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The Future of Health Care

May 2019

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POLICY BRIEF

The future of health care in the United States

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Key Findings

1. The quality of medical care in the United States has advanced tremendously in the past 100 years. Health care policy has likewise changed dramatically over the same period.
2. A movement toward more government intervention and control of U.S. health care policy began early in the 20th century and the trend persists to this day.
3. Although the government is expanding its control over the health care delivery system, America is still a capitalistic country with the private, free market sector of health care remaining viable at the present time.
4. Free market ideas, such as the use of affordable direct primary care, telemedicine, alternative health coverage plans, and technical innovations, are growing outside of government intervention.
5. It is very difficult for lawmakers to reform or reduce benefits in any government entitlement once they have been enacted. Once people receive an entitlement for free, or one that is heavily subsidized, special interests and political advocates strongly resist changes – even though those changes may guarantee the long-term viability of that program.
6. Over 40 percent of Americans are in one of the government-run health care programs. It appears that these entitlements are here to stay and will probably expand.
7. Half of all Americans have employer-paid health insurance plans. These are popular, well accepted in the U.S., and have a 75-year history of success.
8. The country is gradually, but persistently, moving toward a single-payer health care system. The real unknown is how Americans who benefit from good-quality private coverage and are not currently in government entitlement plans will respond.
9. Free market solutions do exist. To control costs, increase choice, and maintain or improve quality, patients should be allowed to control their own health care dollars and make their own health care decisions.

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Introduction

Medical care in the United States has advanced tremendously over the past 100 years. From new antibiotics, to revolutionary cancer treatments, to surgical procedures that were unheard of a century ago, Americans today enjoy greater longevity and a better quality of life thanks to medical progress.

Health care policy has likewise changed dramatically over the past 100 years. Starting after the Revolutionary War, the federal government has provided health care benefits for military veterans. Government licensing of doctors began in the 1920s and health insurance, along with its federal and state regulations, began in the 1930s. Changes to the federal tax code encouraged employers to pay for employee health benefits during World War II, a policy that is firmly entrenched in the U.S. today, with half of all Americans receiving their health insurance tax-free from their employer or spouse's employer.

A movement toward more government intervention and control of U.S. health care policy began early in the 20th century and has persisted to this day. Medicare and Medicaid began in 1965 and were originally designed to be safety-net health insurance plans. The Affordable Care Act, or Obamacare, became law in 2010, while its provisions for Medicaid expansion and taxpayer subsidies in the individual insurance market followed in 2014. Today, over 40 percent of Americans are in one of these three government-managed insurance programs.

Although the government is expanding its control over the health care delivery system, America is still a very capitalistic country with the private, free market sector of health care remaining viable at the present time.

The question is what the future of the U.S. health care system will look like. This Policy Brief describes the various possibilities as American health care continues to evolve.

Government programs

One out of every five Americans is enrolled in the Medicaid entitlement program. One out of every six is enrolled in the Medicare insurance program for seniors and this number is growing as baby-boomers retire. Politically, it is very difficult for lawmakers to reform or reduce benefits in any government entitlement. Essentially, once people receive an entitlement that feels free for the recipients, or at least is heavily

subsidized, they and their political advocates strongly resist changes – even though those changes may guarantee the viability of that entitlement program.

Given this structural problem, what will the future of the government health care plans look like?

The status of Medicare

The federal Medicare program began in 1965 as health insurance for anyone age 65 and older. It is one of the largest social welfare programs in the world and functions essentially as a single-payer system. Workers pay a Medicare tax during their working years and then must enroll in government-provided health care after reaching the age of 65. The average worker uses three times as much health care as he had paid for during his working years.[1]

In 2018, 59 million people nationally (18 percent of the population) and over one million people in Washington state (15 percent of the population) were enrolled in Medicare.[2] Total national spending on Medicare was nearly $702 billion in 2017.[3]

Like Social Security, Medicare was intended to work as a pay-as-you-go system, in which current benefits are funded by current taxes. With the decreasing number of workers in the U.S. in future generations compared to the total population, and with the massive number of baby-boomers approaching retirement age, this pay-as-you-go entitlement system is a fiscal catastrophe waiting to happen.

Medicare currently pays medical providers about 70 percent of what private insurance pays. A growing number of doctors say they are unable to see new Medicare patients and still pay their office overhead and expenses. This trend is increasingly limiting access to health care services for our seniors.

If Medicare is to continue in its present form, policymakers must take one or more of three possible steps - benefits will need to be decreased, payroll taxes will need to be increased, or seniors will need to pay more out of pocket. A fourth option would be to use general taxes to cover more of Medicare's yearly deficit. From an economic standpoint, none of these steps would predictably rein in the rising costs or decrease the demand for health care on the part of Medicare beneficiaries.

Even with these steps, there is virtually complete agreement that the federal Medicare program is not financially sustainable in its present form. 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 about to increase dramatically as the baby-boomer generation approaches age 65.

We now have an entire generation of people who have grown up with Medicare, have paid into it, and now expect 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.

1 "Social Security and Medicare taxes and benefits over a lifetime, 2012 update," by C. Eugene Steuerle and Caleb Quakenbush, The Urban Institute, October 2012.
2 "CMS fast facts," Centers for Medicare and Medicaid Services, cms.gov, August 2018, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html.
3 "The facts on Medicare spending and financing," by J. Cubanski and T. Neuman, The Henry J. Kaiser Family Foundation, June 22, 2018, at https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.

Finding a fair and workable solution for Medicare reform

A fair and workable solution to the Medicare problem must account for both of these generations, as well as 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 up to 76 years for men and 81 years for women, straining an entitlement program that was not designed to provide health services to people for so many years late in life.

As it stands now, there is, understandably, no private insurance market for seniors. Any normal market was crowded out long ago by Medicare. It is virtually impossible to compete with the government, which has monopoly power and an unlimited ability to fix prices and lose money while private competitors go out of business.

The private market for the elderly could be resurrected by allowing people to opt out of Medicare voluntarily and allowing these seniors to purchase tax-free health savings accounts and high-deductible health plans. Physicians should be allowed to receive partial payments from patients or their insurance companies, which by law, patients cannot do now unless they leave the Medicare program entirely.

Future generations of workers should be allowed to continue the individual health insurance they want to keep into retirement. Not surprisingly, younger people as a group are healthier than older people, so as members of the younger generation save, their health insurance nest egg would build until they need it in their later years.

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

The "Medicare for All" proposed single payer system

On the other hand, an increasing number of people believe and support the idea that expanding Medicare to all age groups can result in a single-payer health care system in the U.S. Ideas for the gradual expansion of Medicare include allowing people to buy in to Medicare as they would a plan in the individual market, gradually dropping the age of eligibility for enrollment, and using Medicare for some Medicaid activities such as long-term care.

Senator Bernie Sanders (I-VT) has long advocated for the creation of a single-payer health care system in the United States. He has been joined in this crusade by many people on the political left. His "Medicare for All" is a very robust and specific plan.[4]

4 "Medicare for all: leaving no one behind," Bernie Sanders Campaign website, 2016, at https://berniesanders.com/ issues/ medicare-for-all/.

The non-partisan Committee for a Responsible Federal Budget (CRFB) analyzed Senator Sanders' proposal from a financial standpoint.[5] He calls for six new or expanded taxes. Taxpayers would pay 6.2 percent more in payroll tax and 2.2 percent more in income tax. This combined 8.4 percent tax increase would have the greatest impact on low-income workers, according to the analysis. Rather than receiving "free" Medicaid, these workers would have 8.4 percent less in take-home pay, resulting in lower family income and higher poverty rates.

High-income workers would experience four additional taxes. Income taxes would increase, capital gains would be taxed as ordinary income, certain current deductions would be eliminated, and estate/death taxes would increase. Marginal tax rates for people earning between $18,550 and $75,300 would go from 30.3 percent to 38.9 percent (a 25 percent increase). For higher-income workers (those with incomes greater than $250,000), income plus payroll taxes would go up to 77 percent and capital gains taxes would reach 64 percent.

The "Medicare for All" plan would cut provider payments dramatically. Hospitals and doctors would see their reimbursements drop to Medicaid levels which are only 30 percent to 40 percent of what private insurance pays. Providers would not be able to exist with these low payments, endangering the entire health care delivery system.

Even with these expanded taxes and provider reimbursement cuts, multiple analysts, including the non-partisan Congressional Budget Office, find Senator Sanders' calculations to fall short of funding that would be needed by $14 trillion to $32 trillion over 10 years. Although the proposed tax increases would be staggering, the overall impact on the U.S. economy and on economic growth would be even greater. There are now multiple examples of countries that enacted socialist programs and ultimately became mired in stagnant economies and falling standards of living.

The existing Medicare program, created in 1965, is essentially a socialized health care program for seniors. The cost was seven times over the original budget estimate by 1990. There is no reason to believe a huge government entitlement like "Medicare for All" would remain within its proposed budget.

Half of all Americans receive their health insurance from their employer or their spouse's employer. "Medicare for All" would eliminate employer-paid health insurance and force all of these workers into the government-run, single-payer plan.

Vermont tried to institute a single-payer system at the state-level. In 2011, the state legislature passed, and Governor Pete Shumlin signed, "An Act Relating to a Universal and Unified Health System." The state-wide single-payer system was to start in 2017. By 2014, however, fiscal estimates showed that the state budget would need an extra $2 billion in 2017 to fund the program. This would be a 35 percent increase over the state's original $5.7 billion 2017 budget.[6]

State officials found they would need to raise taxes to levels unacceptable to the public and at the same time, cut doctor payments to unrealistic amounts. Rather than

5 "Analysis of the Sanders single-payer offsets," Committee for Responsible Federal Budget, February 3, 2016, at http:// www.crfb.org/blogs/analysis-sanders-single-payer-offsets.

6 "2017 Fiscal facts, Vermont Legislature, Joint Fiscal Office," at http://www.leg.state.vt.us/jfo/publications/2017%20Fiscal%20Facts%20--%20Final.pdf.

press ahead, Vermont officials admitted failure and abandoned the plan in December 2014.[7]

The status of Medicaid

The traditional Medicaid entitlement program was enacted in 1965 as part of the Medicare bill and provides both federal and state health care funding for poor children and their families, as well as for disabled individuals. It also provides long-term care. As part of the Affordable Care Act, states are allowed to expand their Medicaid programs to include any low-income, able-bodied adult.

As of August 2018, the Medicaid program covered 73 million individuals nationally, including 1.7 million people in Washington state.[8] It is the largest entitlement program in the world by enrollment and functions as a single-payer, government-controlled health insurance plan.

Although the expanded Medicaid program created under the ACA is largely funded by the federal government, approximately half of traditional Medicaid is funded by state taxpayers. Medicaid entitlement expenditures are the fastest growing budget items for virtually all states. The program's cost ranks second behind funding for K-12 public education in Washington state.

Doctor reimbursements in the program are 60 to 70 percent lower than what private insurance pays. Like Medicare, an increasing number of physicians are withdrawing from the program, saying the small government payments they receive are not enough to maintain their practices, which in turn sharply limits access to health care services for enrollees.

The cost of the Medicaid entitlement was $1 billion the first year after enactment, and it exploded to $577 billion by 2017.[9] At the present rate of growth, and even without considering the expansion created by the ACA, Medicaid entitlement costs will reach $700 billion a year by 2020.

Medicaid has resulted in a number of harmful consequences. It discourages work and job improvement for low-paid employees, since with increasing income workers stand to lose their Medicaid benefits. It also encourages low-wage employers not to offer health benefits, leaving it to government to cover these costs instead.

Medicaid discourages private insurance companies from offering long-term nursing-home policies, and as a result this private market shrinks every year. Lastly, a Harvard University study of the Oregon Medicaid program found that clinical outcomes for patients enrolled in Medicaid were no better than a similar group of people who did not have health insurance.[10]

State lawmakers are caught in a vicious cycle. The more state money they spend on Medicaid, the more federal money they receive from the national government,

7 "Six reasons why Vermont's single-payer health plan was doomed from the start," by Avik Roy, Forbes Online, December 21, 2014, at https://www.forbes.com/sites/theapothecary/2014/12/21/6-reasons-why-vermonts-single-payerhealth-plan-was-doomed-from-the-start/#7111b7fd4850.

8 "Medicaid and CHIP total enrollment chart – August 2018," at Medicaid.gov, August 2018, at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/total-enrollment/index.html.

9 "Total Medicaid spending," FY2017, The Henry J. Kaiser Family Foundation, at https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

10 "The Oregon experiment – effects of Medicaid on clinical outcomes," by Katherine Becker, et. al., *New England Journal of Medicine,* 2013; 368: 1713-1722 @ http://www.nejm.org/doi/full/10.1056/ NEJMsa1212321.

even though the cost is borne by their own constituents, who of course are also federal taxpayers.

Republican and Democrat lawmakers alike have voted to expand Medicaid well beyond the original safety-net entitlement. It is no surprise that the Medicaid program is the largest, and fastest growing, budget item for almost all states, and that it crowds out funding for other important government programs such as education and transportation.

There is growing interest to expand Medicaid further, for example, to include funding for low-income housing and for food supplements.[11] The term "health" can be politically expanded to include a number of socio-economic areas, and Medicaid dollars are very attractive for many forms of wealth redistribution. State officials like the federal matching money and lawmakers like to give out apparently "free" benefits. Medicaid expansion could very well become the political platform for creating a single-payer system.

How to reform and improve Medicaid

However, it is not too late to reform Medicaid. The most important first step to reforming and improving the program is to redesign it so it no longer functions as an open-ended entitlement. Welfare reform in the late 1990s, enacted under President Clinton, was successful because it targeted benefits and placed limits on how many years people could expect government support.

Medicaid recipients should have a copay requirement based on income. Where applicable, enrollees should have a work requirement. Like welfare, Medicaid should be viewed as a transition program to help low-income families achieve self-confidence, economic independence, and full self-sufficiency.

It is mean-spirited and 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 a voucher system would financially reward enrollees for leading a healthy lifestyle and making smart personal choices.

Local control of the management and financing of entitlement programs works best. States, rather than the federal government, should be placed in charge of Medicaid. Block grants and waivers from the federal government would allow states to experiment with program design and to budget for Medicaid more efficiently. Some states are already experimenting with work requirements and modest co-pays.

The income requirement should be returned to 133 percent of the federal poverty level. Medicaid should help the neediest families, and not be a subsidized "safety-net" for middle-income people.

The Affordable Care Act, or Obamacare

The Affordable Care Act (ACA) was passed into law with only Democratic votes in 2010. The main goals of the law were to slow the persistent rise in health care costs and to decrease the number of uninsured people in the U.S. The non-

11 "As part of push to treat 'whole person,' hospitals may be able to use Medicaid funds to pay for patients' housing, food," KHN Morning Briefing, Kaiser Health News, November 15, 2018, at https://khn.org/morning-breakout/as-part-of-push-to-treat-whole-person-hospitals-may-be-able-to-use-medicaid-funds-to-pay-for-patients-housing-food/.

partisan Congressional Budget Office (CBO) estimated the cost of the ACA would be approximately $940 billion for the first ten years.

Taxes to pay for the program began in 2010, but benefits did not start until 2014. In other words, the original budget was based on 10 years of income to pay for the program, but only six years of payouts for benefits. There are no CBO estimates for the ACA's costs in its second 10 years, but independent analysis shows the potential cost could be over $2 trillion, adding a substantial financial burden on the U.S. yearly budget deficit and the national debt.[12]

The funding for the ACA comes from two main sources. Almost half of the $940 billion in spending in the first 10 years comes from new or expanded taxes, and the other half comes from large cuts to the Medicare program. These Medicare cuts are essentially an accounting function, because they simply transfer funding from an existing government health care program to the new health care plans in the ACA.

After removing $40 billion to $50 billion for administrative costs, the balance of the $940 billion essentially funds two programs – a large expansion of Medicaid entitlements ($450 billion) paid for by the federal government, and taxpayer subsidies for people to purchase health insurance in newly-created state and federal health insurance exchanges ($450 to $500 billion).

To date, 20 million people have obtained health insurance through Obamacare, with 10 million people put into the expanded Medicaid program and 10 million people receiving taxpayer subsidies in the exchanges.[13]

State taxpayers are also federal taxpayers. Consequently, as states such as Washington expand their Medicaid programs under the ACA, state taxpayers will ultimately be responsible for the cost of that expansion. Supporters of Obamacare would like to see further expansion of the Medicaid program to all states.

For political reasons, a public option was not included in the original ACA law. All Republican and many Democratic Members of Congress felt that placing a public option insurance plan in the exchanges would lead directly to a single-payer system.

A taxpayer-funded public option would devastate the private individual health insurance market and would potentially provide employers with a "free" health insurance alternative for their employees. Yet many states, including Washington state, are considering legislation to introduce a public option in the ACA exchanges. As the country learned with Medicare, it is impossible for private companies to compete with the government.

Both the expansion of Medicaid and the creation of a public option health insurance plan would increase government involvement in the U.S. health care delivery system.

12 "Obamacare now estimated to cost $2.6 trillion in first decade," by Daniel Harper, *The Weekly Standard*, June 11, 2012, at http://www.weeklystandard.com/blogs/obamacarenow-estimated-cost-26-trillion-first-decade_648413.html.

13 "Nearly 20 million have gained health insurance since 2010," by Nicholas Bakalar, *The New York Times*, May 22, 2017, at https://www.nytimes.com/2017/05/22/health/obamacare-health-insurance-numbers-nchs.html

Reform of the ACA

Congress was unable to repeal and replace the ACA in 2017. The longer an entitlement runs, the more accepting the American public becomes and the less likely it is that lawmakers will be willing to remove the program.

There are, however, common sense reforms to the ACA. The individual and employer mandates in the ACA should be eliminated. The Congressional tax reform of 2017 eliminated the "tax" on the individual mandate. A current lawsuit is testing the constitutionality of the entire law. Medicaid reform would make the program a true safety-net for low-income families who need it, while public policy would encourage and support most people in taking advantage of private-sector competition to prepare for unexpected health care costs.

The current federal administration has encouraged states to offer innovative alternatives to the ACA. The administration has also expanded the use of short-term, limited-duration health insurance plans and association health plans to decrease cost and increase access to health care for Americans.

The ACA imposes a huge, unnecessary regulatory burden on our health care system. These heavy regulations could be repealed or dramatically rolled back to allow a free exchange of prices, coverage options and health services between patients and providers.[14]

The Veterans Administration

The Department of Veterans Affairs (VA) is the second largest department in the federal government, serving nine million veterans with a budget of $200 billion per year.[15] Currently, the VA is a true socialized medicine program, with the government owning the hospitals and employing the doctors and staff. In one form or another, the department has been active since the Revolutionary War.

Quality and timeliness of care is not uniform in all VA facilities. Scandals have plagued the organization as veterans have been denied timely care and been placed on waiting lists. Privatization of parts or all of the system has been debated for years.[16] Privatization would allow veterans to obtain health care in the private, efficient marketplace, just as the majority of Americans do. Because of the unique needs of combat veterans and because of widespread support, the VA system will remain in place for the foreseeable future.

Employer-paid health benefits

Employer-paid health insurance is unique to the United States and dates back to 1943. During World War II, the federal government imposed wage and price controls, but it did allow employers to offer tax-free benefits, including health insurance for employees. After the war, the wage and price controls were repealed, but the concept

14 "Health care lawsuit reform in Washington state," by Roger Stark, MD, Policy Brief, Washington Policy Center, August, 2012 at http://www.washingtonpolicy.org/publications/brief/healthcare-lawsuit-reform-washington-state.

15 "We can fix veterans' health care without privatizing it," by N. Schlichting, *The Washington Post*, April 2, 2018, at https://www.washingtonpost.com/opinions/we-can-fix-veterans-health-care-without-privatizing-it-heres-how/2018/04/02/3b85a448-3443-11e8-8bdd-cdb33a5eef83_story.html?utm_term=.dbf96600ab24.

16 "Trump Administration plots costly private-care expansion for veterans," by Isaac Arnsdorf, Pro Publica, Inc., November 15, 2018 at https://www.propublica.org/article/trump-administration-plots-costly-private-care-expansion-for-veterans.

of tax-free employer-paid health insurance remained and has continued to the present time.[17]

Half of all Americans now receive their health care benefits from their employer or their spouse's employer. Although this arrangement has created a tax distortion and is one of the main reasons for job-lock (employees afraid to change jobs because they may lose health benefits), it currently enjoys widespread popularity. Employers often compete for workers based on the generosity of the health benefit plans they offer. Employers also benefit from the policy of a tax break for employee benefits, rather than paying workers higher taxable wages.

Employer-based health plans are also not subject to the ACA and state benefit mandates, but instead are governed by federal ERISA laws. The largest employers self-insure, while most smaller and medium sized employers use private, commercially-available insurance companies.

Employers are seeing their benefit costs go up and are shifting more financial responsibility to employees through the use of health savings accounts and high-deductible insurance plans. However, because of the popularity and the long-standing history of employer-paid health insurance, it will remain a major feature of the U.S. health care delivery system. It will also serve as a major deterrent to Congress imposing a national single-payer plan.

The individual health insurance market

The individual health insurance market is actually the smallest of all the health insurance markets in the U.S. The taxpayer-subsidized ACA exchanges have 10 million enrollees and the private individual market has an additional 10 million participants.[18]

These 20 million people are affected the most by the changes in the health care system caused by Obamacare. The costs of insurance premiums are rising for all people in the U.S. (except for Medicaid enrollees), yet costs are rising much faster for people in the individual market.

The costly individual mandate in the ACA has caused young, healthy people to forgo the purchase of health insurance. They have made a reasonable economic decision that the government-approved health insurance is not worth the price to them, especially with the pre-existing condition mandate that forces insurance companies to sell policies after individuals become ill.

Consequently, the individual market is composed of an ever-increasing percentage of older, sicker people. Insurance companies have responded by raising premium rates and narrowing their provider networks. As premiums increase, the subsidies in the ACA exchanges increase as well. These increases in subsidies will keep the exchanges viable for the foreseeable future. The individual market outside the exchanges will likely collapse.

17 "Health care reform; lowering costs by putting patients in charge," by Roger Stark, MD, Policy Brief, Washington Policy Center, June 2015, at https://www.washingtonpolicy.org/library/docLib/Stark-_Health_care_reform_and_alternatives_to_the_Affordable_Care_Act.pdf.

18 "20.1 million fewer Americans are uninsured post-health law, but coverage remains uneven," KHN Morning Briefing, Kaiser Health News, November 16, 2018, at https://khn.org/morning-breakout/20-1-million-fewer-americans-are-uninsured-post-health-law-but-coverage-remains-uneven/.

Insurance companies

Every year millions of Americans buy auto, home, and life insurance from national companies in the competitive market-place. People are savvy shoppers and have multiple choices when buying these types of insurance.

Insurance is defined as "a practice or arrangement by which a company or government agency provides a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a premium."[19]

People often view health insurance differently than other types of insurance, however. When a person says he has "great health insurance," what he actually means is that his insurance covers nearly everything related to receiving health care, with essentially no out-of-pocket expense. Covered services can include dental treatment, eye wear, and routine visits to the doctor. This is analogous to a person having auto "insurance" that pays for routine maintenance services, including gas, oil, and brakes.

Obviously, the human body is different from a car or a house. However, from an insurance standpoint, which involves assessing and mitigating risk, health insurance should not be fundamentally different from auto or home-owners insurance.

The sale of health insurance in the U.S. began in the early 1900s and within several decades was accepted and well established. Many of the early health plans were set up as pre-payment for major medical expenses, similar to current health maintenance organizations (HMOs). Blue Cross, which pays hospitals, and Blue Shield, which pays doctors, began in the 1930s, and as non-profits both organizations have enjoyed a tax-free status since then.

Multiple private health insurance companies have been founded over the last 50 years. Consolidation among these companies is now occurring at a rapid pace.[20] A few private companies specialize in handling Medicaid patients for state governments.

Health insurance companies are heavily regulated by the federal government and by state governments. The benefits provided by the insurance plans and the price of the plans are dictated by the government, so competition and consumer choice among companies is limited.

Most health insurance companies are reducing their participation in the individual market and are increasing their activity in the group or employer market, as well as the co-pay insurance market associated with Medicare.

The private insurance industry is a big part of health care in the U.S. It is well-financed and has a large political influence in Washington, D.C., as well as in every state capitol. The industry will survive and will continue to play a major role in opposing adoption of a single-payer, government-run health care system.

19 "Is health insurance different than other types of insurance?," by Roger Stark, MD, Policy Note, Washington Policy Center, January, 2018, at https://www.washingtonpolicy.org/library/doclib/Stark-is-health-insurance-different-1.2018.pdf.

20 "What merger mania means for health care," by P. LaMonica, CNN Business, March 8, 2018, at https://money.cnn.com/2018/03/08/investing/health-care-mergers-cigna-express-scripts-consolidation/index.html.

Hospitals and doctors

Hospital mergers and the salaried employment of doctors by hospitals are increasing at a rapid rate, leading to fewer doctors with independent practices.[21] This trend is driven by several factors.

Theoretically, hospital mergers should reduce costs by increasing centralized purchasing power. From an economic standpoint, however, reducing competition leads to monopoly-type pricing and less consumer choice, which actually increases costs.[22]

Medicare and Medicaid set provider reimbursement dollar amounts and these are non-negotiable. Private insurance companies likewise negotiate fees and have followed the government programs in decreasing provider payments. Doctors are moving from independent practice to hospital employment to guarantee at least their base salaries, regardless of what the insurance plans pay. Hospitals employ doctors to lock-in referral sources and to maintain a steady stream of patients.

The latest trend is more health insurance company involvement on the provider side of medicine. Insurance carriers are starting to employ doctors and buy outpatient clinical facilities outright, rather than just paying patients' medical bills.[23] The economic motivator for insurance companies is greater cost containment, since doctors in many cases drive health care costs by the number of tests and procedures they perform.

These company-owned health care models, a variation of health maintenance organizations (HMOs), have been tried in the past. Group Health Co-Operative was very active in Washington state until it was recently sold to Kaiser Permanente. Kaiser remains one of the premier HMOs in the country.

Experience with HMOs in the 1980s and 1990s showed that they can hold health care costs down. However, this was done with a gate-keeper system that tended to deny patients certain treatments and specialty referrals. HMOs were not popular with patients or doctors.

Over the past 20 years, medical care, when possible, has shifted to outpatient clinics. It is cheaper and easier for the patient to use an outpatient facility than to undergo the same procedure in a hospital. The time patients stay in the hospital has likewise been streamlined, and early-discharge, when medically appropriate, is now common.

Changes in physician training

Physician training after graduating from medical school is undergoing change as well. Limits have been placed on the number of hours a medical resident can work in any one week.[24] This model is gaining popularity for doctors employed by hospitals.

21 "How hospital merger and acquisition activity is changing healthcare," by J. LaPointe, Revcycle Intelligence, xtelligent Healthcare Media, 2017, at https://revcycleintelligence.com/features/how-hospital-merger-and-acquisition-activity-is-changing-healthcare.

22 "Monopolized healthcare market reduces quality, increases costs," by A. Kacik, Modern Healthcare, April 13, 2017, at https://www.modernhealthcare.com/article/20170413/NEWS/170419935.

23 "Reigniting the physicians arms race, insurers are buying practices," by S. Livingston, Modern Healthcare, June 2, 2018, at https://www.modernhealthcare.com/article/20180602/NEWS/180609985.

24 "ACGME duty hours are not the only big change in requirements," by B. Doolittle, MD, *New England Journal of Medicine*, NEJM+, May 25, 2017, at https://knowledgeplus.nejm.org/blog/acgme-duty-hours-not-the-only-big-change-in-requirements/.

Instead of one physician caring for a patient 24 hours a day, the trend is now for doctors to work shifts and pass care over to the doctor working the next shift.

All of these provider trends will continue into the foreseeable future.

Health care lawsuit reform

Unlike other western countries, the United States has a very active legal system, and hospitals, doctors, and other health care providers must constantly manage the impending threat of costly medical lawsuits. In many states, health care lawsuit reform, that is, reasonable limits placed on the cost of a medical lawsuit, has helped hold costs down and provided a stable supply of skilled physicians in the area, while still allowing wrongly-injured patients to have their day in court.

The rise in the number of medical malpractice lawsuits has occurred in waves over the past 50 years. Three periods of crisis in soaring medical malpractice costs occurred in the 1970s, in the mid-1980s, and in the late 1990s to the mid-2000s. Malpractice insurance premiums for doctors fluctuate over time, but they predictably increase dramatically during these times of lawsuit crisis.[25]

The experience of several states, particularly Texas and California, shows that reasonable medical malpractice reform works. A meaningful legal cap on the amount of non-economic damages awarded by a court is the most effective element of successful lawsuit reform legislation. To a lesser extent, a reasonable statute of limitations on when lawsuits can be filed and pre-trial screening to weed out frivolous claims are often effective in reducing the cost of specific medical malpractice lawsuits.[26]

Officials in most states have been unable or unwilling to enact meaningful lawsuit reform, adding significantly to the rising cost of health care. Consequently, it has become a federal issue.[27] It is an uphill battle for Congress, however, because of the fundamental issue of states' rights and the powerful trial lawyers' lobby, which encourages and profits from litigation. For these reasons, meaningful medical lawsuit reform is not likely to happen in the foreseeable future on a national scale.

Providing access to reliable and affordable pharmaceuticals

There is a great deal of confusion and misunderstanding in the United States about drug pricing, manufacturing, marketing, and the impact of government regulations.[28]

There is a growing opinion that the government should place a price control on pharmaceuticals. In 2014, prescription drug costs accounted for only 9.8 percent of overall health care expenses. In economics, setting price limits on goods and services always results in scarcity, with less of the price-controlled product being produced and

25 "Health care lawsuit reform in Washington state," by Roger Stark, MD, Policy Brief, Washington Policy Center, August, 2012 at http://www.washingtonpolicy.org/ library/docLib/health-care-lawsuit-reform-washington-state-pb.pdf

26 "Update on the cost of medical malpractice lawsuits in Washington state - lessons from Texas reform," by Roger Stark, MD, Policy Note, Washington Policy Center, April 11, 2016, at https://www.washingtonpolicy.org/library/doclib/Stark-Update-on-the-cost-of-medical-malpractice-lawsuits-in-Washington-State-Lessons-from-Texas-reform.pdf.

27 "Tort and litigation reform in the 115th Congress," by K. Lewis, Congressional Research Service, April 10, 2018, at https://fas.org/sgp/crs/misc/LSB10118.pdf.

28 "Prescription drug pricing – a complex, poorly understood issue," by Roger Stark, MD, Policy Note, Washington Policy Center, January 24, 2017, at https://www.washingtonpolicy.org/library/doclib/FINAL-PDF-drug-pricing-Roger.pdf.

made available to consumers. This has been confirmed by the disastrous centrally-planned economies of communist countries. Similar distorting effects and shortages would occur if government officials sought to control prescription drug prices in the United States.

If public officials really want to bring prices down and increase competition in the drug industry, they should streamline the government drug-approval process to reduce the time and money manufacturers devote to bringing a new medicine to market.

Depending on the study, the average cost of bringing a drug to market today is between $2.5 billion and $5 billion, and it takes from ten to 15 years to get through the government regulatory approval process.[29] There is even a backlog of generic drugs awaiting government approval; these are the medicines that have long been approved and available in patent form. The current Food and Drug Administration is trying to reduce these regulatory barriers and is working to speed up the drug-approval process.

Drug pricing is a complex process that involves not only research and development costs but also is distorted by third-party payers (such as insurance plans) and by pharmaceutical benefit managers. Rather than dealing with the entire process and removing complexity and waste, it is easier and more politically attractive for elected officials to simply demand that the government impose price controls on drugs.

As a result, patients in the U.S. may very well experience price controls on medications in the future, beginning with people in the Medicare and Medicaid entitlement programs.

Innovative and free market ideas

The United States has the most vibrant and innovative economy in the world. It has an abundance of entrepreneurs who work hard to make life better for people. In spite of government regulations and control, free market ideas continue to percolate up to become reality and provide better access to health care at lower costs for patients. Following are examples of how free-market creativity is improving the delivery of quality health care.

Affordable direct primary care

Many primary care doctors have become tired of government regulations, paper work, and ever-decreasing payments from Medicare and Medicaid. They have elected to practice medicine without the hassles of dealing with insurance companies – both private and government plans.

Doctors who have direct primary care (DPC) practices offer patients 24-hour access to a primary care physician for a fixed monthly price. DPC began as an alternative for wealthy patients (then called "concierge medicine"), but it has become affordable and has expanded into the Medicaid population.[30] Patients still need to have a major medical insurance plan to cover hospitalizations, but patients can access all routine primary care directly with an independent doctor using DPC.

29 "Cost to develop new pharmaceutical drug now exceeds $2.5 B," by Rick Mullen, *Scientific American*, November 24, 2014 at https://www.scientificamerican.com/article/cost-to-develop-new-pharmaceuticaldrug-now-exceeds-2-5b/

30 "Qliance; a revolution in primary care," by E. Bliss, MD, Washington Policy Center presentation, June 3, 2009, at https://www.washingtonpolicy.org/library/docLib/erika_bliss_presentation_wpc_09.pdf.

The use of DPC is growing and is a viable and affordable option for millions of Americans.

Telemedicine

People living in certain geographic areas in the United States lack access to primary and specialty health care. These are mostly people living in rural areas where patients have no timely access to doctors, nurses, or other medical professionals. Nearly 59 million Americans nationally and 1.2 million Washingtonians live in areas with a shortage of access to local doctors and clinics.[31]

Telemedicine is defined as "the remote diagnosis and treatment of patients by means of telecommunication technology." It is gaining in popularity because it offers a practical and affordable solution to lack of health care services in rural areas. Telemedicine allows patients to remain in their own town, or even their own home, and receive direct care and medical advice from a distant provider.

Early reports show that patient and physician satisfaction is high with telemedicine. However, the different guidelines imposed by the various insurance programs, both public and private, is an ongoing administrative problem for providers. The use of telemedicine will increase in the future as data and communication costs fall and as patients become more familiar with the technology.

Alternative health coverage programs

Faith-based, or "health sharing ministries," allow people of the same religion to form a health insurance co-op. These plans are not true insurance and are not regulated by the ACA, so they are free of the many costly benefit mandates required by Obamacare. Consequently, they are cheaper than traditional health insurance.[32]

They function similarly to traditional insurance, although these plans do not necessarily have a large "reserve" of money. Instead, they "share" health care costs among plan members. Confidence in these plans is growing, as they demonstrate their value and reliability in paying for life's unpredictable medical expenses. There are currently fewer than 10 ministries throughout the country, but this number is predicted to increase.

A similar plan to faith-based ministries is a start-up company called Health and Prosperity Partnerships for Everyone or HAPPE. It is essentially a non-religious, voluntary co-op in which members share health care costs. If successful, the concept could provide an affordable alternative to traditional insurance for individuals, as well as for employees in large-group employer plans.

Health savings accounts (HSAs), coupled with high-deductible insurance plans, are gaining popularity with people in the individual market and with employers.[33] Approximately 22 million Americans now have HSAs. These individual accounts build tax-free cash over time to use to pay routine medical expenses. They give

31 "Telemedicine in Washington state," by Marcia Frellick, WSMA Reports, Washington State Medical Association, November/December 2017.

32 "What is faith-based healthcare?," by J. Mendelowitz, HealthCare.com, September 24, 2017, at https://www.healthcare.com/info/obamacare-alternatives/what-is-faith-based-healthcare.

33 "Health savings accounts assets up 22% in 2017," Devenir Newsroom, February 22, 2018, at http://www.devenir.com/health-savings-account-assets-22-2017/.

patients more control over their health care dollars and allow patients to become better consumers of medical care.

Voluntary, alternative health coverage options can thrive, provided that bureaucrats do not impose a heavy government regulatory burden on the plans.

Technology innovations

As in so many areas of our daily lives, the boom in technology potentially offers patients more control over their health care at greatly reduced costs. For example, there are currently dozens of smartphone apps for both providers and patients that offer more information in a timelier fashion than traditional medical devices.[34] Competition in the free-market is holding down the cost of these innovations.

For doctors, hospitals and clinics, research and development have made traditional medical devices smaller, more affordable, and more user-friendly. For example, sonogram imaging machines, once large, expensive and cumbersome, are now more affordable, produce higher-quality images, and are portable.

No one can predict the number of innovations that will be available in the future. The market place, through patient experiences, should determine the value of the innovations, not government officials imposing regulations based on the vague guesses they make about future technology.

A two-tiered health care system

There is a possibility that health care in the U.S. will evolve into a two-tiered system. Medicare, Medicaid, the individual market in the Obamacare exchanges, and the Veterans Administration system together now provide health insurance for over 40 percent of Americans. Alternatively, fifty percent of Americans receive their health insurance from their employers or their spouse's employer in a heavily regulated private market.

Before the Medicare and Medicaid law was passed in 1965, communities had charity or county hospitals that provided free and reduced-priced care to low-income people. Patients received excellent care in these facilities, albeit in a multi-bed ward setting with many medical interns and residents providing the care. Many of these hospitals still exist and continue to handle a large portion of Medicaid patients and trauma victims. Before 1965, private hospitals treated patients with private insurance or those who paid out-of-pocket.

Today, private hospitals treat patients who do not have government insurance, Medicare patients, and some Medicaid enrollees. These private facilities compete for patients by offering single-patient rooms, new or remodeled structures, and amenities for patients' families.

Because of the inefficient third-party payer system in U.S. health care (regardless of whether the payer is the government or the patient's employer), patients are isolated from the true costs of their hospital care. Consequently, hospitals have very little incentive to compete on the cost of care.

34 "20 hot apps for healthcare providers," by F. Bazzoli, Health Data Management, September 4, 2018, at https://www.healthdatamanagement.com/list/20-notable-apps-for-provider-organizations.

If patients were paying for their own care, it is conceivable that the hospitals would compete not only on quality, but also on price. This is exactly what occurs in other economic activities. Not everyone owns or wants a Lexus and not everyone wants to eat steak every night. Hospitals currently have so much invested in the modernization trend and the third-party payer system is so firmly engrained in the health care system that a return to private plus public hospitals will probably not happen.

The government would need to de-regulate the private health insurance industry for a two-tiered system to work effectively. Patients can now obtain and pay out-of-pocket for health care outside of the hospital setting. In-hospital care, however, can be very expensive and for most patients requires insurance coverage. There is currently very limited enthusiasm for reducing costs through health insurance de-regulation.

On the other hand, patient care outside of the hospital setting is already forming a two-tiered system through the growth of direct primary care as well as technological innovations.

Conclusion

It is nearly impossible to repeal an entitlement once the government has enacted it, gotten people dependent on it, and attracted powerful interests groups to defend and expand it. For example, Medicare is not financially sustainable in its present form. Yet, even the idea of gradual reform of the program is extremely unpopular with seniors and their political advocates. This creates an atmosphere in which a thoughtful debate is almost impossible. The same is true of reform or replacement of Medicaid and the taxpayer subsidies in the Obamacare exchanges.

Consequently, it appears that the government health care entitlements are here to stay and will probably expand in the future. A fully socialist single-payer system is now a stretch too far for most Americans. However, an incremental movement toward a single-payer system is not only possible but is also being advocated by many on the left. By dropping the age of eligibility for Medicare, by offering a pubic option in the ACA exchanges, by shifting more people into Medicaid, and by allowing people to buy into Medicare or Medicaid, the country could gradually move toward a single-payer, government system by default.

Employer-paid health insurance remains popular, is well accepted in the U.S., and has a 75-year history. It will continue for the foreseeable future. On the other hand, if premiums for employers continue to increase, more costs may shift to employees. Ultimately, employers, especially small and medium-sized companies, may drop employee health benefits completely.

Existing health insurance carriers, drug manufacturers, and medical device companies are extremely well financed. They will remain in place. New companies in these fields will find it difficult to get established in the current financial and regulatory climate unless they are purchased early by an existing company.

Private health care, outside of the insurance market, will continue to grow through technological innovations, health savings accounts, and direct primary care. New insurance models, such as HAPPE and faith-based plans, will thrive if protected from

government interference, but they will still represent a small portion of total health care delivery.

In general, the country appears to be moving gradually, but persistently, toward a socialized single-payer health care system. The greatest unknown factor looking ahead is how Americans who are not currently dependent on government insurance plans and who benefit from good-quality private coverage will respond to even greater political control over their health care.

Free market solutions do exist. To control costs, increase choice, and maintain or improve quality, patients should be allowed to control their own health care dollars and make their own health care decisions. No third party, whether it is the government or an employer, 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 available in a fair, open and free marketplace.[35]

35 "Health care reform: Lowering costs by putting patients in charge," by Roger Stark, MD, Policy Brief, Washington Policy Center, July 6, 2015, at https://www.washingtonpolicy.org/publications/detail/health-care-reform-lowering-costs-by-putting-patients-in-charge.

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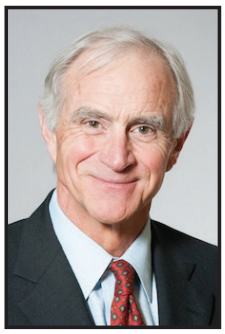

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