Bipartisanship Essential to Fix Healthcare

By Robert Graboyes

On March 24, Republicans' seven-year promise to repeal and replace the Affordable Care Act (ACA, or "Obamacare") suffered an ignominious collapse. The 2016 election finally handed the GOP control of the White House, Senate, and House of Representatives. But in the end, Speaker Ryan and President Trump couldn't muster enough support to bring their long-awaited repeal-and-replace proposal, the American Health Care Act (AHCA), to a vote in the House.

This failure crystalizes a much clearer vision of the past, present, and future of American health care policy.

What Can We Learn?

The most important lesson of these two bills—one enacted, one failed—is that it is nearly impossible to devise coherent, functional health care policy with support from fewer than 60 senators.

In 2010, with only 59 votes, Democrats passed the ACA via the then-obscure reconciliation procedure. Because they were one vote short of a filibuster-proof majority, Democrats could not repair weaknesses in the language that they knew would cause problems in coming years. The result to date has been a law plagued by billowing costs, operational failures, and patchwork administrative fixes.

The ACA's seven rocky years enabled Republicans to make its failures the dominant issue in American politics for four consecutive election cycles, but their promise of swift repeal-and-replace would ultimately confront the same filibuster blockade that Democrats faced in 2010.

Reconciliation severely limits what a bill can do. In 2017, its rules constrained Republicans to a narrow menu of changes to the ACA, meaning they could not hope to repeal the law as a whole. Hence, the AHCA merely nibbled at the ACA's edges and, in some ways, would have worsened the existing problems in insurance markets.

After the AHCA's collapse, Speaker Paul Ryan said, "Obamacare is the law of the land—We're going to be living with Obamacare for the foreseeable future."

These two experiences ought to send a powerful message to both parties: For the foreseeable future, neither party can impose its purely partisan vision across health care. Republicans cannot really undo the ACA, and Democrats cannot reasonably aspire to the single-payer system that has long been the dream of many. Bipartisanship, however remote that may seem today, must be an ingredient in any broad, meaningful reforms.

The Status of the ACA

None of this changes the fact that the ACA remains a deeply troubled law. Its own origins in reconciliation hobbled it with a jerry-built structure whose components began failing as soon as the bill became law. Its signature achievement was to increase the number of Americans with insurance by some millions, mostly through higher Medicaid enrollment. The oft-quoted figure of 20 million is almost certainly exaggerated, as it includes people who had coverage before the 2008 crash, lost it, and regained it (independently of the ACA) as the economy recovered.

The individual exchanges are doing poorly. Enrollments have tapered off and insurers have fled, leaving large swaths of exchange customers with little choice among insurance plans. The small

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business exchanges remain moribund. The co-ops (designed as a faint echo of agricultural co-operatives) are all dying or dead. Premiums are soaring in many states.

Because the ACA remains intact, younger, healthier Americans are still required to subsidize older, sicker (and generally wealthier) people. This reality dissuades many younger people from purchasing coverage, thus pushing premiums even higher for those who do. Plans continue to become stingier as deductibles soar and networks narrow.

For businesses, the ACA's burden of paperwork continues. The employer mandate discourages small businesses from growing and hiring past the law's thresholds. The individual mandate, perhaps the single most unpopular element of the law, remains intact.

At the risk of sounding like a stereotypical economist, here is the bottom line: The AHCA's demise may stabilize the ACA, or it may destabilize it. Undoubtedly, part of the law's rocky history was caused by the uncertainty over whether it would remain on the books. Some insurers very likely fled because the law's demise seemed imminent, rendering the future too murky to warrant the investment and risk. Now, that uncertainty seems to have lessened, and a more distant horizon gives insurers, employers, and individuals more breathing room.

On the other hand, the ACA's problems would have been far worse over the past seven years without a long series of regulatory fixes and selective enforcement by an Obama administration anxious to see the law succeed. The Trump administration carries no pride of parentage in the law and may be less willing to apply duct tape as various features of the law teeter.

What Now?

The current environment makes it difficult to envision bipartisan solutions, but ultimately, that is likely where things will wind up. (It's hard to recall now, but the hot ticket in health care a year or two before the ACA was a far-reaching, bipartisan bill called Wyden-Bennett, which sought to meld Medicaid and the small-group, large-group, and individual markets into one seamless market.)

The great bipartisan failure in America's health care debate is not understanding that retail prices cannot fall below wholesale prices indefinitely.

In health care, the wholesale price is what doctors, hospitals, and other providers charge. The retail price is what we pay insurers who, in turn, pay providers. The ACA and AHCA both focused mostly on the structure of insurance (ineffectively in both cases) while only paying lip service to the underlying costs of care.

Ultimately, better health for more people at lower cost will come from changing the ways we deliver care—the wholesale part of the equation.

These changes must be encouraged by public policies that have little to do with the ACA or AHCA. Faster drug and device approval than the FDA currently enables. Digital technologies that allow patients to self-diagnose in ways that once required a physician. Specialty hospitals that operate with the efficiency of Toyota plants. Greater access to low-cost, high-quality providers outside of the United States, including medical tourism hospitals. Greater reliance on non-physician providers like nurse practitioners. Electronic health records that serve doctors and patients rather than insurers and administrators. Greater access to synchronous and asynchronous telemedicine. Greater hospital and provider competition. The introduction of lean (yet humane) production methods into medical care.

All of these visions are possible, and each, to some extent, is occurring despite the many obstacles the federal and state governments place in their ways. But change could come faster, and the partisan stalemate on the insurance front makes this all the more urgent.

To be sure, insurance reform will still be part of the challenge. Part of the problem is that we have constructed a maze of siloed insurance markets.

Poorer people go to Medicaid and older people to Medicare. Service personnel go to TRICARE, and veterans to the VA. Federal employees get their care through FEHBP plans. American Indians go to the Indian Health Service. Each large business is its own walled insurance city, as is each union plan. Small businesses are walled outposts. Some individuals can get subsidized plans in the ACA exchanges. Really sick people are sent into high-risk pools. Other individuals have to forage for scraps in the wilderness that remains beyond.

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Continued on page 30

Continued from page 29

for each category. And yet, for decades, the thrust of American public policy has been to slice and dice the health insurance market into more and more demographic fiefdoms. Not long ago, I noted in writing that because of this fact, health insurance is one of the few household goods or services where there is no point in leaning over the fence and asking your neighbor for advice on which policy to purpose. With rare exceptions, your neighbors and you live in entirely separate insurance worlds.

For some, the cure for this fragmentation is a single-payer system—one insurer financed by the government. Without going into detail here, the case for such a one-size-fits-all system is weak. On close inspection, single-payer systems fall far short of the sunny image their enthusiasts praise. Their lower costs are partially illusory and partially driven by poor-quality care. The U.S.-versus-elsewhere data that single-payer proponents cite (longevity, infant mortality, etc.) are largely based on poor or deceptive data—apples-to-oranges comparisons. And centrally planned health care systems stifle the technological innovation that will ultimately bring costs down and push quality up.

A less fragmentary, more competitive, market-driven insurance system is achievable, but almost certainly cannot arise from purely partisan proposals on either side of the aisle. An essential part of insurance reform will be to allow markets to decide which services properly fall under the realm of insurance and which do not. Direct primary care (DPC) providers like New England's Iora Health have removed the insurer as middleman in the provision of primary care. Specialists like the Surgery Center of Oklahoma have similarly cut the insurers (and their expenses) out of some parts of specialty care. In doing so, they have lowered both the retail and the wholesale costs of providing care.

Many or most of these great areas of opportunity present the possibility of bipartisan support. And most important, they offer plenty of ways out of the high-cost, substandard quality quagmire in which we find ourselves.

Robert Graboyes (@Robert_Graboyes) is a senior research fellow with the Mercatus Center at George Mason University, where he focuses on technological innovation in health care. He is the author of "Fortress and Frontier in American Health Care" and teaches health economics at Virginia Commonwealth University.