
ESSAYS

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**HEALTH CARE'S FUTURE IS SO BRIGHT, I GOTTA WEAR
SHADES**

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INTRODUCTION

Futurists, investors, and health-law programs all try to catch a glimpse of the future of health care. Lucky for you, you've got me. I'm *from* the future. I've travelled back in time from the year 2045. And I am here to tell you, the future of healthcare reform is awesome.¹

When I presented these observations at the Willamette University College of Law symposium "21st Century Healthcare Reform: Can We Harmonize Access, Quality and Cost?" I was tickled by how many people I saw using iPhones. I mean, *iPhones!* How quaint. Don't get me wrong. We have iPhones in the future. Mostly they're on display in museums; as historical relics, or a medium for sculptors. Hipsters—yes, we still have hipsters—who wouldn't even know how to use an iPhone, will sometimes wear them as fashion accessories. Other than that, iPhones can be found propping up the short legs of restaurant tables. I also noticed you're still operating general hospitals, in 2015. Again, quaint.²

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1. See KEVIN D. WILLIAMSON, *THE END IS NEAR AND IT'S GOING TO BE AWESOME: HOW GOING BROKE WILL LEAVE AMERICA RICHER, HAPPIER, AND MORE SECURE* (2013).

2. See CLAYTON M. CHRISTENSEN ET AL., *THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE* 76, 82, 237 (2008) ("Were it not for today's tangled web of subsidies, administered prices, and regulations that constrain competition, today's general hospitals would not be economically or competitively viable. . . . The Coxa Hospital for Joint Replacement in Tampere, Finland, achieves similarly better costs than general hospitals. The 64 general hospitals in Finland that perform similar surgeries average unanticipated complication rates of 10 to 12 percent; the rate at Coxa is 0.1 percent. . . . The

To answer a few questions people always ask me about the year 2045:

- Justin Bieber crashed pretty hard. He is bald, broke, overweight, and has gone home to Canada where taxpayers must now pay for his diabetes care.³
- SkyNet is not self-aware. At least, not yet. (Fingers crossed!)⁴
- The arc of history is long, but it continues to bend toward justice, equality, freedom, peace, and progress.⁵
- Mortality from war and disease has continued the erratic but substantial long-term decline that you have already begun to see in your lifetimes.⁶
- Billions of people across the globe have been lifted out of

high cost of hospitalization isn't driven by the excess profits of general hospitals. . . . The costs are simply inherent to the one-size-fits-all value proposition they offer.”)

3. *Justin Bieber Talks Sex, Politics, Music and Puberty*, ROLLING STONE (Feb. 16, 2011), <http://www.rollingstone.com/music/news/justin-bieber-talks-sex-politics-music-and-puberty-in-new-rolling-stone-cover-story-20110216> (“The Canadian-born Bieber never plans on becoming an American citizen. ‘You guys are evil,’ he jokes. ‘Canada’s the best country in the world.’ He adds, ‘We go to the doctor and we don’t need to worry about paying him, but here, your whole life, you’re broke because of medical bills. My bodyguard’s baby was premature, and now he has to pay for it. In Canada, if your baby’s premature, he stays in the hospital as long as he needs to, and then you go home.’”).

4. *Contra* TERMINATOR 2: JUDGMENT DAY (Orion Pictures 1991) (T-800 Terminator: “The Skynet Funding bill is passed. The system goes online August 4th, 1997. Human decisions are removed from strategic defense. Skynet begins to learn at a geometric rate. It becomes self-aware at 2:14 a.m. Eastern time, August 29th. In a panic, they try to pull the plug.” Sarah Connor: “Skynet fights back.” T-800 Terminator: “Yes. It launches its missiles against the targets in Russia.” John Connor: “Why attack Russia? Aren’t they our friends now?” T-800 Terminator: “Because Skynet knows the Russian counter-attack will eliminate its enemies over here.”).

5. *See* A CALL TO CONSCIENCE: THE LANDMARK SPEECHES OF DR. MARTIN LUTHER KING, JR. 199 (Clayborne Carson & Kris Shepard eds., 2001) (“Let us realize that the arc of the moral universe is long, but it bends toward justice.”). *See generally* THEODORE PARKER, TEN SERMONS OF RELIGION 84–85 (1853) (“Look at the facts of the world. You see a continual and progressive triumph of the right. I do not pretend to understand the moral universe, the arc is a long one, my eye reaches but little ways. I cannot calculate the curve and complete the figure by the experience of sight; I can divine it by conscience. But from what I see I am sure it bends towards justice.”); STEVEN PINKER, THE BETTER ANGELS OF OUR NATURE: WHY VIOLENCE HAS DECLINED (2011) (arguing that this is the most peaceful era yet).

6. PINKER, *supra* note 5, at 304.

poverty and saved from hunger and disease because we continue to find new, better, and cheaper ways of meeting basic human needs.⁷

- Finally—and I cannot over-emphasize this—we have more excellent water slides than any other planet we communicate with.⁸

Nowhere has this progress been more astounding and rapid than in health care.

HEALTH CARE IS EASIER

In the future, medicine is still complex. But health care is simpler.

Just about every health plan and provider network offers each patient a personal concierge who is equal parts counselor, clinician, and financial advisor. Your concierge helps you communicate with your medical team, helps you understand your treatment options, and even acts as a cost-sharing consultant. As a patient, you understand how much you're going to pay *before* you choose a treatment plan.

Patients can communicate with their concierges—or if they want, with their doctors, health coaches, dieticians, geneticists, and health plans—in a variety of electronic ways. Alternatively, patients can consult diagnostic software on their own—human attention when you want it, technology when you don't.

It's easier to see the doctor, or even get your teeth cleaned.

7. See Bono, Address at Georgetown University (Nov. 12, 2012) (transcript available at <http://www.theguardian.com/social-enterprise-network/2012/nov/14/social-enterprise-bono-georgetown>) (“Commerce, entrepreneurial capitalism takes more people out of poverty than aid, of course, we know that.”); see also Laurence Chandy & Geoffrey Gertz, *Poverty in Numbers: The Changing State of Global Poverty from 2005 to 2015*, BROOKINGS INSTITUTION (2011), http://www.brookings.edu/~media/research/files/papers/2011/1/global%20poverty%20chandy/01_global_poverty_chandy_execsumm.pdf (“Poverty reduction of this magnitude is unparalleled in history: never before have so many people been lifted out of poverty over such a brief period of time.”); Marian L. Tupy, *Bono: Only Capitalism Can End Poverty*, CATO INST. (July 31, 2013, 10:59 AM), <http://www.cato.org/blog/bono-only-capitalism-can-end-poverty> (“According to the World Bank, global poverty is declining rapidly. In 1981, 70 percent of people in poor countries lived on less than \$2 a day, while 42 percent survived on less than \$1 a day. Today, 43 percent live on less than \$2 a day, while 14 percent survive on less than \$1.”).

8. *Accord* BILL & TED'S EXCELLENT ADVENTURE (Orion Pictures 1989) (“Hi, welcome to the future. San Dimas, California, 2688. And I'm telling you it's great here. The air is clean. The water's clean. Even the dirt—it's clean! Bowling averages are way up. Mini-golf scores are way down. And we have more excellent water slides than any other planet we communicate with. I'm telling you, this place is great!”).

Often, you don't have to leave home. Telemedicine is a huge part of healthcare delivery. We keep people out of waiting rooms and hospitals thanks to a revolution that began with, of all things, a car service. I think you called its first generation "Uber."⁹ If you need a doctor, even a specialist, your concierge can schedule a house call, or you can summon one yourself, at a time convenient for *you*. Your specialist comes not only prepared with your entire, accurate, medical history, but is able to perform an increasing number of diagnostic tests and even procedures in your own home.¹⁰

Not everyone uses a concierge or health apps or the other cool stuff that we have and you don't. Just as some people like to homeschool their kids, brew their own beer, raise their own chickens, and build their own log cabins, some people still prefer the complexity of pure indemnity insurance, finding their own specialists, and researching their own treatment options. That choice is still there.

But generally speaking, grandparents frighten—okay, bore—their kids and grandkids with horror stories about when they had to carry *all* their medical records and *all* their prescriptions to *all* their doctors' offices, trying to remember *all* the often-conflicting things each doctor told them. That's what everyone expected. That was *normal*.

The kids and grandkids just shake their heads. They have healthcare providers who know their names, their needs, and their values. They have a single point of contact who coordinates all that complexity, so they can focus on what is important to them. That's the *new normal*.

9. Peter Van Doren, *Uber Provides Case Against Occupational Licensing*, CATO INST. (Jan. 28, 2015, 4:25 PM), <http://www.cato.org/blog/uber-provides-case-against-occupational-licensing>.

10. See, e.g., Melinda Beck, *Startups Vie to Build an Uber for Health Care*, WALL ST. J., Aug. 11, 2015, <http://www.wsj.com/articles/startups-vie-to-build-an-uber-for-health-care-1439265847> ("Pager, in New York City, dispatches doctors or nurse practitioners via Uber, for \$200. Heal, in Los Angeles, San Francisco and Orange County, Calif[ornia], promises to 'get a doctor to your sofa in under an hour' for \$99. (A medical assistant goes along to do the driving and parking.) RetraceHealth, in Minneapolis, has a nurse practitioner consult with patients via video (for \$50), and only comes to their homes if hands-on care like a throat swab or blood draw is necessary (for \$150). Atlanta-based MedZed sends a nurse to a patient's home to do a preliminary exam. Then the nurse connects via laptop with a doctor who provides a treatment plan remotely. . . . And thanks to the boom in mobile-medical technology, providers can carry key equipment with them, from portable blood analyzers to hand-held ultrasounds. . . . 'Health checks,' in which a nurse does cholesterol, blood pressure, blood sugar and other tests for \$75, are also popular—even in office settings.").

HEALTH CARE IS BETTER

Simplifying the patient experience and coordinating care has led to greater treatment compliance, fewer medical errors, and even fewer misdiagnoses.¹¹

Initially, there was a lot of resistance to letting nonphysician clinicians, assisted by diagnostic software, make diagnoses that government regulation previously allowed only physicians to make. But that resistance, which came exclusively from physician groups who benefited financially, became farcical when the software reached the point where the nurse practitioners, physician assistants, and registered nurses started getting the diagnoses right more often (and at a lower cost) than the M.D.'s. People with less education, aided by technology, started outperforming people with more education.¹² Health care prices plummeted, and thank God for it.

In the future, we have more new treatments and cures. I hate to depress you, dear readers, but some of you are going to die from diseases that no longer cause death in the future. Some of those diseases have cures. Other once-fatal illnesses are now managed as chronic conditions. Many once-difficult chronic conditions are now as easy to manage as clipping your fingernails.

HEALTH INSURANCE IS BETTER, ESPECIALLY IF YOU'RE SICK

People have an easier time believing humanity mastered time travel than believing what I tell them about the future of health insurance.

So-called young invincibles voluntarily purchase health insurance in droves. We don't force them to buy it, or force employers to offer it. We simply removed the barriers government had put in the way of insurers offering cash back to people who don't file claims. That made buying coverage look like a better deal to people who thought traditional health insurance was a lousy deal.¹³

11. See Kaveh G. Shojania et al., *Changes in Rates of Autopsy-Detected Diagnostic Errors over Time: A Systematic Review*, 289 JAMA 2849, 2852–53 (2003) (analysis of fifty-three distinct autopsy series over a forty-year period showed a significant decrease over time for major diagnostic errors detected at autopsy).

12. See generally CLAYTON M. CHRISTENSEN, JEROME H. GROSSMAN & JASON HWANG, *THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE* (2008).

13. See Tom Baker & Peter Siegelman, *Tontines for the Young Invincibles*, REGULATION, Winter 2009-2010, at 20, 20 (“Ordinary health insurance provides a tangible benefit only when you need health care. Tontine insurance pays a cash benefit when you *don't*

Insurance against pre-existing conditions is easy to obtain. It costs less than powering up your self-driving car, and a *lot* less than buying a health insurance policy. You don't even have to buy health insurance to get it. Once you buy low-cost "pre-ex" insurance, you can wait until after you get sick to buy health insurance, and you will still pay the same premium as if you were healthy.¹⁴

Governments used to try to achieve the same thing by imposing "community rating" price controls on health insurance premiums. But pre-ex insurance protects patients without the problems government price controls inevitably create. Community rating creates adverse selection, which has destroyed health insurance markets.¹⁵ Even where markets didn't collapse, community rating still drove average premiums higher and created a race to the bottom by forcing insurance companies to compete on the basis of who could provide

use it, as well as covering your medical expenses when you do. As such, tontine insurance is structured to be maximally attractive to those who have an overly optimistic assessment of risk. . . . Tontine health insurance should be especially enticing to people who do not purchase coverage because they think they would 'lose' the ordinary health insurance bet by being healthy—the invincibles."). See generally Jeff Guo, *It's sleazy, it's totally illegal, and yet it could become the future of retirement*, WASH. POST (Sept. 28, 2015), <http://www.washingtonpost.com/news/wonkblog/wp/2015/09/28/this-sleazy-and-totally-illegal-savings-scheme-may-be-the-future-of-retirement/>.

14. See Reed Abelson, *United Health to Insure the Right to Insurance*, N.Y. TIMES, Dec. 2, 2008 at B1 ("For these economically uncertain times, the UnitedHealth Group has a 'first of its kind' product: the right to buy an individual health policy at some point in the future even if you become sick. . . . Those who do pass a medical review, will pay 20 percent each month of the current premium on an individual policy to reserve the right to be insured under the plan at some point in the future. . . . But if changes to the health insurance system do occur under the Obama administration, they say, UnitedHealth's new product may become obsolete. . . . It is initially available in 25 of the 40 states where UnitedHealth currently sells individual insurance, which do not include New York and New Jersey. The company is applying to sell it in the other 15 states, including Connecticut, where it now sells to individuals. . . . A 50-year-old male in Columbus, Ohio, who planned to eventually take an individual policy in which he would be obliged to pay the first \$3,500 in medical bills would pay \$32 a month for the right to eventually get that coverage—or 20 percent of a policy that now costs \$159 a month.").

15. See *The PPACA's Health Insurance Exchanges and Medicaid Expansion: Before the H. Select Comm. on Patient Protection and Affordable Care Act*, 2013 Leg. Sess. (Fl. 2013) (statement of Michael Cannon, Director of Health Policy Studies, Cato Institute), available at <http://www.cato.org/publications/congressional-testimony/ppacas-health-insurance-exchanges-medicaid-expansion> ("The PPACA's 'community rating' price controls will destroy innovations that make health insurance better and more secure. They have already caused the markets for child-only health insurance to collapse in 17 states and caused insurers to flee the child-only market in a further 18 states. When implemented elsewhere, these price controls have forced health insurance companies to compete to avoid and mistreat the sick. Millions of Americans will suffer those consequences if these price controls take full effect in 2014. When informed that these price controls will reduce the quality of care their families receive, consumers overwhelmingly oppose these supposedly popular provisions.").

the worst care to the sick.¹⁶ And supporters called that consumer protection!

If you find pre-ex insurance hard to believe, you're going to want to sit down for this next part. *In the future, health insurance comes with a total-satisfaction guarantee.* If you don't think your health plan is managing your diabetes or cancer care well, if you think their network is too narrow, or if you are unsatisfied with your health plan for any reason, you can fire your health plan, and other health plans will compete to *cover* you, rather than avoid you.¹⁷

EVEN DEATH IS BETTER

Some things haven't changed. Mortality is still with us. We haven't cured all diseases. And when people do get a fatal disease, they can fight it to the very end. They can participate in a clinical trial to help find cures that continue to elude us. It is their choice.

What might strike you the most about dying in the future is how often it happens at home. People are more often choosing not to die in hospitals like a pincushion, but at home, surrounded by their families. Death, dying, and bereavement are more often an intentional process.¹⁸

How that happened was simple: we just ended government subsidies for heroic end-of-life measures. The government leaves that choice with the patient, without creating financial incentives to encourage patients to choose one path over another. The social and professional norms surrounding end-of-life care changed dramatically. Every health plan has a "life panel" to help patients make their choice by providing them with information about the cost-

16. Jeffrey Young, *How Your Health Insurance Company Can Still Screw You, Despite Obamacare*, HUFFINGTON POST (July 21, 2014, 6:59 PM), http://www.huffingtonpost.com/2014/07/21/health-insurance-obamacare_n_5599544.html ("Obamacare didn't magically transform insurers into benevolent entities solely devoted to taking care of sick people. And since health insurance companies can no longer shun the sick to maximize profits—either by denying coverage to people based on their medical histories or by rescinding the policies of paying customers who fall ill and rack up bills—insurers are employing other tactics to shift costs to sick people and make it harder to get health care, consumer advocates say.”).

17. See John H. Cochrane, *Health-Status Insurance: How Markets Can Provide Health Security*, POL'Y ANALYSIS 633 (CATO Inst., D.C.) Feb. 18, 2009, at 1 (“The individual health insurance market is already moving in the direction of [a total-satisfaction guarantee]. To let [such] insurance emerge fully, we must remove the legal and regulatory pressure to provide employer-based group insurance over individual insurance and remove regulations limiting risk-based pricing and competition among health insurers.”).

18. See *generally* ELISABETH KÜBLER-ROSS, ON DEATH AND DYING (1969).

effectiveness of all their treatment options.¹⁹

HEALTH CARE IS MORE UNIVERSAL

In the future, health care is more affordable for the poor, and the poor are receiving better care.

Lower skilled clinicians like nurse practitioners, physician assistants, registered nurses, and dental hygienists are providing an ever-increasing range of services at lower prices than physicians and dentists did. It is not just diagnostics. Lower cost clinicians are writing prescriptions and performing procedures that used to be the sole province of high-cost clinicians.²⁰ The quality is higher, with fewer medication errors and complication rates.

As I mentioned at the outset, there is also *less poverty* in the future, in part because we stopped forcing the poor to give so much of their income to an unconscionably wasteful healthcare system.²¹

HOW DID IT HAPPEN?

The healthcare revolution occurred when we realized that whenever we tried to legislate better, more affordable, and more secure health care, it never happened. We were never able to legislate or regulate our way to higher quality, lower cost care. And we figured out why.

Better, more affordable health care represents a threat to the revenue streams of existing high-cost and low-quality providers. That is true whether you are trying to get them to change their business

19. See Michael F. Cannon, *More Reasons Why IPAB, ObamaCare's 'Death Panel,' Is Relevant To Sylvia Burwell's Nomination*, FORBES (April 15, 2014, 2:48 PM), <http://www.forbes.com/sites/michaelcannon/2014/04/15/more-reasons-why-ipab-obamacares-death-panel-is-relevant-to-sylvia-burwells-nomination/> (“Critics therefore call IPAB a ‘death panel,’ but one could just as defensibly call it a ‘life panel.’”).

20. See, e.g., Beck, *supra* note 10 (“Caren Misky, a nurse practitioner with True North Health Navigation in Denver, says she recently responded to a call where an Alzheimer’s patient had fallen and cut his head. She was able to staple his wound at the kitchen table while he had breakfast. ‘His wife said the last time that happened, they spent eight hours in the ER and had a \$10,000 bill,’ Ms. Misky says. . . . [T]he True North mobile unit goes to the scene along with the fire department’s paramedics. Once the paramedics confirm the situation isn’t life-threatening, the caller can choose between being treated by a nurse practitioner on the spot, for \$200 to \$300, (which is covered by most Colorado insurance plans), or going by ambulance to the ER, which typically costs \$3,000 or more.”).

21. See Elliott S. Fisher, *More Care is Not Better Care*, EXPERT VOICES (NAT’L INST. FOR HEALTH CARE MGMT. FOUND., D.C.), Jan. 2005 (“We may be wasting perhaps 30% of U.S. health care spending on medical care that does not appear to improve our health.”).

model directly,²² or trying to change legal rules to enable competitors to offer better and lower cost services.²³ The dinosaurs *do not like it* when you disrupt their revenue streams, but imagine where humanity would be if the government had made it illegal to introduce lower cost ways of producing food unless high-cost farmers were held harmless. We'd all still be doing back-breaking physical labor on farms, if not starving. Actually, that's not a bad analogy for health care in 2015.

Whenever we tried to legislate our way to better health care, the dinosaurs thwarted us at every turn. The political process responds to whoever has the resources and the incentive to organize and engage in politics, especially legislative and administrative lobbying. In those contests, consumers and innovators cannot compete with incumbent providers, who can therefore bend any new legislation or regulation to protect themselves from competition.²⁴ The result is that the political process protects the very providers of *high*-cost and *low*-quality care we hoped to reform. We realized we had to get those decisions out of the political process and reassign them to the market process, where the dinosaurs have no choice but to compete.

Another impetus to change occurred when we stopped trying to pretend health insurance is the solution to every problem. We learned that beyond a certain point, more health insurance actually makes access *worse*. A couple of decades ago, we had a president who is now hailed as our greatest healthcare reformer. One of her most quoted slogans was, "I would rather have \$50 M.R.I.'s and no health insurance than \$1000 M.R.I.'s and universal coverage."²⁵ Of course,

22. See, e.g., Charles Lane, *Medicare Reform's Slow Progress*, WASH. POST, Mar. 4, 2013, https://www.washingtonpost.com/opinions/charles-lane-medicare-reforms-slow-progress/2013/03/04/9624c4c4-84f8-11e2-999e-5f8e0410cb9d_story.html (Industry resisted a proposal to use competitive bidding to reduce the prices Medicare pays for medical equipment. "One man's absurd waste of taxpayer funds, however, is another man's rice bowl. Organized into an effective lobby, medical equipment manufacturers and distributors resisted change.").

23. See Shirley V. Svorny, *Medical Licensing: An Obstacle to Affordable, Quality Care*, POL'Y ANALYSIS 621 (CATO INST., D.C.), Sept. 17, 2008, at 2 ("[A] powerful physician lobby can block changes to the scopes of practice of mid-level practitioners that would impinge on its members' turf.").

24. See, e.g., Margot Sanger-Katz, *Why Doctors Dictate How Much the Government Pays Them*, NAT'L J., May 18, 2013 ("Medicare accepts the vast majority of the recommendations proposed by the group, known as the Relative Value Scale Update Committee, or, more commonly, the RUC."). The RUC is an advisory panel consisting of thirty-one doctors from different specialties.

25. Cf. Letter from Thomas Jefferson to Edward Carrington (Jan. 16, 1787), in 5 THE FOUNDERS' CONSTITUTION 121, 122 (Philip B. Kurland & Ralph Lerner eds., 1987) ("[A]nd were it left to me to decide whether we should have a government without newspapers, or newspapers without a government, I should not hesitate a moment to prefer the latter.").

that was back when people used M.R.I.'s.

What set it all in motion was when Congress and the President repealed a law that was *supposed* to protect patients and make health care affordable.²⁶ That one step jettisoned the pre-existing-conditions regulations that were preventing innovators from protecting people against pre-existing conditions. It made coverage more affordable by restoring people's freedom to purchase or not to purchase coverage. It led to a rethinking of the entire enterprise, and a flood of reform.²⁷

States began to recognize that beyond a certain point, patient-protection regulation makes health insurance and health care so expensive, it actually hurts consumers rather than helps them. So, states let consumers decide where that point is, by letting them choose other states' consumer protections.

Around the same time we noticed the mid-levels were beating the doctors on diagnoses, we noticed medical licensing doesn't improve quality at all.²⁸ On top of being just an income transfer from patients and lower skilled clinicians (e.g., dental hygienists) to higher skilled clinicians (e.g., dentists),²⁹ licensing increased prices, reduced the availability of services,³⁰ blocked new delivery models, and reduced quality.

What really crystallized the licensing issue for policymakers was how each state's physician lobby used licensing laws to prevent out-

26. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

27. See generally Michael F. Cannon, *Yes, Mr. President: A Free Market Can Fix Health Care*, POL'Y ANALYSIS 650 (CATO Inst., D.C.), Oct. 21, 2009 (offering an agenda for liberalizing health care).

28. See Svorny, *supra* note 23, at 12 ("Quality assurance in today's medical marketplace doesn't come from state medical [licensing] boards but from the fear of medical malpractice liability and from market mechanisms such as malpractice insurers; independent certification agencies like the Joint Commission, specialty boards, and credentials verification organizations; consumer guides such as *Consumer Reports*, HealthGrades, and Angie's List; and insurers' and providers' interest in protecting their reputations and brand names.").

29. See Morris M. Kleiner & Kyoung Won Park, *Battles Among Licensed Occupations: Analyzing Government Regulations on Labor Market Outcomes for Dentists and Hygienists* 19–20 (NAT'L BUREAU OF ECON. RES., WORKING PAPER NO. 16560, 2010), available at <http://www.nber.org/papers/w16560.pdf> ("[G]reater autonomy by legally allowing hygienists to work independently of dentists is associated with an approximately 10 percent higher wage and a 6 percent increase in the employment growth of dental hygienists. In contrast, these state provisions are associated with approximately a 16 percent reduction in dental hourly earnings and a 26 percent reduction in dental employment growth in the states.").

30. *Id.* at 20 (finding that states lose approximately one percent of output of dental services by not allowing hygienists to practice on their own).

of-state clinicians from treating the poor for free.³¹ Starting around 2010, states started fixing that problem.³² After that, the floodgates opened. The more states liberalized their healthcare markets, the more innovation we saw, and the more access to quality health care surged. Support for medical licensing plummeted, and states repealed it. The poor benefited most of all.

The single most transformative thing we did was to change who controls the money. We took all the healthcare dollars that government controls and spends on behalf of patients, and gave it to the patients.³³ We took all the healthcare dollars employers control and spend on behalf of workers, and we gave it to the workers who earned it.³⁴ Patients now control that money and spend it on their own

31. See generally *Should Ohio Expand Medicaid?: Before the H. Select Comm. on Health & Human Servs.*, 2013 Leg. Sess. (Oh. 2013) (statement of Michael Cannon, Director of Health Policy Studies, Cato Institute), available at <http://www.cato.org/publications/testimony/should-ohio-expand-medicaid> (“Volunteer groups like Remote Area Medical engage doctors and other clinicians from around the country to treat indigent patients in rural and inner-city areas. These clinicians are often turned away from providing free medical care to the poor, however, because they are not licensed to practice medicine by the state they are visiting. Remote Area Medical has had to turn away patients or scrap clinics in California, Florida, and Georgia due to these licensing restrictions. ‘Before Georgia told us to stop,’ says founder Stan Brock, ‘we used to go down to southern Georgia and work with the Lions Club there treating patients.’ After a tornado devastated Joplin, Missouri, Remote Area Medical arrived with a mobile eyeglass lab, yet state officials prohibited the visiting optometrists from giving away free glasses. Tennessee, Illinois, and Connecticut have enacted laws that allow out-of-state-licensed clinicians to deliver free charitable care in their states without obtaining a new license.”); see also Jeff Reichert & Fariyah Zaman, *Dear New York City's Uninsured: Screw You, Love Governor Cuomo*, HUFFINGTON POST (Nov. 19, 2014, 11:43 AM), http://www.huffingtonpost.com/jeff-reichert/dear-new-york-citys-unins_b_6184470.html (criticizing New York Governor Andrew Cuomo for not allowing a Remote Area Medical free clinic in New York City).

32. See Michael F. Cannon, *Missouri Lawmakers Override Veto to Enact Good Samaritan Law*, CATO INST. (Sept. 12, 2013, 4:01 PM), <http://www.cato.org/blog/missouri-lawmakers-override-nixon-veto-enact-good-samaritan-law> (“Missouri now joins states like Tennessee, Illinois, and Connecticut that have enacted similar Good Samaritan laws.”).

33. See Michael F. Cannon & Chris Edwards, *Medicare Reforms*, DOWNSIZING GOVERNMENT (Sept. 2010), <http://www.downsizinggovernment.org/hhs/medicare-reforms> (“Medicare reforms that allow individuals to control their health care dollars would eliminate wasteful spending, would provide enrollees better choices and better medical care, and would do so at a lower cost to taxpayers. Congress should move retiree health care from today's dysfunctional system of central planning to an innovative system based on personal savings, individual choice, and competition.”).

34. See, e.g., Michael F. Cannon, *Large Health Savings Accounts: A Step toward Tax Neutrality for Health Care*, 11 F. FOR HEALTH ECON. & POL'Y, no.2, 2008, at 1, 1 (“The creation of tax-free health savings accounts presents a new opportunity to reduce the distortions created by federal tax preferences for health-related expenditures that ultimately could help eliminate those distortions.”); Michael F. Cannon, Op-Ed., *On Health Care, Walker and Rubio Offer Obamacare Lite*, N.H. UNION LEADER (Aug. 27, 2015, 8:39 PM),

behalf. We let them choose which, and how much, coverage to purchase.

That change was also the single most powerful thing we did to improve access for the poor. Not so much because the poor got to control more of their own money—though that mattered a lot to them. It was because those changes turned the *other* 300 million Americans into more cost-conscious and demanding consumers.

When those 300 million consumers got control of the \$3 trillion this nation spends on medical care,³⁵ they changed their behavior, and that in turn changed health care. They became more careful and demanding consumers. They forced prices down, aided by the elimination of regulations that had been protecting high-cost and low-quality providers from competition. Political support from cost-conscious consumers helped us eliminate even more price-inflating regulation. That's when we really saw an innovation explosion in both health insurance and healthcare delivery.

Once we eliminated the price controls that were supposed to protect against pre-existing conditions and gave consumers the freedom to choose their own health plans, consumers demanded protection from those risks. Insurers responded with innovations like pre-ex insurance, total-satisfaction guarantees, and more.

We saw an explosion in integrated delivery systems and prepaid group plans like Kaiser Permanente and Group Health, which delivered innovations in coordinated care, concierge care, medical teams, e-health, and life panels.³⁶

We're even solving public-goods problems that had suppressed investment in all kinds of effectiveness research.³⁷ We have more

<http://www.unionleader.com/article/20150828/OPINION02/150829238/0/SEARCH> (“Large HSAs would let workers take that money as a tax-free HSA contribution, and thereby let taxpayers own and control \$9 trillion of their earnings that someone else currently controls. That's an effective tax cut equal to all of the Reagan and Bush tax cuts combined, and nine times more than taxes would fall by repealing Obamacare.”).

35. See Andrea M. Sisko et al., *National Health Expenditure Projections, 2013-23: Faster Growth Expected with Expanded Coverage and Improving Economy*, 33 HEALTH AFF. 1841, 1843 (2014).

36. See generally SHANNON BROWNLEE, *OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER AND POORER* (2008); TOWARD A 21ST CENTURY HEALTH SYSTEM: THE CONTRIBUTIONS AND PROMISE OF PREPAID GROUP PRACTICE, (Alain C. Enthoven & Laura A. Tollen eds., 2004).

37. See Michael F. Cannon, *A Better Way to Generate and Use Comparative-Effectiveness Research*, POL'Y ANALYSIS 632 (CATO Inst., D.C.), Feb. 2, 2009, at 1 (“A better way to generate comparative-effectiveness information would be for Congress to eliminate government activities that suppress private production. . . . That laissez-faire

information on the effectiveness, comparative effectiveness, and cost-effectiveness of medical treatments than ever before.

In fact, integrated prepaid group plans were doing so much effectiveness research and quality certification of medical technologies, one day we woke up and realized we were sitting on a private-sector alternative to the Food and Drug Administration (FDA). So we got rid of the FDA. We don't even miss it. In its place, private, integrated health plans are evaluating the safety and efficacy of drugs, medical devices, nutritional supplements, and health claims in a way that doesn't deny patients the right to make their own health decisions.³⁸ Health plans attract enrollees by competing to have the most reliable seal of quality approval.

CONCLUSION

We are making health care better, more affordable, and more secure every day. We have achieved greater protections against illness and financial insecurity now than when we tried to legislate our way to better health care. And the progress never ends.

We still have gaps in our healthcare sector. We still have to worry about quality. We still have to worry about effectiveness. We still have to worry about insurance carriers' solvency. Not everyone has health insurance. Then again, health insurance is a lot less necessary.

Yet all of these challenges are smaller than they were in 2015. No one wants to go back to the bad old days, when an obsession with health *insurance* got in the way of providing everyone with health *care*. Access to care is now more universal than when we tried to legislate our way to universal coverage. The future of health care is so bright, I recommend sunglasses.³⁹

Now forgive me, before I can return to the year 2045, I need to pop down to the corner drugstore for a little plutonium.⁴⁰ If you

approach would both increase comparative-effectiveness research and increase the likelihood that patients and providers would use it.”).

38. See *generally* DARCY OLSEN, THE RIGHT TO TRY: HOW THE FEDERAL GOVERNMENT PREVENTS AMERICANS FROM GETTING THE LIFESAVING TREATMENTS THEY NEED (2015) (arguing that the federal government denies sick patients life-saving treatments for their own protection).

39. TIMBUK3, *The Future's So Bright, I Gotta Wear Shades*, on GREETINGS FROM TIMBUK3 (I.R.S. Records 1986).

40. BACK TO THE FUTURE (Universal Pictures, 1985) (“I’m sure that in 1985, plutonium is available in every corner drugstore, but in 1955, it’s a little hard to come by.”).

happen to run into my past self, do me a favor and distract him. Otherwise, things could get ugly.⁴¹

41. BACK TO THE FUTURE: PART II (Universal Pictures, 1989) (Doc Brown: “The shock of coming face to face with oneself 30 years older . . . would create a time paradox, which would unravel the very fabric of the space-time continuum and destroy the entire universe. Granted, that’s a worst-case scenario. The destruction might in fact be very localized, limited to merely our own galaxy.” Marty McFly: “Oh, hey, well, that’s a relief.”).