solution. Shifting resources to prosecuting suppliers while providing treatment for users is a constructive approach, and is not an argument for legalization.

Providing needed pain relief

An unintended consequence of the current opioid crisis is that patients who are truly in pain are often denied the level of prescription pain relief they actually need. This limitation is obviously a disservice to thousands of patients living in pain who

could benefit from opioid medications and whose monitored use of pain medicine is not contributing to the opioid crisis.

Doctors are able to assess and treat a patient's pain in the most timely fashion; they should not be restricted by arbitrary laws that limit how much pain relief they can provide.

6. Policy Recommendation: Enact reforms to strengthen the Medicare entitlement

The federal Medicare and Medicaid entitlement programs are over 50 years old. They have become two of the largest health insurance plans in the country and account for an ever-increasing share of federal and state spending.

In the coming decades, they will also require more public spending than any government program, and will become financially unsustainable unless they are restructured and reformed. The survival of Medicare and Medicaid depends on patient-oriented reforms that must occur sooner rather than later to protect vital health services for patients.

Modernizing Medicare

From the start, the cost of the Medicare program was badly underestimated. The Administration promised Congress in 1965 that the funding would require much less than one percent of payroll taxes. By the late 1980s, however, this was increased to 1.6 percent and subsequently to 2.9 percent.

In inflation-adjusted dollars, spending on Medicare was $4.6 billion in 1967, but had increased to $7.9 billion by 1971. This was a 70 percent increase, whereas enrollment had increased only six percent. By 1990, Medicare was nine times over its original budget.

There is broad agreement that Medicare is not financially sustainable. The program's costs are rising, the number of workers paying monthly taxes into the program is proportionately decreasing, and the number of elderly recipients is dramatically increasing as the post-war generation reaches age 65.

We now have an entire generation of people who has grown up with Medicare, has paid into it and now expects full medical services in return. We also have people in younger generations who understand the bankrupt nature of the program and do not believe Medicare will still exist when they reach age 65.

A fair solution

A fair and workable solution must account for the reasonable expectations of both of these generations, and provide reliable health coverage for future generations. As a country, we have a moral obligation to seniors already enrolled in the program and to those approaching retirement age.

A simple first step to Medicare reform would be to gradually raise the age of eligibility. When the program started in 1965, the average life expectancy in the U.S. was 67 years for men and 74 years for women. Average life expectancy is now 76 years for men and 81 years for women, straining an entitlement program beyond what it was designed to support.

Another simple Medicare reform would be more thorough means-testing, not just in Part B. Wealthier seniors would pay more and low-income people would pay less.

Revive private market choice

As it stands now, there is, understandably, no private insurance market for seniors. Any private market was destroyed by Medicare long ago. It is impossible to compete against the government,

which has monopoly power to fix prices and lose money while private insurers go out of business.

Lawmakers should revive the private market for the elderly by allowing people to leave Medicare voluntarily and buy tax-favored health savings accounts and low-cost health plans. Low-income seniors could use subsidized premium support that would allow them to purchase health insurance in the private market, empowering them to make their own choices.

Protecting Medicare doctors

Lawmakers should ensure that Medicare doctors are protected from unfair sanctions or government penalties when they seek partial payments from patients or their insurance companies, instead of being expelled from the program and legally prosecuted as they are now. Doctors should never be forced to choose between caring for their Medicare patients and receiving fair compensation for their work.

Similarly, lawmakers should allow future generations to continue the individual health insurance they had during their working life in retirement. As the younger generation saves, their health insurance nest eggs would build until they need it in their later years.

This is the same strategy that millions of individuals and families use today to save for retirement. The federal government informs people that they cannot rely only on Social Security to support them after age 67, and that all working people need to plan for the expected living expenses they will incur later on. The same should be true of Medicare regarding future health care costs.

7. Policy Recommendation: Enact reforms to modernize and strengthen Medicaid

There are currently four groups of people receiving assistance through the Medicaid program. These are the poor, the disabled, low-income mothers and children, and individuals needing long-term care. Although mothers and children make up most of the beneficiaries, long-term care accounts for 70 percent of Medicaid's cost.

Fastest-growing state budget cost

Medicaid expenditures are the fastest-growing budget item for virtually all states, even though the federal government supplies, on average, 57 percent of all Medicaid dollars spent in the legacy program and at least 90 percent of dollars in the new ACA-expanded Medicaid program.

In Washington state, Medicaid spending has grown rapidly and now consumes a significant share of the biennial budget. State Medicaid spending rose 44%, from 7.5 billion to nearly $11 billion, from 2012 to 2016.[6]

State reimbursement by the federal government for the traditional Medicaid is based on the wealth of the state, with poorer states receiving a higher percentage match of federal money than wealthier ones.

First step to reform

The most important first step to reforming the federal

6 "Medicaid Spending in Washington," Public Policy in Washington, Ballotpedia (based on data from State Health Facts, Washington state, Kaiser Family Foundation), accessed September 2019, at https://ballotpedia.org/Medicaid_spending_in_Washington#cite_note-28.

Medicaid program is to redesign it so it no longer functions as an unsustainable, open-ended entitlement. Welfare reform in the late 1990s was successful because it placed limits on how many years people could expect to receive taxpayer support. Medicaid recipients should have a co-pay requirement based on income and ability to pay.

Where applicable, able-bodied Medicaid enrollees should have a work requirement. Like welfare, Medicaid should be viewed not as a permanent lifestyle, but as a transition to help low-income families achieve self-confidence, economic independence, and full self-sufficiency.

Promoting health lifestyles

It is condescending to believe poor families cannot manage their own health care. Allowing them to control their own health care dollars through subsidized health savings accounts or premium vouchers would financially reward enrollees for leading a healthy lifestyle and making smart personal choices. It would also show respect for low-income families, allowing them to be treated equally with others in the community.

Respecting local control

Local control of the management and financing of entitlement programs works best. States, rather than the federal government, should be placed in charge of administering Medicaid. Block grants and waivers from the federal government would allow states to experiment with program designs that work best for their residents and to budget for Medicaid spending more efficiently.

Lawmakers should restore the income requirement to 133 percent of the federal poverty level, so that the most needy families are assured of receiving support. Medicaid should not be a subsidized “safety-net” for middle-income people by encouraging

those who can live independently to become dependent for their health care on a tax-subsidized entitlement program.

Additional Resources

"Do socialized health care systems in other countries offer a model for the United States?" by Dr. Roger Stark, Policy Brief, Washington Policy Center, July 2019

"Washington state's tax-subsidized public option is designed as a step toward imposing socialized single-payer health care," by Dr. Roger Stark, Policy Notes, Washington Policy Center, June 2019

"Federal administrative improvements to the Affordable Care Act and state options for health care reform," by Dr. Roger Stark, Legislative Memo, Washington Policy Center, January 2018

"A new approach is needed to solve the opioid crisis," by Dr. Roger Stark, Policy Brief, Washington Policy Center, July 2018

"Is a single-payer health care system right for America?" by Dr. Roger Stark, Policy Notes, Washington Policy Center, May 2017

"Medicare and Medicaid at Fifty," by Dr. Roger Stark, Policy Notes, Washington Policy Center, September 2015