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From the Desk of Kofi Ampaabeng, Bobbi Herzberg, and Elise Amez-Droz

January 7, 2022

RSC Health Care Task Force
Republican Study Committee
1725 Longworth House
Washington, DC 20515

Chair Banks and members of the Republican Study Committee:

We are pleased to respond to the request by the Republican Study Committee (RSC) for policy recommendations to contribute to the Health Care Freedom Commitment to America initiative. The Mercatus Center at George Mason University is dedicated to advancing knowledge relevant to current policy debates. Toward this end, its scholars conduct independent, nonpartisan analyses and propose policy solutions grounded in peer-reviewed literature. With that in mind, this comment does not represent the views of any affected party or special interest group.

The RSC is seeking input on several policy areas. We focus on four: expanding insurance coverage options, ensuring access to quality care and portable insurance, reforming public health policy in the wake of the COVID-19 pandemic, and increasing competition in healthcare. Key to our approach to healthcare reform is the promotion of individual agency in the provision and delivery of healthcare and in the creation of public health laws. Our assumption, grounded in economic theory, is that people make more informed choices when they control more of their healthcare dollars and that the market responds accordingly by delivering better value. We further assume that public health is best safeguarded when the people who are subjected to and benefited by public health laws all have a voice in the policymaking process, because decentralization and individual agency promote general welfare. Finally, we assume that physicians can take care of patients better when not faced with heavy paperwork requirements or barriers to reimbursement for hospital services. On the basis of these assumptions, we propose practical policy solutions to empower patients, physicians, and interdisciplinary experts to transform healthcare.

Expand Insurance Coverage Options

Since the Great Depression, healthcare in the United States has been financed mainly through private or public health insurance. However, there are other ways of financing healthcare, including direct primary care (DPC), association health plans (AHPs), and healthcare sharing ministries (HCSMs), which continue to grow in popularity despite unfavorable treatment by regulations. Nevertheless, the dominance of health insurance means that policy reforms are often centered on it to the detriment of other means of financing healthcare. The use of insurance to finance healthcare creates moral hazard well recognized by scholars. This hazard, which involves overuse of care caused by the third-party payment, has led policymakers to consider alternative

funding arrangements, such as consumer-directed healthcare, that give consumers more control over their healthcare decisions.

One of the most common tools of consumer-directed healthcare is the combination of health savings accounts (HSAs) with high-deductible health plans. However, many restrictions limit the consumer empowerment that this combination was intended to deliver. For example, HSAs, which were introduced in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act, cannot be used to pay for the fees or premiums of a DPC, AHP, or HCSM plan. Congress can rectify the unfavorable treatment of alternative healthcare financing arrangements by including them as eligible HSA medical expenses.

Since their introduction, HSAs have been very popular among Americans to fund their medical expenses. We expect that, as more Americans gain more control over their healthcare expenses, providers will respond by offering competitively priced, quality services. According to a 2021 survey of employers by the Plan Sponsor Council of America (PSCA), 58 percent of employees who have the option to enroll in an HSA choose to do so. After the introduction of HSAs, it soon became evident that the annual contribution limits—initially set at $2,600 for an individual and $5,150 for a family[1]—were too low to allow Americans to accumulate sufficient funds. President George W. Bush proposed laws to increase the contribution limits and remove other restrictions but was ultimately unsuccessful.[2]

For HSAs to have a meaningful effect on healthcare spending and use, more Americans must have access to them, and Americans must be allowed to contribute more to accumulate sufficient funds to cover future expenses, especially during years when they spend little on healthcare. A 65-year-old American couple retiring in 2022 will need $300,000 to finance medical expenses during retirement, and accumulating that amount in an HSA takes many couples at least 25 years.[3]

We propose three specific policies to increase and improve the use of HSAs:

- Expand the list of eligible healthcare expenses.
- Allow more people to open HSAs.
- Encourage Americans to accumulate more funds in their HSAs.

Expand the list of eligible healthcare expenses. The IRS determines what expenses can be financed by an HSA. These expenses do not include premiums, whether for private insurance plans, Medicare plans, or noninsurance health plans such as DPC, AHPs, HCSMs, and short-term limited-duration insurance (STLDI) plans. Expanding the list of qualified expenses to cover both premiums for health plans and STLDIs would enhance the appeal of HSAs.

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[1] Internal Revenue Service, "Internal Revenue Bulletin" (Bulletin no. 2004-2, Internal Revenue Service, Washington, DC, January 12, 2004).
[2] Michael F. Cannon, "Health Savings Accounts: Do the Critics Have a Point?" (Policy Analysis no. 569, Cato Institute, Washington, DC, May 30, 2006).
[3] This result assumes that the couple "contributes the maximum, withdraws 50% each year to pay for current qualified medical expenses, but leaves the remaining 50 percent invested, also earning an average 7% return." Fidelity Investments, "Fidelity's 20th Annual Retiree Health Care Cost Estimate Hits New High: A Couple Retiring Today Will Need $300,000 to Cover Medical Expenses, an 88% Increase since 2002," press release, May 7, 2021, https://sponsor.fidelity.com/bin-public/06_PSW_Website/documents/Cost_of_healthcare-in_ret_Fidelity_2021_RHCCE_NR.pdf.

Recent history has shown that legislatively expanding the list of qualified expenses is possible. For example, the Coronavirus Aid, Relief, and Economic Security (CARES) Act expanded qualified HSA expenses temporarily to include menstrual care products and over-the-counter drugs.[4] Congress could go further and add expenses for health-enhancing activities such as gym memberships, exercise equipment, and wellness programs. The research is clear that physical activity has long-term health benefits, which would lead to lower healthcare spending, all other things equal.[5]

If and when Congress instructs the IRS to expand the list of HSA-eligible expenses, it should also limit the regulatory burden that may arise from those expansions. Healthcare is already one of the most regulated industries. Paperwork requirements arising from the Social Security Act, Patient Protection and Affordable Care Act (PPACA), Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act, Health Information Technology for Economic and Clinical Health Act, and many other acts of Congress now cause doctors and other providers to spend over half of their working hours filing paperwork instead of treating patients.

A growing number of doctors are choosing to exit the (public and private) insurance system and open DPC clinics, a new healthcare model that eliminates insurance and regulatory paperwork. Patients of DPC practices get extensive access to their doctors for a monthly fee of usually well below $100.[6] They enjoy discounted labs and wholesale-priced drugs, and physicians can take care of their patients instead of focusing on paperwork. This model relies entirely on the fact that no third-party payers are involved. Although it would be desirable for patients to be able to use their HSAs to pay for DPC memberships, visits, labs, and drugs, the introduction of regulations governing what types of DPC-related expenses are eligible for HSA expensing risks compromising the model's effectiveness. For instance, the IRS proposed a rule in 2020 that would have classified DPC as insurance, which would have opened the door to the regulation of DPC as an insurance product, instead of as a service. The IRS did so even though 32 states have enacted legislation defining DPC as a medical service and not an insurance product. Additionally, the proposed rule would have explicitly banned people who benefit from a DPC membership from having an HSA: "An individual generally is not eligible to contribute to an HSA if that individual is covered by a direct primary care arrangement."[7] Congress can and should ensure that the IRS does not regulate DPC as an insurance product and ban DPC patients from having an HSA.

The risk is also great when the Centers for Medicare and Medicaid Services (CMS) seeks to copy the model. It did so in 2018, when it issued a request for information to try to implement a DPC model within Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[8] The potential problem is like what can readily be observed with the Supplemental Nutrition Assistance Program (SNAP). Stores that accept SNAP as payment are subject to regulations by the Food and Nutrition Service that make stores undergo a complex application process and abide by extensive program integrity rules. If DPC doctors were to accept Medicaid, Medicare, and CHIP

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[4] Coronavirus Aid, Relief, and Economic Security Act, H.R. 748, 177th Cong. (2020).
[5] Miriam Reiner et al., "Long-Term Health Benefits of Physical Activity—a Systematic Review of Longitudinal Studies," *BMC Public Health* 13, no. 1 (December 2013): 813; Darren E. R. Warburton, Crystal Whitney Nicol, and Shannon S. D. Bredin, "Health Benefits of Physical Activity: The Evidence," *Canadian Medical Association Journal* 174, no. 6 (2006): 801–9.
[6] Gina Roberts-Grey, "What Is Direct Primary Care? A Patient's Guide to DPC," GoodRx, May 19, 2020, https://www.goodrx.com/insurance/health-insurance/direct-primary-care.
[7] Internal Revenue Service, Certain Medical Care Arrangements, 85 Fed. Reg. 35398 (June 10, 2020).
[8] Centers for Medicare and Medicaid Services, "Direct Provider Contracting Models—Request for Information," updated January 4, 2022, https://innovation.cms.gov/innovation-models/direct-provider-contracting.

beneficiaries, they would risk being subject to the paperwork they sought to escape by setting up their clinic.

Allow more Americans to open HSAs. HSAs were intended to be available to all Americans for any medical expense.[9] However, HSAs as implemented include several restrictions that persist to this day. Currently, HSAs are available only to people who are enrolled in high-deductible health plans and do not meet some other requirements.[10] Congress's intent in creating HSAs was to allow people who faced high out-of-pocket costs to save up for those costs. But given the growth of healthcare costs, most Americans face high out-of-pocket costs, even if they are not enrolled in high-deductible plans. That group includes traditional Medicare beneficiaries, whose coinsurance is 20 percent of the price of the services they incur, and many Medicare Advantage beneficiaries, who often owe copays for services.

Congress should allow any willing American to fund and use an HSA to pay for healthcare-related expenses. Young people, especially, would benefit from a lifelong accumulation of healthcare funds through HSAs, and Congress should allow and encourage young people to open and actively fund HSAs. Current laws allow young adults ages 18–26 to be covered by their parents' health insurance, but they cannot have HSAs, even though they can use their parents' HSAs to fund eligible medical expenses. Young people should be allowed to accumulate funds in their HSAs, especially because their healthcare expenses tend to be low.

Encourage Americans to accumulate more funds in their HSAs. Currently, individuals fund their HSAs through pretax deductions and contributions from employers through cafeteria plans. Annual contribution limits apply regardless of the funding source. Federal law allows the IRS to adjust the annual contribution limits of HSAs to account for inflation. Therefore, the current HSA contribution limits of $3,650 for individuals and $7,300 for families for the year 2022 largely reflect cost-of-living adjustments since 2004, when the original limits were determined. After two decades of existence, the benefits of HSAs are clear, and, as scholars have noted, the success of HSAs depend partially on the annual contribution limits set by the IRS.[11]

To help Americans accumulate more funds in their HSAs, Congress could increase the annual contribution limits or set the limit as the larger of current limits and a percentage of adjusted gross income.[12]

In addition to raising the limits, Congress could allow other contribution sources for HSAs. For example, whereas surviving spouses can inherit HSAs without incurring any tax penalties, children cannot. Given that the intent of HSAs is to save for current and future medical expenses, the tax benefits should be able to be passed on to children. Another potential source of funding for HSAs is unspent Flexible Savings Account (FSA) balances. Currently, unspent FSA balances are forfeited if not used for qualified expenses within 15 months. The CARES Act temporarily allows such funds to roll over into the following year. Congress could build on this provision by allowing unspent FSA balances to roll over into HSAs.

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[9] PeopleKeep Team, "History of Health Savings Accounts—MSAs to HSAs," accessed January 4, 2022, https://www.peoplekeep.com/blog/bid/143476/history-of-health-savings-accounts-msas-to-hsas.
[10] Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans" (publication no. 969, Internal Revenue Service, Washington, DC, February 11, 2021).
[11] Juergen Jung and Chung Tran, "The Macroeconomics of Health Savings Accounts" (CAEPR Working Paper no. 2007-023, Center for Applied Economics and Policy Research, Bloomington, IN, April 11, 2008).
[12] "Definition of Adjusted Gross Income," Internal Revenue Service, last updated December 10, 2021, https://www.irs.gov/e-file-providers/definition-of-adjusted-gross-income.

Ensure Access to Quality Care and Portable Insurance

Access to quality care is not inherently dependent on access to insurance coverage, as demonstrated by the example of DPC. But disruptions in coverage can lead to unpredictable costs and exposure to bankruptcy risk. Disruptions are more likely to occur among working-age people and their families, the majority of whom are in an employer-sponsored insurance plan. The most straightforward way of ensuring portability of coverage is to dissociate health insurance from employment, which is currently beyond the realm of the politically feasible. Thus, we propose the legislation of recent executive rules on STLDI plans, which allow Americans on employer-sponsored plans to remain privately insured between jobs.

Before the PPACA and subsequent regulations severely curtailed STLDI plans, Americans used these plans to remain insured between jobs and avoid a health insurance coverage gap. Although employees can continue coverage from a previous employer under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the premium tends to be high. In 2021, for example, the average annual premium for continuation of coverage was $5,969 for individuals and $22,221 for families.[13] According to one study, only 23 percent of COBRA-eligible employees take advantage of coverage continuation.[14] The rest choose to use STLDI plans, Medicaid, or they remain uninsured. All states except California, Massachusetts, New Jersey, and New York allow the sale of STLDI plans, and some states limit either the term or the duration of STLDI plans.[15]

Recognizing these challenges, the Trump administration implemented rules to allow individuals to purchase STLDI plans for a term of up to 12 months and renew over the following 36 months. Before that, coverage under STLDI plans was limited to three months and not renewable.[16] Congress should enact the rule in statute to minimize the uncertainty that comes from frequent rule changes. In addition, Congress could also allow HSAs to cover premiums for STLDI plans, as they allow with COBRA premiums.[17]

Reform Public Health, Especially in Light of the Successes and Failures of the Response to COVID-19

Decision-making during a pandemic represents one of the most difficult situations for policymakers and politicians, but it is one of the most important situations to get right. Doing so means acting quickly with the best scientific evidence available but still recognizing that constituent values and interests vary. Although public health professionals are knowledgeable, their values may not match those of society generally,[18] and their recommendations during a pandemic should therefore be evaluated in a larger context. COVID-19 brought to the fore the ingenuity of scientists, as seen in the rapid development of tests, vaccines, and various effective treatments. However, managing public health during the pandemic has proven controversial. The

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[13] Gary Claxton et al., "Health Benefits In 2021: Employer Programs Evolving in Response to the COVID-19 Pandemic," *Health Affairs* 40, no. 12 (2021): 1961–71.
[14] Ryan J. Rosso, "Health Insurance Continuation Coverage Under COBRA" (report no. R40142, Congressional Research Service, Washington, DC, updated August 13, 2021), 16.
[15] Dania Palanker, Maanasa Kona, and Emily Curran, *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans* (Washington, DC: Commonwealth Fund, 2019), 17.
[16] Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212 (August 3, 2018).
[17] Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans."
[18] This mismatch may be the result of both framing effects and ideological imbalance. L. J. Leininger and Harold Pollack, "Opinion: We're Public Health Experts. We Need to Do a Better Job of Talking to Conservatives," *Washington Post*, October 12, 2020; Elizabeth A. DeVilbiss et al., "Assessing Representation and Perceived Inclusion among Members of the Society for Epidemiologic Research," *American Journal of Epidemiology* 189, no. 10 (2020): 998–1010.

pandemic focused a spotlight on the public health profession's normal ways of making science-led policy, and it is critical that society examines what worked and what failed, especially given the new broad-based use of nonpharmaceutical interventions (NPIs) such as lockdowns, mask mandates, etc.

The effects of NPIs stretch well beyond health to every facet of life—economic, social, and political. As society reviews the effectiveness of COVID-19 policies, it is critical that decision makers incorporate input from all stakeholders, not simply public health experts. There is a long tradition of scholarship examining the failures associated with reliance on narrow experts in forming policy, including F. A. Hayek's work on knowledge and socialist planning and Roger Koppl's more recent work.[19]

The GRADE and DECIDE frameworks used in public health incorporate other voices,[20] but they are so skewed toward public health expertise that they do not balance the various interests of the members of a democratic society. Politicians can achieve better balance of interests by consulting other members, but only if those members are not dismissed as unscientific or nonexpert. They simply reflect other expertise and perspectives.

Some recent public health work incorporates outside perspectives and expertise. For example, Karin Gulbrandsson, Nils Stenstöm, and Regina Winzer, in a 2016 study in Sweden, adapt the DECIDE framework to include individual autonomy and method sustainability as specific Swedish values of importance. This could explain why Sweden has taken a different route than virtually every other country with the COVID-19 pandemic. Public health officials incorporated Swedish values into the policy framework to improve its application in their community. A similar approach that recognizes additional values is critical for the US context.[21]

Given the limited information that policymakers have, it is critical that, when creating new policy, they continually evaluate the policy's effects and introduce corrective measures. This is what happens naturally in a federalist system, where individual states learn from each other but also reflect the specific knowledge they have of their own constituencies. America should be using this diversity to determine best policies and not get caught in political battles over federal consolidation. Recognizing which aspects of public health are best addressed at the national level (for example, vaccine development) and which are best addressed at the state or local levels (for example, most NPIs) will permit less costly solutions.

Before the next pandemic, America should develop a policy process that takes into account broad input from many areas, especially those outside healthcare. Such a process would permit policymakers to move quickly in the face of the next crisis, without as many accusations of partisanship or calls for one type of expertise to be considered to the exclusion of all others. If NPIs are to be a viable part of public health strategy, then the type of experts required to make such policy must include economists, business leaders, educators, religious leaders, and others.

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[19] F. A. Hayek, "The Use of Knowledge in Society," *American Economic Review* 35, no. 4 (1945): 519–30; Roger Koppl, *Expert Failure* (Cambridge, UK: Cambridge University Press, 2018).

[20] GRADE = Grading of Recommendations, Assessment, Development, and Evaluations; DECIDE = Define, Extrapolate, Consider, Incorporate, Develop, and Evaluate.

[21] Karin Guldbrandsson, Nils Stenström, Regina Winzer, "The DECIDE Evidence to Recommendation Framework Adapted to the Public Health Field in Sweden," *Health Promotion International* 31, no. 4 (2016): 749–54.

It is important that Congress reviews the various laws that permit public health agencies to impose certain restrictions. Specifically, we recommend that Congress do the following:

- Conduct a full cost-benefit or cost-effectiveness analysis of the NPIs recommended during the COVID-19 pandemic. Take into account individual autonomy and method sustainability in the analysis, as officials do in Sweden.
- Use the laboratory of federalism to catalog pandemic policies according to their effectiveness and net benefit. Such a catalog could provide a starting point for future public health crises. A broad set of experts should contribute to the creation of the catalog, making special note of past policy failures so that future policymakers do not repeat those mistakes.
- Examine how the federal response to the COVID-19 pandemic has altered the balance between federal, state, and local public health policymakers. Doing so would allow Congress to consider how any such alteration affects the future development of effective, robust, and resilient public health policies.
- Review section 361 of the Public Health Services Act of 1944, which grants broad powers to health agencies to take necessary actions during a public health emergency, with the aim of narrowing the scope of actions agencies can take.

Increase Competition in the Healthcare Industry

The growth of healthcare regulations in recent decades has made the healthcare industry less competitive by increasing the cost of compliance, hindering entrepreneurship, and fostering consolidation. But in some cases, Congress has acted directly to reduce competition in the sector. One particularly egregious example is section 6001 of the PPACA, which prevents new hospitals owned by physicians from receiving reimbursements from Medicare.

Congress started implementing restrictions on physician-owned hospitals (POHs) in 1992 under pressure from the hospital industry, which claimed that doctors' simultaneous owning and operating of hospitals represents a conflict of interest. The restrictions on POHs came to a head in 2010, when CMS forbade new and existing POHs from participating in Medicare. Medicare beneficiaries represent almost a fifth of all American patients, effectively making the restriction a ban on POHs. Indeed, there are just 200 POHs in the country (compared with 6,000 nonprofit and investor-owned hospitals), the same number as when the ban came into effect.[22] A new peer-reviewed study reviewing over 30 years of research finds that the quality of POHs is equivalent to other hospitals—and superior in some cases. Physician-owned community hospitals have similar costs and quality of care as nonprofit and for-profit community hospitals. Specialty POHs—i.e., hospitals that focus on certain medical specialties, such as cardiology or orthopedic surgery—have higher quality and lower or similar costs.[23] Restrictions on POHs are restrictions on private enterprise and innovation by physicians, stifling the efforts and ideas of some of the brightest and best-educated Americans. For these reasons, Congress should consider allowing POHs to participate in Medicare, like they did in the past.

Conclusion

In this comment, we propose policy solutions in four areas. First, we offer ways to expand insurance coverage options by changing the rules on HSAs to ensure that more Americans can use them for current healthcare expenses while also accumulating funds for future use. We propose

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[22] Brian J. Miller and Jesse Ehrenfeld, "Covid-19 Has Revealed the Hazards of Blocking Physician-Owned Hospitals," *STAT*, September 30, 2021.

[23] Ted Cho et al., *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review* (Arlington, VA: Mercatus Center at George Mason University, 2021), 23.

the relaxation of current restrictions on HSAs and other cafeteria spending plans to allow Americans to spend their tax-advantaged funds on other innovative payment mechanisms. In suggesting those relaxations, we stress the caution that Congress should take to avoid creating policies that increase the already extensive involvement of the government in healthcare decisions. To forestall such an occurrence, laws by Congress should communicate their intent clearly to rulemaking agencies. Second, we explain that portability issues arise from employer-sponsored insurance but acknowledge that, in the short term, an overhaul of the employer-sponsored system would be challenging. We therefore suggest that, in lieu of such an overhaul, Congress prioritize the legislation of executive actions that have expanded access to STLDI plans. Third, we go on to point out that the creation and implementation of public health policy requires the involvement of many types of experts, not only public health experts, and we offer recommendations for diversifying the voices that influence public health laws. And fourth, noting the complex reasons underlying the lack of competition in today's healthcare system, we highlight a particularly egregious law that bans POHs from participating in Medicare and suggest that Congress overturn that law.

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