Chapter 5

Free-Market Healthcare Promotes Choice and Competition

Driven by unparalleled medical innovation, the American healthcare system remains the envy of the world. However, its past success does not mean that healthcare in the United States always delivers the value that it should. Costs for many procedures and medications are too high, access to the healthcare that patients demand is limited, and competition is lacking. But these challenges do not mean that the only solution is increased government intervention. These improvements can be accomplished by enhancing healthcare choice and competition in ways that embrace the value of the market while focusing on patients' needs.

The Trump Administration has already made major progress in delivering high-quality, lower-cost healthcare by creating more choice in health insurance markets and more competition among healthcare providers. In other words, it is possible to keep what works and fix what is broken. For example, the Administration has sought to make healthcare more affordable by lowering out-of-control prescription drug prices and expanding access to more affordable healthcare options. Additional policy changes put patients in control of their healthcare by ensuring price transparency and allowing Americans to pick the care that fits their needs. At the same time, accelerating medical innovation has provided new treatment options for patients living with disease.

Under the Trump Administration, the Food and Drug Administration approved more generic drugs than ever before in U.S. history and updated its approval process for new, lifesaving drugs. This past year, prescription drug prices experienced the largest year-over-year decline in more than 50 years. Whether

it is through reforms that seek to expand association health plans, promote health reimbursement arrangements, or give terminally-ill patients access to potentially lifesaving drugs, among many other successes, every healthcare reform that lowers costs and increases quality allows American workers to live longer, healthier lives and keep more of their paychecks.

The Administration's focus on consumer-centric health policies will make the healthcare marketplace more competitive and protect as well as enable consumers to obtain life-enhancing technologies. For example, the Administration's recent policy change to permit insurers to offer policies with additional benefits covered before a deductible is met and allow enrollees to maintain health savings accounts are real changes already helping those with preexisting conditions. And with future changes under way to enable patients using the real price for major medical services, the effect of the free market to lower health care costs for all consumers has just begun.

Healthcare regulations at all levels of government can increase price, limit choice, and stifle competition—which, in combination, lead U.S. healthcare to fail to provide its full value. These regulations can also harm the broader economy. For example, the Affordable Care Act has impeded economic recovery by introducing disincentives to work. The Trump Administration's successes in addressing these policies over the past three years show the value of empowering the market to deliver the affordable healthcare options that Americans rightly expect. Further patient-centered reforms will provide Americans with improved healthcare through enhanced choice and competition.

The United States' healthcare system relies more on private markets to provide health insurance and medical care than do those of other countries. And the U.S. system is supplemented by public sector programs to finance the care of vulnerable populations, which include low-income and senior populations. Most Americans are in employer-sponsored group health plans and are often satisfied with the insurance coverage and medical care they receive. However, the U.S. system does not always deliver the value it should. Market competition leads to an efficient allocation of resources that should

lower prices and increase quality. But every market has features that deviate from optimal conditions, and healthcare is no exception. Last year (CEA 2019), we discussed obstacles in healthcare markets and concluded that they are not insurmountable problems that mandate the government's intervention.

This chapter identifies government barriers on the Federal and State levels to healthcare market competition that lead to higher prices, reduce innovation, and hinder quality improvements. The chapter proceeds with a review of barriers to competition and choice, and then it provides a summary of the accomplishments and expected effects of Administration health policy in reducing these impediments and creating competitive innovation in the healthcare markets for all Americans. The Administration's reforms aim to foster healthcare markets that create value for consumers through the financing and delivery of high-quality and affordable care. Government mandates can reduce competitive insurance choices and raise premiums.

By focusing on choice and competition, the Administration is encouraging States to provide flexibility to develop policies that accommodate numerous consumer preferences for healthcare financing and delivery. The Administration has addressed these problems through a series of Executive Orders, deregulatory measures, and signed legislation. By 2023, we estimate that 13 million Americans will have new insurance coverage that was previously unavailable due to high prices and overregulation.[1]

Building a High-Quality Healthcare System

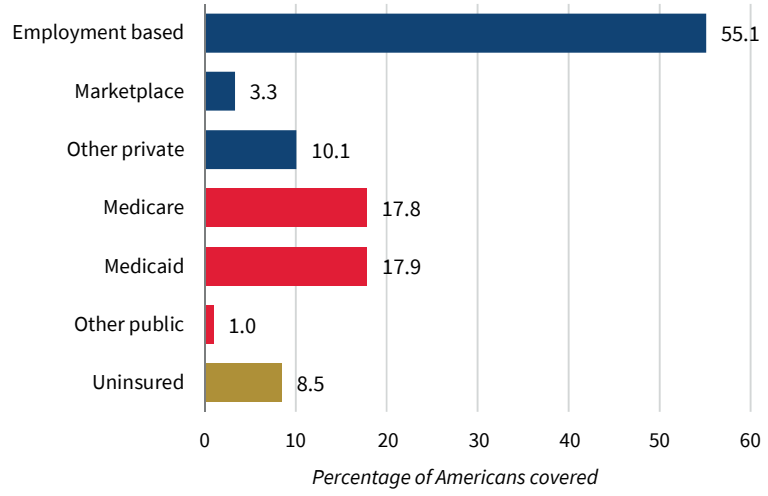
A key goal for the healthcare marketplace is to provide effective, high-value care to all Americans. Achieving this goal requires careful consideration and revision of specific Federal and State regulations and policies that inhibit choice and competition. This section identifies two ways to increase choice and competition: creating more choice in health insurance markets, and creating more competition among healthcare providers.

Creating More Choice in Health Insurance Markets

The majority of Americans obtain health insurance coverage through private sector, employer-sponsored group plans and other private (individual or nongroup) plans (see figure 5-1). The public sector Medicaid program provides coverage to people with low incomes, while Medicare provides coverage to older Americans. Figure 5-1 shows the percentages of Americans that have various

[1] The CEA previously released research on topics covered in this chapter. The text of this chapter builds on the 2019 *Economic Report of the President*; the CEA report "Measuring Prescription Drug Prices: A Primer on the CPI Prescription Drug Index" (CEA 2019c); the CEA report *Mitigating the Impact of Pandemic Influenza through Vaccine Innovation* (CEA 2019d); the report "Reforming America's Healthcare System through Choice and Competition," from the Department of Health and Human Services (HHS 2018); and policy announcements from the Executive Office of the President.

Figure 5-1. Health Insurance Coverage by Type of Insurance, 2018



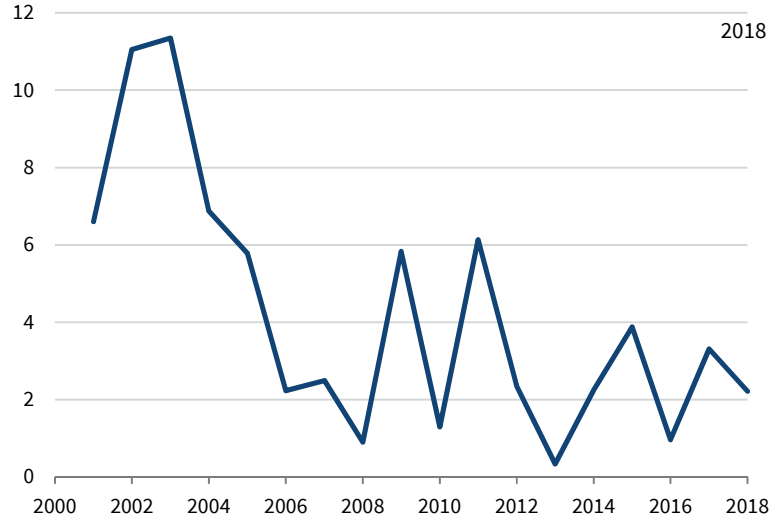
Sources: Census Bureau; CEA calculations.
Note: Numbers do not sum to 100 percent due to overlap for individuals with multiple health insurance plans. Other private plans include nongroup, direct-purchase plans, and TRICARE. Other public plans include veterans health insurance. Blue indicates private health insurance plan types, and red indicates public health insurance plan types.

types of health insurance coverage, but many people have multiple coverage sources; for instance, many older adults on Medicare purchase private supplemental insurance plans. In 2018, more than 67 percent of all Americans were covered by private health insurance plans, while just over 34 percent were covered by public plans. Among the insured population, 12.2 percent had more than one type for all of 2018 (Census Bureau 2019). Employer-sponsored insurance dominates most of the private health insurance market. The individual insurance market accounts for a smaller share of the insured population. In the individual market, consumers buy their insurance through the insurance exchanges established by the Affordable Care Act (ACA) or through ACA-compliant individual policies.

Since earlier in the 2000s, when private health insurance premiums grew rapidly, growth rates have moderated, especially since 2017 (Claxton et al. 2019). Figure 5-2 shows the inflation-adjusted growth in the average premium for family coverage through employer-sponsored group plans. The total premium is paid partly through the employer contribution and partly through the employee contribution. We focus on the total premium because health economists agree that, ultimately, employees also pay the employer-contribution in the form of reduced wages. In the individual insurance market, after the Affordable Care Act established health insurance exchanges, the premiums almost doubled in the first few years. From 2018 to 2019, the benchmark ACA premiums dropped by 1.5 percent. From 2019 to 2020, the benchmark ACA premiums dropped by an additional 4 percent (CMS 2018, 2019).

Figure 5-2. Annual Change in Average Family Premium Including Employee and Employer Contributions, 2000–2018

Percent change (year-over-year)

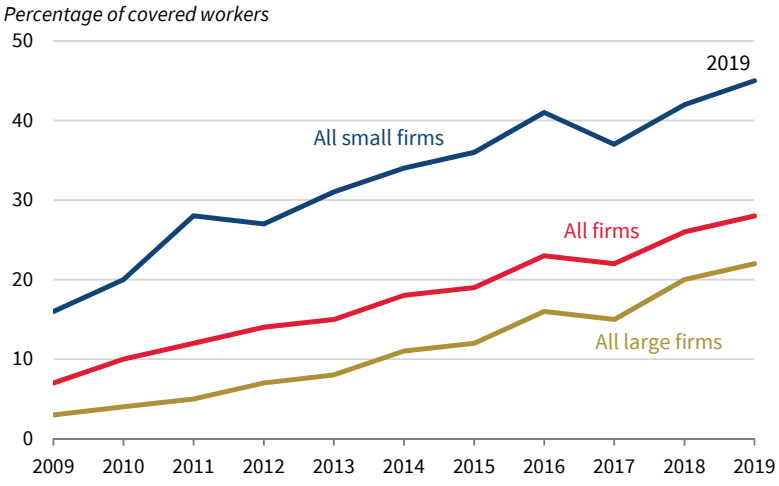


Sources: Kaiser Family Foundation's Employer Benefits Survey; CEA calculations.

Recent health policy changes at the Federal and State levels have sought to give consumers more control over their medical expenditures so they can seek greater value for their health investment. Two of the best illustrations of these consumer-focused policies are health saving accounts (HSAs) and health reimbursement arrangements (HRAs). As described in the Department of Health and Human Services' (HHS) report "Reforming America's Healthcare System through Choice and Competition," the promotion and expansion of these policies, combined with price and quality transparency initiatives, will encourage consumers to make better and more informed care choices to enhance their health (HHS 2018).

"Consumer-directed health plans" (CDHPs) is an all-encompassing term for HRAs, HSAs, and similar medical accounts that allow patients to have greater control over their health budgets and spending. The growth of CDHPs has been substantial, especially by large employers that offer these high-deductible plans, HRAs, and HSAs in a larger strategy to introduce consumerism in employer-sponsored health insurance. HRAs allow employees to shop in the individual market for their preferred plans. Expanding consumer choice in health plans decreases the deadweight loss associated with poor plan matching and leads to gains in consumer surplus (Dafny, Ho, and Varela 2013). HSAs may be especially attractive to consumers because they may be used for nonmedical healthcare expenses and are portable (Greene et al. 2006). In an analysis of firms that completely replaced traditional managed care plans with

Figure 5-3. Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, 2009–19



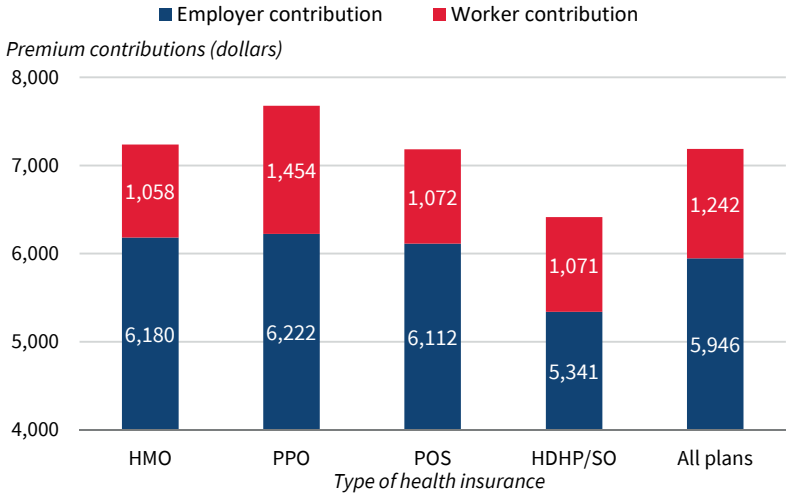
Source: Kaiser Family Foundation's Employer Benefits Survey.
Note: Small firms have 3 to 199 workers, and large firms have 200 or more workers.

CDHPs for their employees, Parente, Feldman, and Yu (2010) saw significant decreases in total healthcare costs, though they were inconsistent among firms that offered different mixes of HRAs and HSAs. CDHPs may also be beneficial for low-income families and high-risk families, where total health spending significantly decreased for vulnerable (low-income or high-risk) families with CDHPs (Haviland et al. 2011). Healthcare costs are also lower for employers offering CDHPs, whose costs in the first three years after a CDHP is offered are significantly lower relative to firms that do not offer a CDHP (Haviland et al. 2016).

As seen in figure 5-3, the share of individuals enrolled in high-deductible health plans in the employer-sponsored health insurance market has risen substantially. This has led consumers to have greater incentives to shop for medical services that are not reimbursed before their deductible is met.

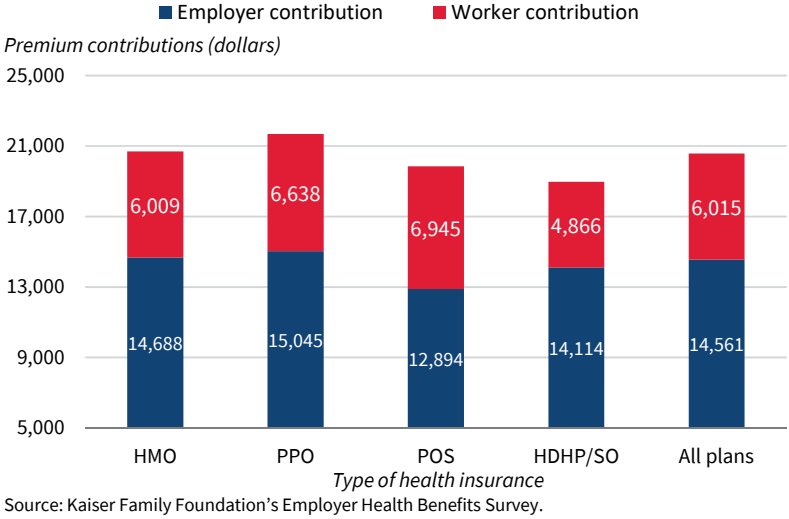
Although the growth of CDHPs has increased out-of-pocket medical expenses on average, the plans are available with significantly lower premiums than other health insurance choices, as seen in figures 5-4 and 5-5. Furthermore, with the Administration's new options to cover predeductible care for the chronically ill with little to no out-of-pocket expense, as discussed later is this chapter, more choices are available for more vulnerable populations than before 2016.

Figure 5-4. Average Annual Worker and Employer Premium Contributions for Single Coverage, 2019



Source: Kaiser Family Foundation's Employer Health Benefits Survey.
Note: HMO = health maintenance organization; PPO = preferred provider organization; POS = point-of-service plan; HDHP/SO = high-deductible health plan with savings option.

Figure 5-5. Average Annual Worker and Employer Premium Contributions for Family Coverage, 2019



Source: Kaiser Family Foundation's Employer Health Benefits Survey.
Note: HMO = health maintenance organization; PPO = preferred provider organization; POS = point-of-service plan; HDHP/SO = high-deductible health plan with savings option.

Creating More Competition among Healthcare Providers

Recent studies of variation in health service pricing suggest that the market lacks needed competition. If competition is reduced among providers (e.g., physicians or hospitals), and in addition there is no change in patient demand, then higher prices and fewer choices are likely to result. These can also lower overall healthcare quality and limit the efficient allocation of resources. Government policies can diminish competition by adversely limiting the supply of providers and the scope of services they offer.

Choice and competition can be limited by State policies that restrict entry into provider markets. This, in turn, can stifle innovation that could lead to more cost-effective care provision. Higher healthcare prices and fewer incentives for quality improvement by providers can be the results of these market-stifling State policies. In particular, state-specific certificate-of-need laws could reduce provider access and create unnecessary monopoly pricing where there is limited competition. In chapter 6 of this *Report*, we discuss advocacy efforts by the Trump Administration to limit the harmful effects of certificate-of-need regulation.

Since the 1990s, markets for a variety of healthcare services have become more consolidated (NCCI 2018). Some consolidation involves cross-market mergers—as, for example, when hospitals operating in different regions form a system—but there is also evidence of increasing concentration in local markets. As discussed in chapter 6, the Federal Trade Commission (FTC) and the Department of Justice's (DOJ) Antitrust Division classify markets using the Herfindahl-Hirschman Index (HHI). Between 1990 and 2006, the proportion of metropolitan statistical areas (MSAs) with hospital market HHIs classified as "highly concentrated" (i.e., with an HHI above 2,500) rose from 65 percent to more than 77 percent (Gaynor, Ho, and Town 2015). Concentration has also risen significantly in health insurance markets. Even when consolidation occurs between close competitors, consumers can benefit from substantial efficiency gains.

However, the trends of rising concentration have properly drawn attention to the question of how consumers are affected. A recent but growing body of literature has linked increasing concentration in hospital markets to rising prices, markups, and falling quality. A number of studies have found that mergers between hospitals that are close competitors leads to significantly higher prices without improving quality (Vogt and Town 2006; Gaynor and Town 2012), or in settings with regulated prices, to lower quality (Kessler and McClellan 2000; Cooper et al. 2011). This literature is still young, and more needs to be done, particularly to assess what is driving the consolidations. Fuchs (1997) argued that the rise of health maintenance organizations is a contributing factor, as hospitals seek to offset the bargaining power of large

insurers by becoming large themselves; but as discussed by Gaynor, Ho, and Town (2015), the empirical evidence for this is mixed.

More generally, it is important to understand if rising concentration is associated with factors, such as rising fixed-cost investments or economies of scale, that may benefit consumers. This causality issue is discussed in chapter 6. At a minimum, however, these results suggest that market structure is an important aspect of healthcare markets.

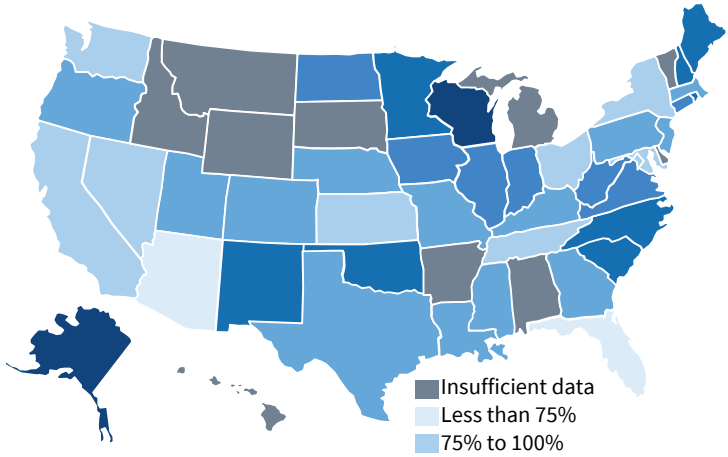
Consolidation is also seen in the prescription drug market. The growth in importance of pharmacy benefit managers (PBMs) to serve as intermediaries between drug manufacturers and health insurers also increased the size of the largest PBMs, their purchasing power, and their ability to obtain rebates and discounts from manufacturers (Aitken et al. 2016). PBMs are resistant to list drug price increases, as their profits are usually a percentage of drug list prices—thus, there is little incentive to reduce the amount charged to insurers. As discussed later in this chapter, the three largest PBMs hold 85 percent of market share.

One way to gauge the uneven competition among healthcare providers is to examine the degree of competition (or lack thereof) in major metropolitan markets. Data made available by the Health Care Cost Institute (HCCI 2016) used negotiated provider price data to illustrate the degree of lack of competition present in the market at the national and regional levels. Using data from HCCI, Newman and others (2016) examined variations in the negotiated rates of providers from 242 possible medical services. They calculated the ratio of the average price paid in each State to the average national price for a given medical service by ratio categories for each of the 242 services. Figure 5-6 presents a map depicting variation in cataract surgery prices by state.

The map illuminates both regional patterns and variations among State-level average cataract removal prices. For example, Iowa, Illinois, and Indiana all have prices between 125 and 150 percent of the national average price. Alternatively, across four States in the Southeast, the ratio of State average price to national average price decreases from 150 through 175 percent in the Carolinas to a ratio of less than 75 percent in Florida.

Kansas and New York have prices close to the national average price for cataract surgery, at $3,382 and $3,678, respectively, compared with $3,541 (HCCI 2016). However, the average prices in the neighboring States of Nebraska and Connecticut are $957 and $1,181 more. With respect to knee replacements, New Jersey and Kansas have the lowest average prices; and Washington, Oregon, and South Carolina have the highest average prices. Prices in Connecticut and Iowa are about the same as the national average price of roughly $36,000. The data show that Arizona, Texas, Rhode Island, and West Virginia have the lowest average prices for a pregnancy ultrasound, while Oregon, Wisconsin, and Alaska have some of the highest average prices.

Figure 5-6. Ratio of State Average Price to National Average Price of Cataract Removal, 2015



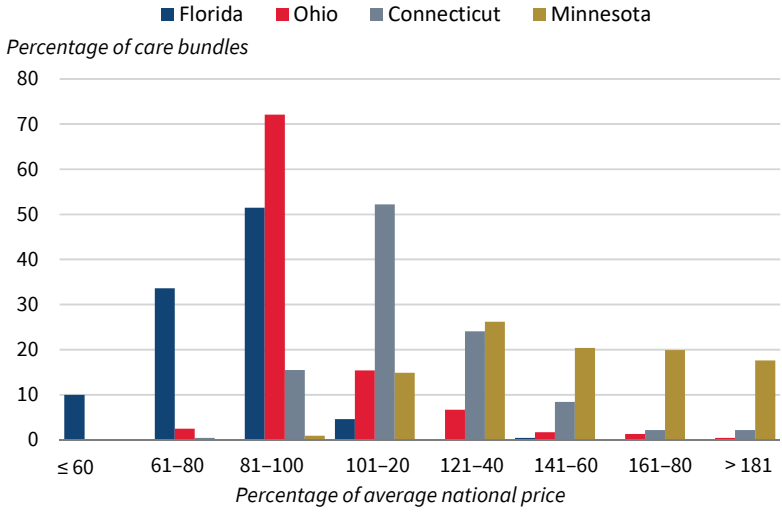
Sources: Newman et al. (2016); Health Care Cost Institute.

Although the national average price for a knee replacement is more than 100 times larger than a pregnancy ultrasound, there is greater variation in average prices for ultrasounds. For example, in South Carolina, the average knee replacement price is more than 30 percent higher than the national average, while in Wisconsin the average pregnancy ultrasound is more than 220 percent greater than the national average. This suggests that relative to the average price, there are higher high prices and lower low prices among the pregnancy ultrasound prices. Much of this variation could be due to the lack of transparency in shoppable services to create a truly competitive market.

There is also variation within regions or States in price trends. HCCI (2016) also calculated the ratio of each State's average price relative to the national average price for each medical service. The percentages of services within eight ranges of ratios were then graphed for each state (Newman et al. 2016). Figure 5-7 provides a visual representation of the distribution of all care medical services and can be compared across States.

Figure 5-7 shows the distribution of prices for four States: Florida, Ohio, Connecticut, and Minnesota. Of the 241 care bundles calculated for Florida, the prices for 95 percent of them were at or below the national averages. Ohio, with 240 care bundles, had higher prices on average than Florida; but roughly 75 percent of all prices were at or below the national averages. Connecticut, with 232 care bundles estimated, on average had higher prices than Florida and Ohio, with 30 percent of its care bundle prices being at least 20 percent

Figure 5-7. Distribution of Average State Price Relative to Average National Price of Care Bundles in Four States, 2015



Source: Health Care Cost Institute.
Note: Price data for Florida include 241 care bundles; for Ohio, 240 bundles; for Connecticut, 232 bundles; and for Minnesota, 221 bundles.

higher than the respective national averages. Minnesota, with 221 estimated care bundles, had the highest prices on average, with more than 45 percent of the care bundles having prices 50 percent or more above the national average.

Table 5-1 presents the highest average and lowest average price for a knee replacement reported for a metropolitan statistical areas in 12 States.[2] Sacramento has the highest average price ($57,504)—more than twice as high as Tucson, Miami, Saint Louis, Syracuse, Toledo, Allentown, Knoxville, and Lubbock. California also has the largest within-State difference in average price ($27,243) across any paired set of MSAs in the State. Though the two California markets are 440 miles apart, it is worth noting that a three-hour drive from Palm Bay, Florida, to Miami could potentially save $17,122 on knee replacement surgery—a difference of roughly $100 per mile driven—assuming one's insurance plan design covered the individual in both locations. Absolute dollar differences across MSAs were small in Connecticut, South Carolina, and Virginia for the MSAs for which we had sufficient data to calculate prices.

These findings demonstrate that there is wide geographic variation in prices within the privately insured population. Although some of the variation may be a result of the differences in the costs of doing business (e.g., supplies,

[2] These are indicative differences because prices could not be calculated for every MSA in a State. There could have been higher or lower prices in an unreported MSA in a State. These reported prices should drive inquiries into why these differences exist and whether any differences are justified by local differences or other evidence.

Table 5-1. Variation in Knee Replacement Prices across MSAs within States, 2015

State	Number of MSAs	Highest MSA-level average price (dollars)	Lowest MSA-level average price (dollars)	Difference between highest and lowest MSA-level average price (dollars)	Distance between MSA cities (miles)
Arizona	2	28,264	21,976	6,288	116
California	6	57,504	30,261	27,243	440
Connecticut	3	37,417	33,594	3,823	39
Florida	8	44,237	27,115	17,122	173
Missouri	2	26,601	23,114	3,487	248
New York	4	36,584	24,131	12,453	247
Ohio	7	34,573	24,491	10,082	203
Pennsylvania	3	33,338	27,188	6,150	62
South Carolina	2	46,591	43,635	2,956	103
Tennessee	2	34,895	26,291	8,604	180
Texas	5	45,275	28,456	16,819	345
Virginia	2	39,298	39,292	6	107

Source: Health Care Cost Institute.
Note: MSA = metropolitan statistical area.

wages, and rent), the remaining variation could be attributable to other factors, such as a lack of transparency, market power, or alternative treatments.

A patient-centered healthcare policy's goal would be the least unjustified price difference as possible and a low average price for a service. For example, Arizona has the sixth-largest price difference ($123) in the pregnancy ultrasound prices—a service that should be similar in scope and quality across providers, care settings, cities, and States. The average of the average prices paid in Tucson and Phoenix is the lowest ([$320 + $197] / 2 = $258.5).

To address how competition can lower prices more broadly, the Administration's report "Reforming America's Healthcare System through Choice and Competition" outlined many other important measures to increase competition for the entire healthcare sector, including hospitals and doctors, which make up the bulk of total spending. For example, a recent Executive Order set the way for increasing price transparency in healthcare, which allows competition to more effectively operate.

Healthcare Accomplishments under the Trump Administration

Since the beginning of his Administration, President Trump has sought to make healthcare more affordable by lowering prescription drug prices and making new, affordable healthcare options available. Policies have been advanced to provide transparency and choice so patients can choose the care that fits their needs. In addition, pathways have been sought to unleashing American innovation that will provide new treatment options for patients living with disease. To increase choice, the Administration has increased insurance options and reduced the regulatory burden. To increase competition, the Administration has focused on three major areas: (1) accelerating innovation, (2) increasing access to valuable therapies, and (3) making the health market stronger with greater transparency. Efforts in each of these areas are discussed in this section, with the goal of setting out how to keep what works and fix what is broken.

Increasing Choice

This subsection addresses a number of key aspects of how to increase choice. These include reducing regulatory burdens, stabilizing health insurance exchanges, lowering the individual mandate penalty to zero, encouraging State innovation in insurance design, expanding association health plans and short-term limited-duration insurance, strengthening Medicare, expanding health reimbursement arrangements, and modernizing high-deductible health plans.

Reducing regulatory burdens. In our 2019 *Report*, we estimated the impact of deregulated health insurance markets to provide more plan competition and choice for small businesses and American consumers through expanding association health plans and short-term, limited duration plans. These deregulations, in addition to eliminating the individual mandate, were estimated to generate $450 billion in benefits over the next decade. We estimated that the reforms will benefit lower- and middle-income consumers and all taxpayers but will impose costs on some middle- and higher-income consumers, who will pay higher insurance premiums. The benefits of giving a large set of consumers more insurance options will far outweigh the projected costs imposed on the smaller set who will pay higher premiums. In 2019, we provided estimates supporting the claim that these reforms do not "sabotage" the ACA but rather provide a more efficient focus of tax-funded care for those in need.

Stabilizing health insurance exchanges. In April 2017, HHS issued a final rule aimed at stabilizing the exchanges. Among other provisions, this rule made it more difficult for consumers to wait until they needed medical services to enter the exchanges. This limits gaming of the program and the driving up of premiums for those who maintain continuous coverage.

The 2019 HRA rule is expected to cause a significant increase in individual market enrollment in the early 2020s. The rule is projected to do so through additional choice and market competition and without any new government mandates. Younger and healthier employees may be more likely to prefer the typical individual market coverage of relatively high deductibles and more limited provider networks due to their lower premiums, so it is possible that the HRA rule could lead to an improved individual market risk pool (Effros 2009). This would occur if the HRA rule generates greater demand in the individual market and from younger and older workers, given the relative attractiveness of lower premium cost generated by the HRA contribution to the employee when they purchase insurance.

Lowering the individual mandate penalty to zero. In December 2017, President Trump signed the Tax Cuts and Jobs Act, which set the ACA's individual mandate penalty to zero. This benefits society by allowing people to choose not to have ACA-compliant health coverage without facing a tax penalty, and by saving taxpayers money if fewer consumers purchase subsidized ACA coverage. As we discussed last year, the CEA estimates that from 2019 through 2029, setting the mandate penalty to zero will yield $204 billion in net benefits for consumers (CEA 2019).

Encouraging State innovation in insurance design. As of 2019, seven States operated State Innovation waivers under Section 1332 of the ACA that utilized a reinsurance component. As a way to lower risk, the State establishes a fund to subsidize insurers for a certain amount of the expenses from people with costly claims. These waivers lead to lower ACA plan premiums and thus lower associated premium tax credit costs. These seven States had a median premium decline of 7.5 percent, compared with an increase in nonwaiver states of 3.0 percent (Badger 2019). Compared with what would have occurred if the States had not passed waivers, the decrease in premiums has likely caused increased enrollment in these States. By the end of 2019, States received back roughly 60 percent of savings of their initial contribution in Federal pass-through funding (Blase 2019a).

Expanding association health plans and short-term limited-duration insurance. In June 2018, the Department of Labor (DOL) finalized a rule to expand the ability of employers, including sole proprietors, to join together and purchase health coverage through association health plans (AHPs).[3] For many employers, employees, and their families, AHPs offer more affordable premiums by reducing the administrative costs of coverage through economies of scale. The AHP rule also gave small businesses more flexibility to offer their employees health coverage that is more tailored to their needs.

In August 2018, HHS, the Department of the Treasury, and DOL finalized a rule to expand Americans' ability to purchase short-term, limited-duration

[3] The revised definition of an employer for bona fide AHPs established under this rule is being adjudicated.

insurance (STLDI). STDLI premiums generally cost less than premiums for individual insurance on the ACA exchanges. Because of lower costs, additional choice, and increased competition, millions of Americans, including middle-class families that cannot afford ACA plans, stand to benefit from this reform. Recently, the Congressional Budget Office (CBO 2019) stated that is will count some short-term plans as health coverage, just as it did with pre-ACA plans with benefit exclusions or annual and lifetime limits (Aron-Dine 2019). Though these plans are more limited in coverage than the ACA-compliant insurance plans, they are priced at up to 60 percent less than the unsubsidized premium cost of ACA exchange plans and give consumers more insurance protection than being uninsured.

As a result of STDLI and AHP rules, the CBO and the U.S. Congress's Joint Committee on Taxation estimates that over the next decade, roughly 5 million more people are projected to be enrolled in AHPs or short-term plans. Of this increase, almost 80 percent constitute individuals who would otherwise have purchased coverage in the small-group or nongroup markets. The remaining 20 percent (roughly 1 million people) are made up of individuals who are projected to be newly insured as a result of the rules (CBO 2019).

Strengthening Medicare. The Administration's reforms to Medicare include payment policies that align with patients' clinical needs rather than the site of care, simplified processes for physicians' documentation of evaluation and management visits, new consumer-transparency measures, and increased flexibility for insurers so that they can offer more options and benefits through Medicare Advantage.

In 2019, President Trump signed an Executive Order to improve seniors' healthcare outcomes by providing patients with more plan options, additional time with providers, greater access to telehealth and new therapies, and greater alignment between payment models and efficient healthcare delivery (White House 2019b). In addition, a priority will be streamlining the approval, coverage, and payment of new therapies while reducing obstacles to improved patient care. Finally, the effort improves the fiscal sustainability of Medicare by eliminating waste, fraud, and abuse.

Expanding health reimbursement arrangements. In June 2019, HHS, the Treasury Department, and DOL issued a final rule expanding the flexibility and use of health reimbursement arrangements to employers (84 *FR* 28888). The rule issued two new types of tax-advantaged HRA plans—excepted benefit HRAs (EBHRAs) and individual coverage HRAs (ICHRAs)—to be offered as early as January 2020. EBHRAs may be offered to employees with traditional group plans to receive an excepted benefit HRA of up to $1,800 a year in 2020 (indexed to inflation afterward) for the purchase of certain qualified medical expenses, such as short-term, limited duration, vision, and dental plans. ICHRAs allow employers to reimburse employees who purchase their own health plans and

equalizes the tax treatment of a traditional employer-sponsored insurance plan and an individual market plan paid by employer contributions.

The Treasury Department performed microsimulation modeling to evaluate the coverage changes and transfers that are likely to be induced by the final rules. The Treasury's model of health insurance coverage assumes that workers are paid the marginal product of their labor. Employers are assumed to be indifferent between paying wages and payroll taxes and paying compensation in the form of benefits. The Treasury model therefore assumes that total compensation paid by a given firm is fixed, and the employer allocates this compensation between wages and benefits based on the aggregated preferences of their employees. As a result, employees bear the full cost of employer-sponsored health coverage (net of the value of any tax exclusion) in the form of reduced wages and the employee share of premiums.

The Treasury Department's model assumes that employees' preferences regarding the type of health coverage (or no coverage) are determined by their expected healthcare expenses and the after-tax cost of employer-sponsored insurance, exchange coverage with the premium tax credit (PTC), or exchange or other individual health insurance coverage integrated with an individual coverage HRA, and the quality of different types of coverage (including actuarial value).

When evaluating the choice between an individual coverage HRA and the PTC for exchange coverage, the available coverage is assumed to be the same, but the tax preferences are different. Hence, an employee will prefer the individual coverage HRA if the value of the income and payroll tax exclusion (including both the employee and employer portion of payroll tax) is greater than the value of the PTC. In modeling this decision, the Federal departments assume that premiums paid by the employee are tax-preferred through the reimbursement of premiums from the individual coverage HRA, with any additional premiums (up to the amount that would have been paid under a traditional group health plan) paid through a salary reduction arrangement.

In the Treasury Department's model, employees are aggregated into firms, based on tax data. The expected health expenses of employees in the firm determine the cost of employer-sponsored insurance for the firm. Employees effectively vote for their preferred coverage, and each employer's offered benefit is determined by the preferences of the majority of employees. Employees then decide whether to accept any offered coverage, and the resulting enrollment in traditional or individual health insurance coverage determines the risk pools and therefore premiums for both employer coverage and individual health insurance coverage.

Based on microsimulation modeling, the Federal departments expect that the final rules will cause some participants (and their dependents) to move from traditional group health plans to individual coverage HRAs. As noted above, the estimates assume that for this group of firms and employees,

employer contributions to individual coverage HRAs are the same as contributions to traditional group health plans would have been, and the estimates assume that tax-preferred salary reductions for individual health insurance coverage are the same as salary reductions for traditional group health plan coverage. Thus, by modeling construction, there is no change in income or payroll tax revenues for this group of firms and employees (other than the changes in the PTC discussed below).

Although the tax preference is assumed to be unchanged for this group, after-tax, out-of-pocket costs could increase for some employees (whose premiums or cost sharing are higher in the individual market than in a traditional group health plan) and could decrease for others. A small number of employees who are currently offered a traditional group health plan nonetheless obtain individual health insurance coverage and the PTC, because they cannot afford a traditional group health plan or such a plan does not provide minimum value. Some of these employees would no longer be eligible for the PTC for their exchange coverage when the employer switches from a traditional group health plan to an individual coverage HRA because the HRA is determined to be affordable under the final PTC rules.

The regulatory impact analysis conducted by the Treasury Department concluded that the benefits of the HRA rule substantially outweigh its costs. The Treasury Department estimated that 800,000 employers are expected to provide HRAs after being fully ramped up. In addition, it is estimated that there will be a reduction in the number of uninsured by 800,000 by 2029. From these employers' HRA contributions, it is expected that firms will cover more than 11 million employees with individual health insurance by 2029.

Modernizing high-deductible health plans. A major component of the Trump Administration's health policy has been a focus on consumer-directed health plans, in particular modernizing high-deductible health plans (HDHPs) and their accompanying HSAs. As directed by the President, the Treasury released a new Internal Revenue Service (IRS) guidance (Notice 2019-45) on July 17, 2019, that allows high-deductible health plan issuers to permit coverage of prevention therapies for those with certain chronic conditions, including diabetes, asthma, heart disease, and major depression. The impact could be profound. For example, these plans could now cover all or nearly all the cost of insulin for diabetic patients before the deductible being met.

HSA-eligible plans are a growing proportion of the overall HDHP market. In 2018, about 21.8 million Americans were enrolled in HSA-eligible HDHPs, up from an estimated 15.5 million in 2013 (AHIP 2017). In 2018, nearly 29 percent of all firms offered an HDHP with a savings option, such as an HSA (KFF 2018). Among companies studied in 2018 by a survey of the National Business Group on Health, 30 percent offered a full replacement HSA-type plan to employees in 2019 (NBGH 2018). HSA market growth is expected to continue.

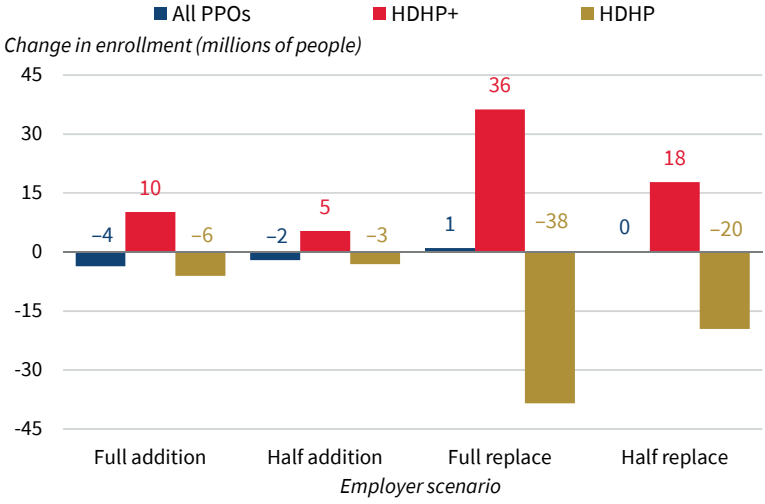
According to the Centers for Disease Control and Prevention (CDC 2019), about 60 percent of Americans have a chronic disease such as heart disease or diabetes. The economic burden of chronic diseases in the United States is estimated to be about $1 trillion per year (Waters and Graf 2018). Decreasing financial barriers to evidence-based care for chronic conditions provides opportunities to enhance clinical outcomes and reduce the long-term growth rate of healthcare spending. Because about 75 percent of total U.S. health spending is due to chronic diseases, appropriate chronic disease management is key to lowering long-term healthcare cost growth (NACDD n.d.). The IRS guidance allows for the creation of an enhanced HSA-eligible plan to provide predeductible coverage for targeted, evidence-based, secondary preventive services that prevent chronic disease progression and related complications. This can improve patient outcomes, enhance HDHP attractiveness, and add efficiency to medical spending.

The creation of these new high-deductible health plans plus secondary prevention coverage (HDHP+) will give patients with certain conditions better access. VBID Health (2019) estimated that it could increase tax revenue in a variety of scenarios dependent on the updating of the new plan. Note that VBID Health's analysis was performed before Congress repealed the Cadillac tax in December 2019.

The authors of this report (VBID Health 2019) used the ARCOLA micro-simulation model to gauge the Federal tax revenue and insurance take-up impact of an HDHP+ among those under 65 and not in the Medicare market. The model assumes bronze plans in health insurance exchanges migrate into the new HDHP+ design. That said, it is challenging for HSA-eligible plans in the exchanges to meet bronze level actuarial value given their lower out-of-pocket maximum required in statute compared with the out-of-pocket maximum limits for the individual market. Providing more predeductible coverage will make this more challenging. The model also assumes that everyone in the individual market has the option of an out-of-exchange HSA-eligible plan that does not switch to the HDHP+ design. The results are split into four scenarios for firms that offer an HSA-HDHP: all firms additionally offer HDHP+, half of all firms additionally offer HDHP+, all firms replacing current plans with HDHP+, and half of all firms replacing current plans with HDHP+. Differences across employer scenarios illustrate a range of possibilities that may play out.

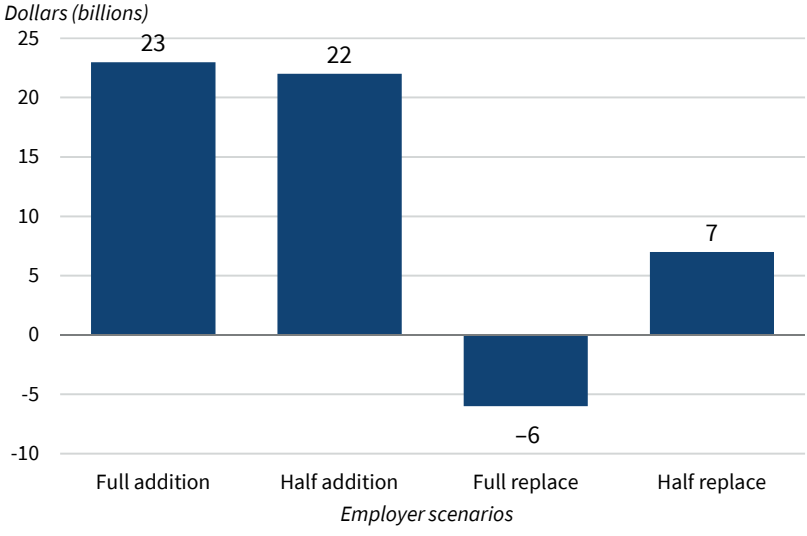
Across all employer scenarios, the initial uptake and forecasted growth of the novel HDHP+ are positive as people switch plan types. What varies by employer scenario, however, are the magnitude and growth of uptake over time. The HDHP+ generally has high initial uptake across employer scenarios. The lowest uptake is in the scenario where half of employers additionally offer the HDHP+ with other HDHP options. Because of the higher HDHP+ premiums, due to selection, this result is expected (figure 5-8).

Figure 5-8. Health Insurance Enrollment across Employer Scenarios, 2019–29



Sources: VBID Health (2019); CEA calculations.
Note: PPOs = preferred provider organizations; HDHP+ = enhanced high-deductible health plan; HDHP = high-deductible health plan.

Figure 5-9. The Net Revenue Impact of Expanding High-Deductible Health Plans, 2019–29



Source: VBID Health (2019).
Note: Scenarios apply to the 7 percent premium for enhanced high-deductible health plans.

Net revenue effects can be seen in three of the four scenarios modeled after introducing HDHP+ to employer and individual markets and the migration of people across plan types (figure 5-9).

Different employer decisions regarding plan offerings, as seen in the scenarios modeled, may lead one scenario to have a larger effect than another one (VBID Health 2019). More than the magnitudes of the different budget effects is the clustering of each scenario around budget neutrality. The one scenario that shows a small net reduction in tax revenue (full replacement) was modeled as an extreme case. The net effects of each scenario are small relative to the net impact of tax subsidy of the entire employer-sponsored insurance market. Thus, the net impact of expanding the secondary prevention safe harbor is likely close to zero, if not modestly positive.

Increasing Competition

This subsection explores how to increase competition in providing healthcare. The topics it covers include enforcing antitrust laws, accelerating generic drug approvals, creating price and quality transparency, promoting new vaccine manufacturing, and clarifying the Physician Self-Referral Law and the Federal Anti-Kickback Statute.

Enforcing antitrust laws. Chapter 6 discusses the importance of sound antitrust policy, which protects consumers from anticompetitive mergers. As discussed there, the Antitrust Division of the DOJ and the FTC—collectively, the Agencies—share responsibility for enforcing the Nation's antitrust laws. Although the vast majority of mergers do not raise competitive concerns, the Agencies use their investigative powers to identify those that do by obtaining and analyzing the detailed evidence that is needed to make this distinction.

Challenging a merger is often risky, as evidenced by the fact that between 1994 and 2000, the Agencies lost all seven lawsuits that they filed to block hospital mergers (Moriya et al. 2010). In response to this, the FTC engaged in a retrospective study of hospital mergers that advocated against the outdated methodology that the courts had been using to evaluate these mergers. Joseph Simons, the FTC chairman, recently reported to Congress that the FTC has successfully defended in blocking a merger between healthcare providers (*FTC v. Sanford Health*). This was the FTC's fifth straight appellate victory involving health provider mergers.

The DOJ has worked to stop anticompetitive mergers among health insurers. In 2016, the DOJ successfully blocked two proposed mergers that would have combined four of the largest health insurers (Anthem, Cigna, Aetna, and Humana) into two companies. More recently, the DOJ reached a settlement with CVS in its bid to acquire Aetna. The DOJ raised concerns relating to the sale of individual prescription drug plans (PDPs) under Medicare's Part D program. CVS and Aetna competed head-to-head in U.S. regions covering 9.3 million PDPs, of which 3.5 million had coverage from CVS or Aetna.

The DOJ alleged that this competition had led to lower premiums and lower out-of-pocket-expenses, and had improved formularies and service in many regional markets. To preserve competition, the DOJ required Aetna to divest its individual prescription drug plan. As discussed in an earlier report (CEA 2018), CVS, Express Scripts, and OptumRx are the three largest pharmacy benefit managers in the United States. The American Medical Association (2018) expressed concern to the DOJ that but for the CVS-Aetna merger, Aetna might become a disruptive competitor in PBM markets. At the time, Aetna engaged in some PBM activities while outsourcing other activities to CVS. The DOJ did not raise concerns along these lines.

The DOJ also recently reached a settlement in a conduct case against Atrium Health (formerly the Carolinas HealthCare System). The DOJ was concerned about provisions in Atrium's contracts with health insurers that were preventing insurers from offering financial incentives to their customers to choose providers that offer better value than Atrium, in terms of lower prices, better service, or both. The restrictions undercut the efforts of health insurers to induce competition between providers by creating health plans that provide incentives for consumers to use providers that qualify for preferred tiers or in-network status. As discussed by Gee, Peters, and Wilder (2019), the DOJ's economic analysis was consistent with academic research suggesting that these plans help to reduce premiums.

Accelerating generic drug approvals. HHS has taken a number of actions to empower consumers and promote competition, building on accomplishments such as the Food and Drug Administration's (FDA's) record pace of generic drug approvals (CEA 2018). Initiatives to clarify regulatory expectations for drug developers, coupled with internal review process enhancements, improved the speed and predictability of the generic drug review process at the FDA, resulting in a record number of generic drug approvals in the first three years of the Trump Administration. In fiscal year 2019, the FDA approved a record 1,171 generic drugs, after record approvals from the previous two years (HHS 2019c). These actions contributed to the recent decrease (see box 5-1) in prescription drug prices; in June 2019, these prices saw their largest year-over-year decrease in 51 years (see chapter 2 for more discussion of the Administration's deregulatory actions).

Creating price and quality transparency. On June 24, 2019, the President signed an Executive Order to promote price and quality transparency through a set of new initiatives (White House 2019b). A major problem in the healthcare market is that patients often do not know the price or quality of healthcare services. This lack of transparency denies patients the vital information they need to make informed choices and exacerbates increased costs, suppressed competition, and lower quality. As a result, there are wide variations in prices across healthcare markets, even for the same services, as was described earlier in this chapter. Accurate, accessible price and quality information will allow

Box 5-1. The Consumer Price Index for Prescription Drugs

Despite arguments that prescription drug prices have increased in 2019, drug prices according to the Consumer Price Index for prescription drugs (CPI-Rx) have declined (year-over-year) in 9 of the past 11 months, as of the October 2019 release of CPI. The CPI is designed to provide an empirical measure of the impact of price changes on the cost of living. As a component of the general CPI, the CPI-Rx measures how prices are changing in the prescription drug market by indexing the weighted average of the price changes in a random sample of prescription drugs (see figure 3-5).

The CPI-Rx has several strengths (CEA 2019c). First, it includes a random sample of prescription drugs and provides a summary measure that is representative of the entire market of prescription drugs. Even if prices are increasing for a large number of rarely prescribed drugs, the CPI-Rx can show an average decrease if the prices of the most commonly prescribed drugs are decreasing. A second strength of the CPI-Rx is that it accounts for generic drugs. Lower-cost generic bioequivalents of many prescription drugs are widely available and are often purchased over name brands, and the CPI-Rx captures price decreases from new generic entries. The CPI-Rx also measures transaction prices instead of list prices. The transaction price includes all payments received by the pharmacy, including out-of-pocket payments and payments from insurance companies, and it corresponds to the negotiated price and reflects discounts—though not rebates. The list price does not include discounts and rebates and is less representative of what the customer pays.

Though the CPI-Rx is the best measure of overall prescription drug inflation, it is not a perfect measure. One of its main limitations is that it does not account for the improvement in consumer value that occurs with the entry of new goods, particularly when they are of a higher quality than existing goods. This bias is believed to cause the CPI-Rx to overstate the true level of prescription drug inflation and has been estimated to be as high as 2 percentage points a year (Boskin et al. 1996). A comparison between the CPI-Rx and a separately constructed large alternative data set of drug prices from the research firm IQVIA showed larger price increases in the IQVIA index, indicating that the CPI-Rx may not be fully representative of a larger sample (Bosworth et al. 2018). Additionally, even though the CPI-Rx for drug prices indicates reasonable increases or declines, there may be some drug products for which price changes can appear extreme.

patients to identify savings by "shopping" for healthcare services and make choices that fit their healthcare needs and financial situations. Additionally, transparency in healthcare prices and quality will lead to better value and more innovations by facilitating increased competition among healthcare providers. One of the first results of this initiative is a rule requiring hospitals to publish their negotiated hospital charges (84 *FR* 61142). The new Executive Order

directs providers as well as insurers to reveal negotiated prices on a routine basis to aid consumers in their purchase of competitively priced medical care and treatments.

The Executive Order also includes the development of the Health Quality Roadmap (HHS 2019a). The Roadmap will align and improve reporting on data and quality measures across Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Marketplace, the Military Health System, and the Veterans Affairs Health System. To accomplish this goal, the Roadmap will provide a strategy for advancing common quality measures, aligning inpatient and outpatient measures; and eliminating low-value or counterproductive measures.

The Executive Order also calls for increased access to de-identified claims data from taxpayer-funded healthcare programs and group health plans. Healthcare researchers, innovators, providers, and entrepreneurs can use these de-identified claims, which will still ensure patient privacy and security, to develop tools that enable patients to access information that helps with decisions about healthcare goods and services. Increased data access can reveal inefficiencies and opportunities for improvement, including performance patterns for medical procedures that are outside the recommended standards of care.

The 2019 Price and Quality Transparency Executive Order seeks to make all healthcare prices negotiated between payers and providers non-opaque and to help those shopping for healthcare to get the best value and lowest price, as they do in other markets outside healthcare. The policy execution of revealing negotiated prices between payers is currently under way, and the impact will be able to be assessed in future analyses. One estimate places the potential savings from common medical procedures to be nearly 40 percent on a nationwide basis (Blase 2019b).

Promoting new vaccine manufacturing. In September 2019, the President signed an Executive Order promoting new influenza vaccine manufacturing technologies to reduce production times and increase vaccine effectiveness. Millions of Americans suffer from seasonal influenza every year, and new vaccines are formulated each year to decrease infections from the most prevalent influenza viruses. Vaccines are incredibly effective against influenza, with one study finding that vaccines prevented over 40,000 influenza-related deaths between 2005 and 2014 (Foppa et al. 2015). Despite their effectiveness, current methods of vaccine production are often very slow and can diminish vaccines' efficacy in protecting against seasonal influenza infection. Production delays could be even more important in the event of a pandemic influenza outbreak. The CEA (2019d) found that the cost of delay in vaccine availability in the case of a pandemic is $41 billion per week for the first 12 weeks and $20 billion per week for the next 12 weeks.

The new Executive Order identifies the weaknesses in current methods of vaccine production and promotes new technologies, such as cell-based and recombinant vaccine manufacturing, to speed vaccines' development and improve their efficacy. Additionally, the new initiative establishes a task force to increase Americans' access to vaccines. If sufficient doses of vaccines are delivered at the outset of an influenza pandemic, the CEA (2019c) estimates that $730 billion in economic benefits could be gained by Americans, primarily due to the prevention of loss of life and health.

Clarifying the Physician Self-Referral Law and the Federal Anti-Kickback Statute. The Administration proposed two rules in 2019 to provide coordinated care for patients (84 *FR* 55766) and to ensure that there are safeguards and flexibility for healthcare providers in value-based arrangements (84 *FR* 55694). The first rule proposed by CMS is part of the Administration's efforts to promote value-based care by lifting Federal restrictions on healthcare providers so that they have greater ability to work together on delivering coordinated patient care.

The second proposed rule issued by the HHS Office of the Inspector General focuses on the Federal Anti-Kickback Statute and the Civil Monetary Penalties Law. This proposal addresses the concern that these laws needlessly limit how healthcare providers can coordinate patient care. Expanding flexibility could, for example, encourage outcome-based payment arrangements that reward improved health outcomes. The changes would also offer specific safe harbors to make it easier for healthcare providers to ensure they are complying with the law (HHS 2019b).

Increasing Access to Valuable Therapies

This section covers a number of key topics on how to increase access to valuable therapies. These include ending the HIV epidemic, expanding kidney disease treatment options, combating the opioid crisis, and expanding the right to try clinical trials.

Ending the HIV epidemic. For the last four decades, the Human Immunodeficiency Virus (HIV) has been one of the most prominent health risks confronting people in our country and around the world. In 2019, President Trump announced a plan to end the HIV epidemic within 10 years. This epidemic has claimed the lives of about 700,000 Americans since 1981. The new initiative is designed to reduce the number of new HIV infections in the United States by 75 percent over the next five years, and by at least 90 percent over the next decade. Through efforts across HHS, an estimated 250,000 HIV infections could be averted over the next 10 years. The Administration also facilitated a large private donation of pre-exposure prophylaxis (PrEP) medication, which will help reduce the risk of HIV infection for up to 200,000 patients per year for up to 11 years to provide critical PrEP medication to uninsured individuals who might otherwise be unable to access or afford it.

Expanding kidney disease treatment options. In July 2019, the President signed an Executive Order to enable better diagnosis, treatment, and preventive care for Americans suffering from chronic kidney disease. In line with the Administration's broader deregulatory agenda, a key focus of the Executive Order is an effort to remove regulatory barriers to the supply of kidneys. Currently, the Federal Government bears most of the cost paying for chronic kidney disease and end-stage renal disease care, which affect more than 37 million Americans (White House 2019d). More than 100,000 Americans begin dialysis each year to treat end-stage renal disease, half of whom die within five years. The Executive Order seeks to modernize and increase patient choice through affordable treatment options that are too expensive and fail to provide a high quality of life.

As directed by the Executive Order, the Centers for Medicare and Medicaid Services issued a proposed rule to hold organ procurement organizations more accountable for their performance (84 *FR* 70628). More than 113,000 Americans are currently on the waiting list for an organ transplants, a number that far exceeds the number of organs available. The rule raises performance standards for organ procurement organizations to reduce discarding viable organs, encourage higher donation rates, and shorten transplant waiting lists (CMS 2019a). Additionally, the Health Resources and Services Administration issued a proposed rule to alleviate financial barriers of organ donations (84 *FR* 70139). This rule would allow for reimbursement of lost wages and childcare and eldercare expenses for living donors lacking other means of financial support, potentially increasing the number of transplant recipients over a shorter time period.

Combating the opioid crisis. The Trump Administration is using Federal resources to fight against the opioid crisis in U.S. communities. Actions are focused on supporting those with substance use disorders and involving the criminal justice system to crack down on illicit opioid suppliers, both foreign and domestic. Over $6 billion in funding was secured in fiscal years 2018 and 2019 for preventing drug abuse, treating use disorders, and disrupting the supply of illicit drugs (OMB 2019). Investments include funding for programs supporting treatment and recovery, drug diversion, and State and local assistance. Chapter 7 outlines in more detail many of the Administration's accomplishments in combating the opioid crisis.

Expanding the right to try. The Administration has *made* increased access to new and critical therapies a priority. One of the new bold programs in 2018 was the passage of "Right-to-Try" legislation for patients with terminal illnesses, such as cancer. The National Cancer Institute (n.d.) estimates that 1.76 million new Americans will be diagnosed with cancer and 606,880 will die from cancer in 2019. Currently, only 2 to 3 percent of adult cancer patients are enrolled in clinical trials—an indication of the limited options for patients with life-threatening diseases (Unger et al. 2019). For these patients who are

ineligible to participate in clinical trials and have exhausted all approved treatment options, this bill amended Federal law to provide a new option, in addition to the FDA's long-standing expanded access program, for unapproved, experimental drugs (including biologics) to potentially extend their lives. To ensure safety and transparency, manufacturers or sponsors of an eligible drug that has undergone the FDA Phase I (safety) testing are required to provide annual summary reports to the FDA on any use of the drug under Right-to-Try provisions.

Conclusion

This chapter has identified Federal and State barriers to healthcare that increase prices, reduce innovation, and hinder improvements in quality. It also provided a summary of the accomplishments and expected effects of the Trump Administration's policies to address these barriers and deliver a healthcare system that offers high-quality care at affordable prices. By 2023, we estimate that 13 million Americans will have new insurance coverage that was previously unavailable due to high prices and overregulation.

In contrast to the Administration's focus on improving consumer-directed healthcare spending, government mandates often reduce consumer choice. At all levels of government, healthcare regulations that limit choice, stifle competition, and increase prices should be updated so that the U.S. healthcare system can provide greater value. These regulations can also harm the broader economy. For example, the Affordable Care Act has impeded economic recovery by introducing disincentives to work (Mulligan 2015). Though market competition leads to an efficient allocation of resources that should lower prices and increase quality, every market has features that deviate from optimal conditions, and healthcare is no exception. Although the U.S. healthcare system has challenges, they are not insurmountable problems that mandate greater government intervention. The healthcare policy successes over the past three years show the value of empowering the market to deliver the affordable healthcare options that Americans rightly expect, and further reform will provide Americans with improved healthcare through enhanced choice and competition.