FOUR URGENT HEALTH-CARE REFORMS

By **Paul Howard**[1]

Obamacare has made America's $3.2 trillion health-care system more costly and bureaucratic, while still leaving many millions of Americans uninsured. To lower costs and improve care, a healthy dose of competition and deregulation is urgently needed. Here are four steps that Congress and the new Trump administration can take:

1. **Repeal Obamacare and transition to catastrophic health-insurance plans linked to expanded Health Savings Accounts**
2. **Enact per-capita Medicaid spending caps**
3. **Create a new conditional-approval framework at the FDA**
4. **Encourage outcomes-based payments**

1.

Repeal Obamacare and Transition to Catastrophic Health-Insurance Plans Linked to Expanded Health Savings Accounts

Thanks to the Affordable Care Act's many regulations, average insurance premiums have steadily increased—they're up 22% in 2016 alone. This has helped drive younger, healthier applicants from the market, which puts further pressure on premiums and, with an older, sicker group of insured, leads to losses for insurance carriers. Four of the five largest U.S. health insurers have sharply reduced their Obamacare exchange offerings.

The result: millions of uninsured Americans now enjoy fewer health-insurance choices; the options that remain have higher deductibles and smaller networks of doctors and hospitals. To correct this, Congress and the new administration need to replace Obamacare with a more affordable system, giving insurance companies sufficient time to design and price new plans.

[1]For further discussion, see Paul Howard, "Precision Oncology in the Era of Health Care Reform: Improving Outcomes, Sustaining Innovation, Increasing Efficiency," Manhattan Institute, Apr. 28, 2016; and Peter Huber and Paul Howard, "Biopharmaceutical Policy for American Leadership in the 21st Century," in Unleashing Opportunity, eds. Yuval Levin and Emily MacLean (Washington, D.C.: National Affairs, 2016), 52–77.

Post-Obamacare, baseline health-insurance coverage should be tiered to high-deductible plans that are linked to Health Savings Accounts (HSAs), and Obamacare's cost-sharing subsidies should be converted into generous HSA contributions for low-income individuals. A 2014 Manhattan Institute study found that premiums under an HSA-based coverage strategy would fall by 17%–28%, on average, with 12 million more Americans gaining coverage, compared with under Obamacare.

Critically, Congress should reform HSAs, allowing tax-exempt deposits up to a health plan's full annual deductible, as well as premium payments for qualified health plans (including direct primary-care plans). For patients with preexisting chronic illnesses, high-deductible plans should be allowed to cover drugs that prevent complications—including diabetes, high cholesterol, and depression—before the plan's deductible is met.

During the transition to a post-Obamacare health-insurance market, Congress and the new administration should empower states to design more affordable coverage options and stabilize their insurance markets.

First, the Trump administration should encourage states to make use of "innovation waivers," a little-known provision in Section 1332 of the Affordable Care Act. Beginning in 2017, these waivers allow states to ditch many of the law's most expensive regulations—including mandated benefits—in the individual insurance market, provided that the insurance options that replace them offer comparable financial protection, cover approximately the same number of people, and are deficit-neutral.

To make innovation waivers more attractive, the Centers for Medicare and Medicaid Services (CMS) should overturn a 2015 guidance from the Obama administration that prohibits states from merging Obamacare funding with Medicaid subsidies. Merging these two funding streams would allow states to offer lower-cost exchange plans that would be more attractive to younger, healthier enrollees (thus stabilizing the risk pool)—and then use the savings to purchase private coverage for Medicaid enrollees.

2.

Enact Per-Capita Medicaid Spending Caps

Medicaid—the second-largest expenditure in most states' budgets—crowds out spending on other priorities. States attempt to control their Medicaid costs by paying doctors so little that many won't accept new Medicaid patients. This reduces low-income residents' access to medical services.

The first step in reforming Medicaid is for Congress to enact per-capita spending caps. First proposed by President Clinton in 1995, per-capita caps would allot federal funding for discrete categories of enrollees, including able-bodied adults, the disabled, and elderly. According to the Congressional Budget Office, per-capita spending caps could reduce the deficit by $370 billion–$576 billion over 10 years. To help ensure that low-income individuals have access to private insurance, Medicaid funding could be combined with tax credits.

In return for predictable Medicaid spending growth for federal taxpayers, states should be given much greater flexibility to design and administer Medicaid coverage. The CMS can do this by, among others, standardizing Medicaid waivers; allowing states to experiment with Medicaid HSAs; adopting work requirements for able-bodied enrollees; or shifting Medicaid spending to non-health services (like housing vouchers) that might later produce better health outcomes. In return for embracing transparency on spending and health outcomes for beneficiaries, states should get expedited approval for standardized waivers.

3.

Create a New Conditional-Approval Framework at the FDA

The FDA's current drug-approval framework is costly, time-consuming, and insufficiently transparent. To bring a single new medicine to market, it costs $2.6 billion, on average, and takes nearly a decade, according to the Tufts Center for the Study of Drug Development. Most of this expense is related to the high cost of failure: only 12% of medicines tested in humans reach FDA approval.

Modernizing how medicines are tested and evaluated using cutting-edge tools—such as biomarkers, advanced trial designs, and collection of real-world outcomes data—would help manufacturers identify "what works" faster, while weeding out dangerous or ineffective candidates earlier. Reducing reliance on large Phase III trials, currently used to test the efficacy of drugs, could slash development costs by 50% or more, too.

To accelerate the use of these precision-medicine protocols, Congress should create a new conditional-approval framework that would allow the FDA to approve (after initial safety and efficacy testing) targeted medicines for subsets of patients—identified though biomarkers or other sophisticated selection criteria—who currently lack good treatment options. These promising new medicines would then be administered at medical centers with the rapid-learning databases and advanced analytical systems required to reliably monitor patient safety and other outcomes, such as longer lives or fewer disabilities.

This structured approach to early access and evidence generation would be much more transparent, less costly, and less time-consuming, compared with the FDA's mostly binary approval process. It would help physicians tailor treatment strategies to individual patient profiles, as opposed to the average patient profiles generated by current trial requirements.

4.

Encourage Outcomes-Based Payments

"[U.S.] academic medicine and health policy research," notes the Health Care Cost Institute, "resemble the automobile industry of the early 20th century—a large number of small shops developing unique products at high cost with no one achieving significant economies of scale or scope." Indeed, while much of the U.S. economy, from retail to manufacturing, has embraced big-data analytics, America's health-care industry has largely missed the boat.

To boost transparency on health-care costs and patient outcomes, Congress and the CMS should repeal federal regulations that both inhibit the creation of pay-for-performance contracts and the aggregation of large health data sets that are widely accessible to commercial and academic researchers.

Federal regulations like Medicaid Best Price prevent drug manufacturers and insurers from creating pay-for-performance contracts that link drug prices to real-world outcomes—such as helping patients live longer, reducing hospital admissions, or improving the quality of life. CMS should enact robust safe harbors for such contracts to encourage their adoption, and Congress should allocate seed funding for the development of secure, state-based digital warehouses to collect cost and outcomes data (including Medicare, Medicaid, electronic health records, and commercial claims data) that allow patients and physicians to rapidly identify the best, and most efficient, strategies for extending and improving health.

Given this country's massive, diverse population, secure data enclaves accessible to academic and commercial researchers would provide a tremendous platform for medical innovation, allowing the U.S. to extend its international leadership in this vital field.