



THE SESSIONS-CASSIDY HEALTH PLAN

By John C. Goodman

The remarkable, bicameral Sessions-Cassidy Health Plan (H.R. 5284/S. 2985) was introduced in Congress in late May 2016, by Representative Pete Sessions (R-TX), who, as Chairman of the Rules Committee, is thought to be the second most powerful member of the House of Representatives, and by Senator Bill Cassidy, M.D. (R-LA), who probably knows more about healthcare policy than anyone else in the Senate.

These two gentlemen call their proposal, “The World’s Greatest Healthcare Plan.”¹ Given what they are attempting to do, that appellation may not be unreasonably boastful. Of twelve bold ideas in the legislation, fully half have never appeared in any previous bill or in any previous proposal—Republican or Democrat—and the bill is based on my Independent Institute books, *A Better Choice: Healthcare Solutions for America*² and *Priceless: Curing the Healthcare Crisis*.³ Here are the goals of the bill:

- Based on a thorough review of the major ways in which federal policies create perverse incentives, the legislation corrects those perversions and removes the federal government as a source of some of our most important health policy problems.
- Along the way, the bill makes good on what many regard as the three broken promises of the Affordable Care Act: universal coverage, cost control, and real protection for people with pre-existing conditions.

- At the same time, it paves the way for a medical marketplace in which empowered patients can make more of their own choices, while enjoying protection against the cost of catastrophic illness—both the financial cost and the cost of rationing by waiting.⁴

PRINCIPLES FOR REPLACING OBAMACARE

The Sessions-Cassidy Health Plan embodies principles I have long championed as necessary for sensible, comprehensive healthcare reform:

- **Choice:** People should be able to choose a health insurance plan that meets their needs, not the government’s needs.
- **Fairness:** All families should get the same help from government when they obtain health insurance, regardless of income. (The legislation allows for different levels of government help only by age and geography.)
- **Lower Cost:** People should have access to affordable coverage that protects their income and assets in case of catastrophic medical events.
- **Higher Incomes:** Employees should be able to pocket dollar-for-dollar any savings realized through the reduction of health-insurance costs achieved through waste reduction.

- **Portability:** Employers should be allowed to purchase insurance for their employees that is individually owned and that travels with them, from job to job and in and out of the labor market.
 - **No Surprises:** Insurers should be required to make their networks of doctors and hospitals visible at all times and to alert potential enrollees about any restrictions on access to expensive drugs and procedures.
 - **Patient Power:** If patients are willing to take a greater role in managing their own care, they should be able to manage the money that pays for that care in tax-free accounts.
 - **Real Insurance for Pre-existing Conditions:** Insurance should not just pay for the cost of becoming ill, it should also pay the higher premium required if patients switch health plans.
 - **Protection for the Most Vulnerable:** A portion of unclaimed tax relief should be made available to local safety-net institutions when they serve uninsured people who cannot pay their own medical bills.
 - **Protection for the Doctor-Patient Relationship:** Doctors should be allowed to offer patient care (including telephone and email consultations) for a monthly fee without the threat of being regulated as insurance companies, and patients should be allowed to pay these fees without being penalized under the tax law.
- insurance premiums and deposits to Health Savings Accounts
- Let employees earn higher wages by eliminating waste in their health plans
1. **A Universal Health Tax Credit:** Modeled after the child tax credit,⁷ this tax credit varies by age and geography but not by income, and will average \$2,500 per adult and \$1,500 per child in 2017—an amount that should give almost everybody access to a private plan similar to a well-managed Medicaid plan.⁸ It applies to spending on health-insurance premiums and deposits to Health Savings Accounts. It is advanceable, refundable, and assignable, and can be easily administered by tax preparers, insurance brokers, employers, and others.
 2. **Limited-Benefit Insurance:** Individuals may receive a portion of the tax credit when they choose a plan that includes a limited level of protection of income and assets⁹ and is more suitable for low-income family budgets.
 3. **Health-Status Insurance:** For the first time, people with pre-existing conditions will have real protection against discrimination and against the “race to the bottom,”¹⁰ reflected in narrow provider networks and high drug costs for the chronically ill. Risk adjustment between health plans (similar to Medicare Advantage) will ensure that each plan receives an actuarially fair premium when it takes an enrollee from a different insurer. (Plans will not have incentives to cater only to healthy people or to avoid the sick.) Plans are free to voluntarily seek better risk adjustments, so eventually the free market will adjust prices according to risk.¹¹ We expect plans to eventually specialize, with some plans focusing on cancer treatment, others on heart care, and so on.

SUMMARY

In short, the Sessions-Cassidy Health Plan features twelve reforms⁵ that would achieve the following goals:⁶

- Abolish the Obamacare mandates
- Repeal the anti-job provisions of Obamacare
- Repeal thousands of pages of Obamacare-related regulations
- Deregulate and denationalize the health-insurance marketplace in every state
- Offer all Americans a universal tax credit (similar to the child tax credit) for health-

4. **Roth Health Savings Accounts:** They are flexible, they can wrap around any third-party insurance plan, and they are an alternative to use-it-or-lose-it insurance coverage. Above the amount of the tax credit, premium payments and HSA deposits will be made with after-tax

dollars. In this way, individual self-insurance and third-party insurance will compete on a level playing field.¹² Individuals will be able to save for future health care and have an active role in managing the money that pays for their care.

5. **A Workable Safety Net:** A portion of unclaimed tax credits (for people who remain uninsured) will be sent to safety-net institutions in communities where the uninsured live. This local transfer payment supplements the disproportionate-share money that providers receive under the current system. For the first time, federal tax relief for private health insurance and federal support for safety-net care¹³ will be completely integrated. Money follows people.
6. **Transparency:** Insurers will make their provider networks known in real time and online. Bait-and-switch tactics (advertising a broad network and then narrowing it after enrollment) will not be allowed. Plans that impose high costs on enrollees for specialty drugs must disclose the fees in a very visible way prior to enrollment. Providers who accept package cash payments must publicly disclose the price.
7. **Tax Fairness at Work:** For the first time, the federal government will give everyone the same tax relief for health insurance,¹⁴ regardless of where it is obtained—at work, in the marketplace, or in an exchange. Employees will not be able to double dip, however. Other tax relief, such as allowing an employer to purchase insurance with pre-tax dollars, will be clawed back or topped up to the tax-credit amount.
8. **Portability.** Federal laws that prevent employers from providing their employees with portable insurance that travels with the employee from job to job¹⁵ and in and out of the labor market will be repealed.
9. **Liberating Medicaid.** Medicaid will be block-granted to the states for each of four Medicaid populations. Over time, the per capita amount from the federal government for each of the populations will be equalized nationwide. (See Cassidy.^{16, 17}) Medicaid enrollees will have

the option of leaving Medicaid, claiming the tax credit, and purchasing private insurance.

10. **Liberating the Doctor-Patient Relationship:** Doctors will be able to form “direct pay” or “concierge” relationships with their patients (including phone and email consultations) without fear of being regulated as insurance companies. Patients will be able to pay for these services from their HSA.
11. **Liberating the Local Practice of Medicine:** The federal Centers for Medicare & Medicaid Services will be authorized to lift national restrictions on doctor-owned hospitals, clinics, and other facilities; state and local restrictions on walk-in clinics, free-standing surgical centers, and other market-based services; and state restrictions that in other ways prohibit the delivery of high-quality health care.
12. **Grandfathering.** To minimize potential disruption, self-insured employer plans and labor union plans may elect to remain in the current tax system.¹⁸ Individuals with insurance obtained from an (Obamacare) exchange may elect to remain in that system.

25 OBAMACARE PROBLEMS THAT THE SESSIONS/CASSIDY HEALTH PLAN SOLVES BY STREAMLINING AND MINIMIZING THE ROLE OF GOVERNMENT¹⁹

1. **People are being forced to buy the wrong kind of insurance.**

Young, healthy, low-income families are forced to buy insurance they consider almost worthless—plans with a \$6,850 deductible (\$13,700 for a family) that cover procedures they are unlikely to ever need. About 7.5 million people paid an average fine of \$200 in 2014,²⁰ because they considered the coverage they were offered not worth the premiums charged—even with government subsidies.

The Solution: The individual mandate goes away. People may choose insurance based upon individual and family needs, not the gov-

ernment's needs. With a credit of \$8,000, for example, a family of four is free to buy whatever coverage the market can offer for that amount—with no additional cost. There is no reason for anyone to be uninsured.

2. People are being forced out of plans they want to keep.

An estimated 4.7 million people²¹ received notices in 2013 cancelling policies many of them would have preferred to keep, and that process is continuing. When consumers shop for new plans, many find the premiums are 50 percent or even 100 percent higher for similar coverage.

The Solution: We cannot undo all the damage that has been done. But going forward, insurers will not be allowed to end some plans in order to push their enrollees into more expensive plans. (All insurance should be guaranteed renewable.) Moreover, insurers will not gain by unloading high-cost patients onto other plans. (See the discussion of health-status risk adjustment below.) Also, states will be allowed to set up risk pools and reinsurance arrangements designed to keep the premiums low for healthy enrollees.

3. Premiums and deductibles are rising faster than wages.

The Affordable Care Act is designed to force people to buy a product whose costs will almost certainly grow faster than the average family's income—meaning that families will have less and less available to meet other needs. Nationwide, premiums have been growing at about 4 percent per year, while wages have been stagnating. Since Obamacare became law, deductibles have grown seven times as fast as wages.²² In the future, insurance affordability will get worse because the government's commitment is capped, whereas the burden of the health insurance mandates is free to grow without limits.²³

The Solution: Obamacare takes a defined-benefit approach. It tells people what benefit they must have and leaves them on their own to worry about how to pay for it. The Sessions-Cassidy Health Plan is a defined-contribution

approach. It fixes the government's commitment and leaves buyers and sellers free to see what the market can provide for that contribution.

4. Low-income employees are being forced to obtain insurance neither they nor their employers can afford.

Insurance plans with no annual or lifetime limits are good for hospitals—especially if a low-income employee has a \$1 million premature baby. But for a plan with out-of-pocket exposure of \$13,700, a family will be effectively uninsured for almost all of its likely medical needs.

The Solution: Limited Benefit Insurance would allow low-income families to protect their income and assets with plans that cover, for example, 90 percent or 95 percent of all expected medical costs. Hospitals will still need to find ways to pay for rare and expensive cases. But the solution is not to solve the hospital's problem by forcing families to buy insurance that is inappropriate for their medical and financial needs.

5. Employers are being penalized for offering full-time employment.

Employers can avoid the costs of Obamacare by using part-time labor, temporary labor, and independent contractors and by outsourcing in other ways. There is anecdotal evidence of this in nearly every state.²⁴

The Solution: All the anti-job provisions of Obamacare will be eliminated, including the employer mandates.

6. People at the same income level can receive radically different subsidies.

A \$15-an-hour worker (and his family) with coverage from the insurance exchange can get a \$10,000 subsidy. However, a worker earning the same income but who obtains coverage through his employer, say a hotel or fast food restaurant, gets a tax subsidy of about \$1,800.

The Solution: Everyone will receive the same, universal tax credit, regardless of where they obtain their insurance—at work, in the marketplace, or in an exchange.

7. Millions of low-income families, trapped in an Obamacare coverage gap, are ineligible for subsidized care and vulnerable to fines.

Between 2.9 million²⁵ and 6.4 million²⁶ low-income people fall into the “Obamacare coverage gap.” They are neither eligible for Medicaid nor a subsidy in the exchange.

The Solution: Everyone will be offered the same universal tax credit—regardless of income and regardless of eligibility for Medicaid.

8. Employers are ending their previous plans and offering employees insurance they cannot afford.

One way employers can escape the cost of Obamacare is by offering employees a Bronze plan with a \$6,600 deductible and charging the employee a premium equal to more than 10 percent of take-home pay. The employee is asked to pay the full premium for dependent coverage. Almost all low-income workers are turning these offers down. If they do, they cannot get a subsidy in the exchange and they are subject to a fine if they do not pay full price for insurance on their own.

The Solution: With no employer mandate, this perverse incentive goes away. Since the tax credits are refundable (you get it even if you owe no taxes), advanceable (you don’t have to wait until next April 15th to get it), and transferable (to an employer or insurance company), employers will have every incentive to help employees get the insurance they want and need.

9. Since most people with below-average wages get a better deal from government in Medicaid or in an exchange and most people with above-average wages get a better deal obtaining insurance at work, entire industries are re-organizing their structure.

Increasingly, the janitors, bus drivers, food service workers, security guards, and other lower-paid workers who staff corporate campuses are no longer employed by the corporations they service.²⁷ Instead they are employees of contracting firms. This allows two different approaches to health insurance—one for higher-paid

employees and a different one for the lower-paid. Some of these changes might have occurred anyway. But health insurance costs now account for such a large percentage of compensation that much of the trend must result from the lack of uniformity in Obamacare subsidies.

The Solution: With a uniform subsidy, employers will be free to make production decisions based on economic factors, not based on health insurance subsidies. As a result, American companies will be better positioned to compete in a global marketplace and employees will have a better chance of obtaining the insurance they want and need.

10. Individuals are penalized for failing to do the impossible: guess their next year’s income.

H&R Block estimated that 3.4 million people faced higher taxes in 2015 because they underestimated their income when they enrolled in an Obamacare plan in 2014 or 2013.²⁸ On the average, about 60 percent of those receiving a health insurance tax credit in 2015 were required to repay some of it. The average repayment was \$580.²⁹

The Solution: Since the universal tax credit is independent of income, people get the same tax relief regardless of what they earn.

11. There is a race to the bottom in the exchanges, producing narrow provider networks that exclude the best doctors and hospitals.

The health plans have concluded that healthy people buy on price and only sick people favor the purchase of plans with wide networks. And the health plans in the exchanges are clearly trying to attract the healthy and avoid the sick. By offering low provider fees (that drive away the best doctors and the best facilities) they can keep their premiums as low as possible. The chronically ill who join these plans may have extreme difficulty getting needed care. But the health plans didn’t want those enrollees in the first place.

The Solution: With health status risk adjustment, individuals are protected against

higher premiums after they get sick. When they switch plans, the new plan receives an actuarially fair premium from the previous plan—making the sick just as attractive as the healthy, in a manner similar to the Medicare Advantage program.

12. Some health plans in the exchanges are engaged in bait and switch—promising networks and coverage that they subsequently renege on.

Doctors who were promised as part of the provider network turn out not to be in the network at all. Coverage for expensive, life-saving drugs turns out to require extraordinarily high, special deductibles.

The Solution: Health plans will be required to be completely transparent—making their networks visible online at all times. Charges for specialty drugs must be transparent and not hidden at the point of enrollment. Providers who accept package-cash payments for procedures must post those prices.

13. On the buyer side, people are gaming the system by waiting to insure until they get sick.

In Massachusetts they are called jumpers and dumpers. People wait until they get sick. Then they jump in and obtain insurance, get health care, and get their bills paid. They dump the plan when they are healthy again. If everyone does this, only sick people will be insured and the cost of the insurance will be so high, almost no one will be able to afford it. Obamacare tries to discourage this by levying fines on the uninsured and limiting the enrollment period to a few months each year. However, the fines are small, weakly enforced, and contain numerous loopholes. And there are numerous exceptions that allow people to buy insurance year round. A March 2016 news report, for example, found that diabetes had become nearly twice as common among the newly enrolled as among those previously enrolled. Hepatitis C was more than twice as common, and H.I.V. was more than three times as common. The result: more trips

to the doctor, more hospitalizations, higher overall costs and therefore higher premiums.³⁰

The Solution: As is the practice in Medicare Parts B and D and in the Medigap market, no one will be allowed to game the system as a buyer. Those who do not enroll when they are first eligible will face financial penalties in the form of higher premiums.

14. The Obamacare subsidies penalize people who work more and earn more.

The implicit marginal tax created by the Obamacare subsidies is about 10 percentage points. At several cliff points along the income continuum, families can lose \$10,000 or more in subsidies by earning an additional dollar of income. These perverse incentives are expected to reduce the labor force by the equivalent of 2.3 million workers.³¹ Over all, Obamacare's anti-work provisions will create a long-term loss to the U.S. economy on the order of 5 percent of GDP—or more than \$800 billion a year at current prices.³²

The Solution: Because the universal tax credit is independent of income, no one is penalized for working more and earning more, and because mandates are abolished, no employer is penalized for hiring additional employees and employing current employees for more hours.

15. The Obama administration has virtually outlawed portable health insurance.

Many employers have been reimbursing their employees for the cost of insurance they buy on their own. This employee-owned insurance is portable, traveling with the individual from job to job and in and out of the labor market. Now that insurers can no longer discriminate based on pre-existing conditions, there is no reason not to encourage this practice. Yet the Obama administration threatened to fine employers who do this, by \$100 per employee per day. Over the course of a year that adds up to \$36,500 per employee, up to \$500,000 in total.

The Solution: All provisions of the federal law that prevent employers from paying for insurance that is personal and portable will be eliminated.

16. Obamacare has no mechanism for ensuring that we can continue to meet the needs of the uninsured.

Advocates of the 2010 health reforms assumed that once more people were insured, safety-net hospitals would have a new source of revenue. However, once people have insurance they don't go to safety-net hospitals, where waiting times may be interminably long. Moreover, Medicaid patients, whose plan pays rock-bottom fees, often rely on emergency rooms for non-emergency care. So the safety-net institutions are facing a bigger work load and less money to meet that load.

The Solution: A portion of unclaimed tax credits will be returned to communities where the uninsured live. Money follows people. If the number of uninsured rises, safety-net hospitals get more funds. If the number falls, the subsidies shift to support private health insurance.

17. New restrictions limit the use of Health Savings Accounts and create perverse incentives to engage in wasteful health care spending.

The Affordable Care Act lowers the allowed deductible, keeps the rigid across-the-board deductible requirement, and raises the penalty for non-health spending. The first two features make it virtually impossible to combine HSAs with chronic care, as, for example, Medicaid's Cash and Counseling program works for the disabled. As for the third feature, consider a person in the 30 percent income-tax bracket. If she withdraws HSA funds for non-health purposes, she faces a 20 percent penalty on top of her regular tax liability. That means she must choose between spending a dollar on health care and 50 cents on other goods and services. Health care will be preferable even if the services are worth only 51 cents to her.

The Solution: With a Roth HSA, withdrawals will be tax-free and penalty-free one year after the funds have been deposited. That means health and non-health goods and services will trade on a level playing field. People won't spend a dollar on health care unless they view

that this is worth a dollar. Also, Roth HSAs will be completely flexible—wrapping around any third-party health insurance plan.

18. About 80 percent of people with an Obamacare plan are ineligible to have a Health Savings Account.

Despite deductibles and out-of-pocket costs that can exceed \$6,000, most plans sold in the exchanges are incompatible with the requirements for an HSA.³³ The reason: the extreme rigidity of the current law, which prevents insurers from, for example, paying for the costs of specialty drugs or specialist services below the deductible for patients with chronic illnesses.

The Solution: People will be able to combine any third-party insurance plan with a Roth HSA, which conveniently wraps around it without any deductible requirements.

19. Obamacare is undermining the role of the broker.

Traditionally, the way most individuals and small businesses have accessed health insurance is through an insurance broker, who assumes the role that HR departments play in large companies. They answer questions, resolve disputes, and help untrained individuals navigate the complicated world of health insurance. Yet a number of insurers have announced they will no longer pay commissions outside of open season, and some are even refusing to pay them during open season.³⁴ One problem: the Obama individual mandate has so many exceptions that buyers can obtain coverage through the exchange almost any time of year, and insurers have discovered that off-season enrollees are disproportionately sick. A second problem: it is illegal for brokers to seek out and solicit clients with chronic ailments, such as diabetes—for which the current risk-adjustment formula is actually quite generous. Rather than tailored service, brokers basically must treat everyone who walks in their door the same.

The Solution: (1) As noted above, no one will be allowed to game the system. (2) With

health status risk adjustment, there is no need for an open season; enrollees may continuously switch health plans at any time during the year. (3) Insurers—along with their brokers—will be encouraged to specialize in the treatment of chronic diseases and seek out enrollees who could benefit from their services.

20. Obamacare’s Cadillac Plan tax is inefficient and unfair.

For employees in the 40 percent tax bracket, taxing employer-provided health insurance above a certain level can put extra health insurance and extra wages on a level playing field. That may make some sense for high-income earners. But for someone in the 15 percent tax bracket, the 40 percent Cadillac Plan tax means that health insurance is being taxed at almost three times the tax rate on their wages. That’s unfair and it makes no sense. Moreover, the Cadillac tax is inefficient: it affects only decisions above a very high spending threshold. For all the spending below the threshold, the perverse incentive to overspend on health insurance is as perverse as ever.

The Solution: The fixed-sum tax credit subsidizes the first dollars, not the last dollars of health insurance. It pays for the insurance we want everyone to have, leaving people free to purchase additional coverage with after-tax dollars. For the same amount of tax relief, this tax credit will have ten times more impact on workplace incentives than the Obamacare approach.

21. The exchanges still aren’t working, including the federal exchange, and the administrative cost of Obamacare is absurdly high.

They probably never will work as long as the computer programs of different agencies are required to talk to each other. The Department of Defense and the Department of Veterans Affairs spent ten years and more than one billion dollars trying to get their computer systems to connect. They never did make it work. Actuaries with the Centers for Medicare & Medicaid Services project that Obamacare

will result in an additional \$274 billion in administrative costs alone over the period of 2014 through 2022.³⁵ That’s equal to almost \$14,000 per newly insured person. And remember, the Affordable Care Act was created by people who claimed that private-sector administrative costs are too high!

The Solution: The main problem is income verification. With a uniform tax credit, there is no need to verify income. Everyone gets the same credit, regardless. We could turn the administration of the exchanges over to a private firm like EHealth, which could easily enroll people with off the shelf technology.

22. Millions of families have no continuity of insurance coverage and no continuity of care.

Some families, those with household incomes between 100 percent and 200 percent of the federal poverty level, typically become eligible and ineligible for Medicaid many times over the course of several years. About 29 million people will shift eligibility between Medicaid and subsidized exchange insurance in a single year.³⁶ Only one in five adults on Medicaid remain continuously eligible over a period of four years.³⁷ The high rate of churning is not just administratively inconvenient. It is expensive. Lack of continuity of care also affects health.³⁸

The Solution: Families would be able to leave Medicaid, claim the tax credit, and enroll in private insurance instead. They could remain there, regardless of how their income changes. Also, two-thirds of Medicaid enrollees nationwide are currently in private-sector plans that contract with state Medicaid programs. These plans would be able to offer the same plan in the individual market (say, for low-income families) so that people could remain in the same plan as their income (and therefore their eligibility for Medicaid) rises and falls.

23. Patients on Medicaid often face non-price barriers to care that are far more costly than the fees doctors charge non-Medicaid patients.

In one case, a one-way, seven-mile trip took five-and-a-half hours, in order for a woman to obtain a blood pressure cuff. Then she had to get back home.³⁹ Also, because we do not allow Medicaid patients to pay for health care the way they purchase food with Food Stamps, they are effectively denied low-cost, high-quality, easily accessible care at almost all of the 2,000 walk-in clinics around the country. To add to the misery, one-third of doctors nationwide are not accepting new Medicaid patients and the fraction is even higher in urban areas. These constraints may be some of the reasons why 8.2 million uninsured people who qualify for Medicaid or S-CHIP coverage have not enrolled.⁴⁰

The Solution: We will create something the political left has been clamoring for over the past six years—a public-sector option. Medicaid will need to compete with private insurance in every state. Enrollees will be allowed to take the state’s share of Medicaid insurance, claim the federal private-insurance tax credit, and obtain insurance that looks very much like some of our best Medicaid, managed-care programs in return for premiums that will average only a few dollars a month.⁴¹

24. Current law discriminates against concierge medicine.

One of the most innovative alternatives to fee-for-service medicine is the concierge (or “direct payment”) doctor, who typically provides a bundle of services (including phone, email, and other telemedical services) in return for a fixed monthly fee. These doctors are now harassed by state regulators who threaten to treat them as “insurance companies” and by federal laws that bar patients from using HSA funds to pay doctors’ fees.

The Solution: The Sessions-Cassidy Health Plan explicitly states that concierge doctors are not “insurers” under both federal and state law. Further, people will be able to use their HSA funds (both traditional and Roth accounts) to pay concierge doctor fees.

25. Obamacare imposes new restrictions on providers and keeps in place a great many existing unwise regulations.

Studies show that doctor-owned hospitals provide care that is of lower cost and higher quality than traditional hospital care. Yet the Affordable Care Act has imposed a moratorium on such services. Health City in Grand Cayman, for example, maintains very high-quality benchmarks and offers patients package prices that average about one-third of what they would pay at a typical mainland hospital. Yet, it is illegal for Health City to operate in the United States because it is doctor-owned.⁴² The Affordable Care Act also makes no attempt to free providers from other onerous government restrictions.

The Solution: The Secretary of Health and Human Services will be able to free providers from unreasonable restrictions wherever doing so would clearly reduce costs, improve quality, and increase access to care.

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