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An Alternative to Obamacare

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Introduction

The Patient Protection and Affordable Care Act (PPACA), commonly known as Obamacare, consolidates and centralizes power and money in the federal government to a degree without precedent in modern American history. The legislation's four cornerstones are its expensive exchange subsidies, large Medicaid expansion, panoramic and burdensome federal regulation of the health-care sector, and coercive individual mandate.

Obamacare's exchange subsidies, which the Congressional Budget Office (CBO) [projected](#) would cost \$464 billion over ten years when the legislation passed the House in March of 2010, are now [projected](#) by the CBO to cost \$849 billion over a decade. Moreover, this increased expense isn't arising from increased coverage. The CBO originally [predicted](#) that 21 million individuals would have exchange-based coverage as of 2016, and it [reiterated](#) that prediction five years later. But the Obama administration recently [announced](#) that it "expects" just 10 million people to be covered through the exchanges as of the end of 2016—less than *half* the promised reach.

Most middle-class Americans are shut out of the taxpayer-funded subsidies that help individuals buy increasingly expensive PPACA-compliant insurance through government-run exchanges. While Obamacare's subsidy formula is of byzantine complexity, the Kaiser health calculator [shows](#) that a typical 36-year-old (or younger) single woman making \$36,000 a year or more doesn't get a dime in exchange subsidies—she's too young and too middle class. Nor does the typical single man of that age and income receive anything. Obamacare's subsidies are geared instead to the near-poor and near-elderly, at others' expense.

Obamacare's Medicaid expansion, which the CBO [projected](#) in 2010 would cost \$434 billion over ten years, is now [projected](#) by the CBO to cost \$847 billion over ten years—despite the fact that many states have elected not to participate in it. (Overall, the CBO now [projects](#) that the 10-year gross cost of Obamacare's insurance coverage provisions will be \$1.707 trillion, [compared](#) with \$938 billion when the bill passed the House.) President Obama seldom talks about this part of his signature legislation, yet the CBO [says](#) that roughly 60 percent of Obamacare's coverage expansion results from a larger population of Medicaid beneficiaries; only about 40 percent of expanded coverage has come from increased private-insurance enrollment—a trend the CBO projects will continue going forward.

Obamacare's regulations, the third cornerstone, generally have one thing in common: They sharply curtail the freedom of private citizens to make individual decisions and enter into contracts of their own choosing. The president and his congressional allies promised Americans that if they liked their insurance, they could keep their insurance—and if they liked their doctor, they could keep their doctor. Yet Obamacare banned millions of Americans' insurance plans as noncompliant. The insurance sold through the PPACA exchanges is heavily regulated in almost every respect *except* where doctor networks are concerned. Predictably, then, insurers have

narrowed their doctor networks—the only means they have left to keep costs down, and millions of Americans have lost access to the doctors they’ve come to know and trust.

Beyond this, Obamacare upends the core principle of insurance itself, dating back at least to the Renaissance: namely, that one buys protection *before* experiencing whatever’s being protected *against*. The PPACA requires that insurers accept all comers, no matter how sick or injured, at no additional cost, thereby driving up costs for everyone else. Obamacare imposes particularly harsh costs on younger people, establishing a much higher floor on their premiums—no lower than one-third the charge for older customers—even though younger people are generally much healthier and consequently account for a much smaller percentage of medical expenditures than the PPACA allows insurers to reflect. Obamacare also—unfairly—drives up insurance costs for Americans who don’t have children, as childless individuals and families are prohibited from purchasing plans that don’t include coverage for services they do not need, like pediatric dental care. And this is hardly a solitary example; Obamacare is riddled with similarly expensive—and unnecessary—coverage mandates.

In addition, Obamacare effectively bans the construction or expansion of doctor-owned hospitals. It is spurring massive consolidations in the hospital and insurance industries. And it is driving private-practice doctors toward big hospital conglomerates that can better handle Obamacare’s newly imposed regulatory burdens. Once there and working as hospital employees, rather than as independent physicians responsible only to their own patients and practices, these doctors can be more easily regulated and managed—a clear goal of the PPACA. In sum, Obamacare’s federally imposed, coast-to-coast (and therefore inescapable) regulations—many of them senseless—work to drive up costs, restrict choice, and generally undermine the quality of care.

The fourth and final cornerstone is **Obamacare’s individual mandate**, probably the least popular and most controversial element of the 2,400-page PPACA. Defended by its supporters as a valid exercise of congressional authority to regulate interstate commerce, the individual mandate was rejected as unconstitutional on those grounds by the Supreme Court, and was rescued only because five of the Court’s nine justices decided that the mandate could be reinterpreted as a constitutionally permissible “tax”—despite the fact that the president had all along insisted the mandate wasn’t a tax, and despite the fact that the legislative text declares it is an “individual responsibility requirement” paired with a “penalty” for noncompliance.

Whatever it’s called, the individual mandate is truly unprecedented. It marks the first time in American history that the federal government has required private citizens—simply as a condition of their living in the United States—to buy a particular product or service. Obamacare’s proponents generally concede that the legislation’s entire architecture would collapse were this cornerstone mandate to buy government-compliant insurance removed—which is exactly why the legislation should be *made* to collapse, through repeal and replacement with a far better alternative. American health care—something of such intimacy and importance to individual citizens, and so central to the national economy—simply cannot and must not be rooted, at bottom, in a system of coercion.

An Alternative

A well-conceived alternative to Obamacare would be able to make the following claim: health costs will drop, liberty will be restored, and any American who wants to buy health insurance will be able to do so.

Before Obamacare, Americans had three core concerns with our health-care system: the large number of uninsured; the plight of those who are uninsured and have expensive preexisting conditions; and the high cost of care. To a large extent, the solution to all three problems involves fixing what the federal government had already broken even before the PPACA was enacted. As such, real reform requires both repealing Obamacare and solving the problems that preceded it.

A well-conceived alternative should meet three basic criteria. First, it should be simple and explainable. Second, it shouldn't jeopardize employer-based insurance, or veer into crucial yet distinct—and often controversial—areas like Medicare reform. Third, and most importantly, it should meaningfully address Americans' trio of goals for real health-care reform: *lowering costs, dealing with preexisting conditions, and significantly increasing the number of people who are insured versus the pre-Obamacare status quo*. Indeed, an alternative that meaningfully addresses only two of these three core goals for real health-care reform would likely be toppled over like a two-legged stool.

Since Obamacare *compels* Americans to buy health insurance—whether they want to or not—an alternative need not necessarily be expected to match it entirely on coverage numbers. *This* alternative, however, would actually *surpass* it in terms of the number of Americans who would have private health insurance (as is discussed on pp. 8-9), as the freedom to buy something affordable would prove more powerful than the command to buy something that's not.

The following “three legged” proposal, which would repeal and replace Obamacare in full, borrows extensively from ideas advanced by a wide array of commentators and policymakers.

The First Leg: Ending Unfairness in the Tax Code Through Tax Credits to the Uninsured and Individually Insured

A core aspect of real health-care reform is solving the longstanding problem of too few people having health insurance. Fortunately, such a solution mostly involves fixing what the federal government had already broken pre-Obamacare. For decades, the federal government has driven Americans to employer-provided health insurance by giving it preferential treatment in the tax code. Why should millions of Americans who get insurance through their employer get a tax break, while millions who buy it on their own through the individual market do not? This is unfair, and it makes no sense.

What's more, this is a place where an alternative would prove particularly popular, because it would solve a problem that the PPACA—despite its extraordinary expense and recourse to government coercion—has failed to solve. For Obamacare fails to equalize the tax treatment of health insurance.

Obamacare provides large taxpayer-funded subsidies to older Americans at the expense of younger ones, and to the near-poor at the expense of the middle class. But it provides no subsidies or tax breaks in the individual market to most single people in their 20s or early 30s who make over \$35,000 a year; none to most single people under 40 who make over \$40,000 a year; and none to any married couples without children who make over \$65,000 a year. ([See](#) the Kaiser health calculator.) Such middle-class Americans continue to pay federal taxes on their income and then use a portion of what's left to buy health insurance, while millions of their fellow Americans get their health insurance provided with tax-free income, simply because they get it through their employer.

In a political vacuum, one might consider addressing this unfairness in the tax code by ending and replacing the tax break for employer-provided health insurance. But as James Capretta, Tom Miller, Ramesh Ponnuru, Yuval Levin, and others have noted, this would be politically foolish and would undermine efforts to repeal Obamacare and then replace it with real reform. Americans simply do not want—and will not accept—any further attacks on their existing insurance.

Rather than ending the employer-provided tax break, then, the sensible solution is to offer a corresponding tax break in the individual market, thereby roughly leveling the playing field. To avoid suffering a tremendous decline in the number of people who have insurance, such a tax break needs to take the form of a tax credit—which, unlike a tax deduction, would help Americans of all income-levels. (As early as 2009, then-Sen. Jim DeMint of South Carolina proposed such a tax-credit-based approach.)

This alternative would provide a simple, non-income-tested, refundable health-insurance tax credit of \$1,200 for those under 35 years of age, \$2,100 for those between 35 and 50 years of age, and \$3,000 for those 50 and over, in addition to \$900 per child. These tax credits would be made available to those who do not have access to health insurance through a large employer and who therefore purchase their own health insurance through the individual market.

The value of the tax credits would rise 3 percent per year. That is less than the historical rate of health-care inflation; however, the point of these tax credits is to revitalize an individual market that the federal government has broken, thereby lowering health costs. Besides, Congress can always raise such spending, but it is better to require an affirmative vote for such a change than to put such spending increases on excessively generous autopilot, as has too often been done in the past.

Every American citizen or family seeking insurance through the individual market would be able to use such a tax credit to help buy an insurance policy of their own choosing. There would be no Obamacare-style regulations forcing people to buy insurance that covers things like maternity care, pediatric dental care, or [the abortion drug ella](#), and no more forcing citizens into government-run exchanges. Importantly, the tax credits would go directly to individuals or families—in marked contrast with Obamacare's subsidies, which are generally paid directly to insurance companies. Such subsidies to insurance companies are not actually tax credits, as they do not lower people's taxes.

The vast majority of Americans shopping in the individual market would supplement the tax credit with their own expenditures. For them, the tax credit would be a source of savings—freeing them from the burden of paying for all of their insurance costs with after-tax dollars, while those with employer-based insurance have theirs paid for with pre-tax dollars. For example, for a family of four with parents in their early 30s, the tax credit would cover the first \$4,200 in premiums (\$1,200 x 2 + \$900 x 2), and they could, of course, supplement that with whatever amount they chose. Meanwhile, those who buy insurance that costs less than the amount of their tax credit would be allowed to keep the difference and put it into a health savings account (HSA), thereby encouraging them to shop for value.

Even those who didn't contribute a dime of their own money would still be able to use the tax credit to buy basic coverage providing protection against a potentially catastrophic illness. Indeed, tax credits of these amounts would make it possible for people in almost all of the 50 states to buy health insurance—based on [a report on individual-market insurance premiums](#) published by the Government Accountability Office. The exception would be those living in one of a handful of states where hyper-regulation has caused insurance prices to skyrocket.

That GAO report examined individual-market premiums in all 50 states for a 30-year-old single man, a 30-year-old single woman, a 40-year-old couple with two children, and a 55-year-old couple without children. Its analysis was based on 2013 health insurance premiums, and thereby took into account the cost spike that occurred after Obamacare's enactment, when (according to [the Kaiser Family Foundation](#))—premiums rose 9.5 percent across all markets combined in 2011—roughly twice the average annual premium increase recorded over the preceding five years.

The GAO report showed the following: Using the tax credits recommended in this proposal, healthy members of all four examined demographic groups could have purchased insurance through the individual market in any of the 50 states, either just by using the tax credit or else by supplementing it with no more than \$15 a month of their own money—except in Maine, Massachusetts, New Jersey, New York, or Rhode Island. (Some smokers would also have had to pay a bit more to cover premiums in Alaska, Washington, and Wyoming.) Even people in those five outlier states, however, would have been able to buy insurance using just the tax credits outlined in this proposal, as they would have been permitted to shop for affordable insurance across state lines (see Part 3: Lowering Health Costs).

Contrast this \$15-a-month-or-less cost with the costs now common under Obamacare. Under the PPACA, the typical person who makes \$35,000 a year is unable to purchase health insurance coverage for even \$150 a month—ten times as much. The affordability advantages of the proposal described in this paper are undeniable. For a typical American shopping in the individual market, Obamacare cannot compare.

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In all, a tax credit to buy health insurance through the individual market would offer myriad benefits. It would end the unfairness in the tax code, breathe new life into a moribund individual market, and greatly increase the number of people with insurance compared with the pre-PPACA status quo at just a fraction of Obamacare's cost. Moreover, because the tax credit envisioned here would not be so generous as to cover the cost of the most lavish prepaid health plans, that tax

credit would encourage the purchase of genuine *insurance* (primarily designed to protect against large, unforeseeable costs) while simultaneously freeing policy-holders to exercise greater control over day-to-day health-care expenditures. The result would be a system that applies significant *downward* pressure on health-care costs—in which individuals and families have the opportunity and incentive to shop for value, and providers have new reason to compete for value-conscious customers on the basis of price and quality.

Ending the unfairness in the tax code by offering a simple, non-income-tested, refundable tax credit for the purchase of insurance through the individual market is the core element of a well-conceived alternative. Indeed, this first leg is the most important of the three legs.

Question & Answer: Who would receive a tax credit to purchase health insurance?

In addition to those currently buying (or looking to buy) insurance through the individual market, the tax credit would be made available to those who currently get insurance through a relatively small employer. If they chose to do so, employees of such small businesses would be free to buy insurance in the individual market, rather than through their employer, and claim the individual-market tax credit. Those who work for larger employers that provide health insurance as a benefit would continue to receive that coverage just as before (and just as they did before Obamacare was passed), thus protecting employees who prefer their existing arrangements while also protecting employers from a selective exodus into the individual market by their healthier employees (which would lead to higher costs for those who remained behind). Those who were part of Obamacare's Medicaid expansion would instead get the tax credit to buy private insurance of their choice. And Medicaid-eligible individuals—based on pre-Obamacare eligibility rules—who might rather purchase private insurance, would be offered the option of taking the same tax credit in lieu of staying on Medicaid.

The only requirement would be that the tax credit be used to purchase real insurance—namely, insurance that is licensed and solvent and which abides by the rules of the state in question. No one would be auto-enrolled in any insurance plan. And the tax credit would be received only by those who purchase insurance, not by those who don't.

Q & A: Why offer a tax credit rather than a tax deduction?

Again, the three core goals for meaningful health-care reform are as follows: substantially increasing the number of people who are insured versus the pre-Obamacare status quo; solving the problem of prohibitively expensive preexisting conditions; and lowering health costs. A tax *deduction*—as opposed to a tax credit—cannot effectively meet the first of these three goals.

The vast majority of the benefits from an income-tax deduction would go to the top half of income-earners. A significant percentage of Americans currently pay no income taxes at all, so they would be unaffected by such a deduction; it would be useless to them. A tax deduction applied to payroll taxes as well *would* affect lower-income workers. But it would further constrict the nationwide tax base (which most economists agree is best kept broad) and still likely fail to achieve the desired effect on insurance coverage.

A specific example might help to illustrate the difficulty of relying on a tax deduction in this regard. Even a very large tax deduction of, say, \$10,000 for an individual, which applies to both income and payroll taxes—and which applies in full regardless of whether someone spends anywhere near that much on health insurance—would still net a tax break of only \$765 for someone who pays only payroll taxes (much less than Obamacare’s taxpayer-funded subsidies for the near-poor, which are slated to grow ever-larger over time). For millions of individuals in the upper half of the income stratum, however, the same tax deduction would provide a net federal tax break of more than \$3,250. So a tax deduction would be expensive, without doing much to increase insurance coverage numbers.

In order to achieve the basic goal of making affordable health insurance available to any American who wishes to purchase it, any successful alternative to Obamacare must be based on a refundable tax credit, not a deduction. Whatever understandable theoretical misgivings some might have about refundable tax credits in a vacuum, supporting them in this context is a small pill to swallow to bring about the crucial policy goal of repealing and replacing Obamacare.

Q & A: Why not means-test the tax credits?

Not income-testing the tax credits is much simpler, reduces the role of the I.R.S. (which would otherwise be involved in checking incomes to establish eligibility), avoids creating a disincentive to work, and lets every individual or family quickly calculate what they’d be getting. In direct contrast, Obamacare’s income-based subsidies are byzantine, empower the I.R.S., discourage work, and make it nearly impossible for individuals or families to calculate what, if anything, they (or, more exactly, their insurance company) will be getting. (Not income-testing the tax credits also avoids marriage penalties, whereas Obamacare’s income-based subsidies routinely penalize marriage.)

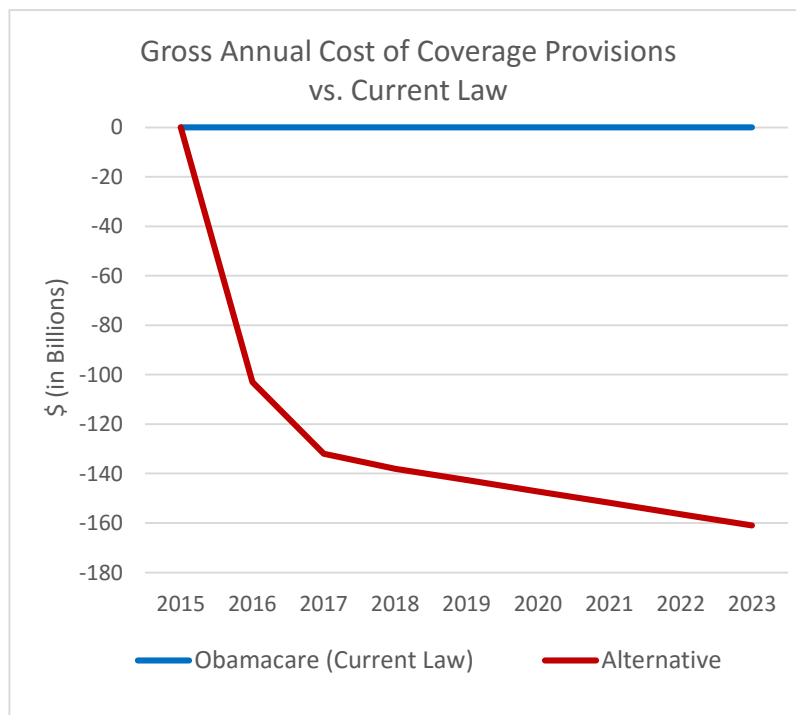
Moreover, the tax credits proposed herein will usually take the form of a tax cut. But when they don’t—because their recipients don’t pay as much money in income taxes as they will get through the tax credits—they will count as spending. Most of that spending—[more than two-thirds, in fact](#)—will be paid for by the top ten percent of income-earners. Not making the tax credit available to people at that income level would therefore be like having ten people order dinner together in a restaurant, having one of them agree to pick up two-thirds of the tab, and then telling that person that he or she can’t have any of the food.

The tax credits would already be quite progressive in their impact: the wealthier would cover most of their costs, while the less-wealthy would receive most of their benefits. Yet there is also a refreshing level of equality, fairness, and simplicity involved: each person would get the same tax credit, subject only to his or her age (a factor that directly relates to health costs). To make the tax credits available to all but, say, the top ten percent of income-earners would shift this alternative from being a program for all Americans to being something more akin to a welfare program for the middle class. To make them available only to, say, those making up to 200 or 300 percent of poverty would shift this alternative from being a program for all Americans to being a program that neglects most of the middle class, much like Obamacare does.

Additionally, and importantly, the goal here—apart from paving the way to full repeal—is to end the unfairness in the tax code. Wealthier Americans already get a tax break for employer-provided health insurance and will continue to get one. (Under this proposal, however, that tax break would no longer be open-ended and wouldn't offer ever-higher tax breaks for ever-pricier plans.) To deny wealthier Americans a tax break in the individual market, therefore, would artificially incentivize them to seek insurance through an employer. In many if not most cases, this would actually end up costing the federal treasury more money, as wealthier Americans' tax exemption for employer-based insurance would exceed the tax credit that they would have gotten for buying insurance on their own. Even apart from concerns about increasing the I.R.S.'s role, creating work-disincentives, and making it harder for people to see what their tax credit would be, excluding some Americans from the tax credits could well end up costing taxpayers more money.

Many advocates of limited government believe that Medicare should be means-tested, but these two positions (espousing means-testing for Medicare and opposing means-testing for these tax credits) are not inconsistent. There is an important difference between fixing a broken program that is bankrupting us and designing a new program. A new program designed by advocates of limited government should reflect limited-government principles. One of Obamacare's worst features is its preoccupation with income, which pits Americans against one another and empowers the federal government to redistribute money from young to old and from the middle class to the near-poor ([leaving behind a good portion in Washington, D.C.](#)). An Obamacare alternative shouldn't focus on income-redistribution but should instead embrace simplicity and treat all Americans equally.

Q & A: How much would this cost, and how would it affect the middle class?



The nonpartisan and politically neutral Center for Health and Economy (H&E), a group co-chaired by liberal Princeton health-policy expert Uwe Reinhardt and center-right former CBO director Douglas Holtz-Eakin, [scored](#) this plan (which I originally released as executive director of the 2017 Project). H&E's scoring found that, in relation to Obamacare, this alternative would save \$1.13 trillion from 2016 through 2023, while resulting in 6 million more people having private health insurance than under the PPACA. This alternative would also reduce premiums by between 4 and 25

percent (depending upon the category of plan) versus Obamacare, increase medical productivity by 10 percent, and increase provider access—"access to desired physicians and facilities"—by 57

percent. Obamacare, which compels people to buy health insurance whether they want to or not, would cover 6 million more people overall, but only because it would put an extra 12 million people on Medicaid. According to H&E’s scoring, 6 million more people would *freely* choose to buy insurance under this alternative than would buy the government-mandated insurance they are *required* to buy under Obamacare.

Even apart from considerations of liberty, health care, and fiscal responsibility, the vast majority of Americans would personally fare much better under this proposal than under Obamacare, as the following chart demonstrates:

Obamacare’s Subsidies vs. Alternative’s Tax Credits

	Single 25-year-old		Single 40-year-old		Single 60-year-old	
Income:	Obamacare Subsidy	Alternative’s Tax Credit	Obamacare Subsidy	Alternative’s Tax Credit	Obamacare Subsidy	Alternative’s Tax Credit
\$20,000	\$1,600	\$1,200	\$2,310	\$2,100	\$6,031	\$3,000
\$35,000	\$0	\$1,200	\$0	\$2,100	\$3,688	\$3,000
\$50,000	\$0	\$1,200	\$0	\$2,100	\$0	\$3,000
\$65,000	\$0	\$1,200	\$0	\$2,100	\$0	\$3,000
\$85,000	\$0	\$1,200	\$0	\$2,100	\$0	\$3,000
\$125,000	\$0	\$1,200	\$0	\$2,100	\$0	\$3,000
	25-yr.-old parents, 2 kids		40-yr.-old parents, 2 kids		60-year-old couple	
Income:	Obamacare Subsidy	Alternative’s Tax Credit	Obamacare Subsidy	Alternative’s Tax Credit	Obamacare Subsidy	Alternative’s Tax Credit
\$20,000	Medicaid*	\$4,200	Medicaid*	\$6,000	Medicaid*	\$6,000
\$35,000	\$7,155	\$4,200	\$8,575	\$6,000	\$11,571	\$6,000
\$50,000	\$5,155	\$4,200	\$6,576	\$6,000	\$9,287	\$6,000
\$65,000	\$2,802	\$4,200	\$4,223	\$6,000	\$0	\$6,000
\$85,000	\$369	\$4,200	\$1,789	\$6,000	\$0	\$6,000
\$125,000	\$0	\$4,200	\$0	\$6,000	\$0	\$6,000

*Or Medicaid/CHIP for the kids and nothing for the parents, depending upon the state.

Source: Kaiser Health Calculator, national average for 2015, as of June 5, 2015.

How, in light of this chart, can Obamacare possibly be so expensive? First, the outlays for its Medicaid expansion are huge, making up about 50 percent of the PPACA’s gross outlays over the next decade, [according to the CBO](#). Second, the taxpayer-funded subsidies for Obamacare’s exchange plans are projected to skyrocket in future years, partly in response to the premium spikes (an estimated 12 to 13 percent from 2015 to 2016, [according](#) to one PPACA supporter) that the health-care overhaul is causing. The CBO [projects](#) the cost of Obamacare’s taxpayer-funded premium and cost-sharing subsidies as \$28 billion in 2015, but says they will cost a whopping \$103 billion in 2025—nearly quadrupling over a decade. Third, Obamacare’s subsidies, not only for premiums but also for the out-of-pocket costs of care (copays, deductibles, etc.—95 percent of which are covered by taxpayers in some cases), are massive for those who make under about \$20,000 as well as for those who make under about \$30,000 and are over about 60 years of age—

as Obamacare redistributes huge amounts of wealth from younger to older Americans and from the middle class to the near-poor. Thus, its benefits are narrowly distributed, while its costs are widely felt.

Q & A: Is this Obamacare Lite?

No, not remotely—it's more like Obamacare's opposite. It would pave the way to full repeal, wipe the slate clean, and implement real health-care reform that would shift things in a limited-government, free-market direction from the pre-Obamacare status quo. It would revive an individual market that the federal government broke, provide a long-overdue tax cut for millions of Americans, and thwart efforts to move toward a "single payer" system for decades to come. It would save trillions of dollars in federal spending, preserve liberty, lower health costs, and improve the quality of care.

Obamacare Lite could come about in one of two ways. The first is if Obamacare's opponents pass an alternative that costs nearly as much as the PPACA, features income-based subsidies to insurance companies, and/or resorts to provisions like "auto-enroll," whereby the government enrolls citizens in plans they didn't pick, using direct subsidies to insurance companies to cover the costs. An alternative that meets this description would be a less full-bodied version of the PPACA—indeed, Obamacare Lite.

The second, perhaps more likely, way that Obamacare Lite could come about is if Obamacare's opponents fail to repeal and replace the PPACA. If they fail to unite around a compelling alternative, and if Obamacare therefore isn't repealed but is merely "tweaked," "improved," or "fixed" over time—with its basic architecture (based on 2,400 pages' worth of directives) remaining the same while portions of it are made somewhat less objectionable at the margins—Americans will be left not only with Obamacare Lite but with Obamacare Forever. More exactly, they will be left with this resulting "fixed" version of Obamacare until its blend of high costs and poor care causes it to give way to a government monopoly.

The only way to avoid Obamacare Lite (and likely worse to follow) is to repeal Obamacare, fix what the government had broken even before Obamacare was passed, and let the health-care market thrive—in other words, to give the American people the sort of simple, understandable, real reform they have long desired and asked for.

The Second Leg: Solving the Problem of Expensive Preexisting Conditions

Predictably, Obamacare's use of heavy-handed mandates to address the challenge of preexisting conditions has caused health insurance premiums to rise. In order to expand insurance coverage to those who are already sick, Obamacare bans insurers from basing the price of a policy on the health status of an applicant. In doing so, it encourages people to game the system by waiting until they get sick or injured before purchasing insurance, which is a lot like letting people buy homeowners' insurance after the fire trucks have already arrived on the scene. Fortunately, there

are ways to meet the same goal that don't send insurance costs soaring and don't uproot the very notion of what insurance is.

First, no one should be dropped from their existing health-insurance, or have their premiums or other costs increased, on the basis of a health condition. This protection would apply both to health conditions that developed after a policy took effect and to ones that were already in existence when a policy took effect and were not willfully hidden from the insurer. This protection would apply to all plans, including those purchased during the PPACA era.

Second, there should be a one-year buy-in-period for young adults who are looking to buy health insurance on their own for the first time, during which time they would be exempted from paying more or being treated differently by insurers due to preexisting conditions. This one-year buy-in-period would start on a person's 18th birthday. For those who remain covered under their parents' health insurance (perhaps because they are full-time students), this one-year grace-period would begin once they cease to be covered under their parents' insurance, or on their 25th birthday—whichever comes first. With this framework in place, no responsible young person would face higher health-insurance costs simply because he or she happens to suffer from a medical condition that was acquired as a child.

Third, parents should be granted a similar one-year buy-in-period for newborns, during which time they couldn't be denied insurance for their child, or be charged more, because the child was born with, or had quickly acquired, a preexisting condition. And once the child was insured, the parents couldn't be charged more for the child's condition going forward, either under that plan (per the first proposal in this section) or under a different plan at that same level of coverage (see the fifth proposal, below).

Fourth, the transition from employer-based insurance to the individual market should be made easier, in the following manner: Those who have maintained continuous employer-sponsored coverage (for a period of at least a year), but then lose access to that coverage, should be able to transition to a plan in the individual market—one of their own choosing—without paying higher premiums because of a preexisting condition. They should have a two-month grace-period between the time they leave a job (or otherwise lose access to an employer-provided plan) and the time they buy insurance through the individual market, during which time this protection would apply.

Fifth, as health policy experts such as James Capretta and Tom Miller have suggested, new regulations should protect Americans if they stay continuously insured and want to switch from one individual-market plan to another. Under these regulations, those who have remained continuously insured in the individual market (again, for at least a year) could switch to a different plan—either with their existing insurer or another—that provides *the same, or a lower, level of coverage* (with such classifications to be determined by the states), without paying more because of a preexisting condition that has developed since they first became insured under their current plan.

Sixth, \$7.5 billion a year (with a 3 percent annual increase following year-1) in federal funding should be allotted for state-run "high risk" pools, an insurance framework championed by Capretta, Miller, and others. Those with expensive preexisting conditions would be able to

purchase policies through such pools. Through these high-risk pools, a person could purchase a partially subsidized health-insurance policy, and his or her share of the premiums could not exceed some set percentage of income, or some set percentage (say, 150, 200, or 250 percent) of the average cost of a policy for a person without preexisting conditions in that same demographic group (based on age, sex, and geography)—with the exact percentage of income or cost to be set by each separate state. No one could be denied affordable coverage through such high-risk pooling, no matter how unhealthy he or she might be.

Importantly, this federal funding would be provided to each state as a defined contribution. Each state would get a set amount each year (to spend only on its intended purpose) based upon its population of American citizens. While some states would likely supplement this federal funding with funding of their own, states' outlays would not trigger any matching federal funds. As Medicaid and other examples have sufficiently demonstrated, the practice of matching states' contributions with federal money merely encourages states to be generous in spending money (as every dollar spent nets them more in federal revenues) and reluctant to stop spending money (as every dollar cut nets them only some portion of the savings).

In combination, these six provisions would ensure that no one in America would be denied affordable health insurance on the basis of a preexisting condition.

The Third Leg: Lowering Health Costs Across the Board

It is not difficult to lower health costs in relation to Obamacare, as Americans have long understood. Indeed, even before Congress passed Obamacare [the CBO projected](#) that, by 2016, the PPACA would cause the average health-insurance premium in the individual market to be 10 to 13 percent higher than it otherwise would have been.

To be sure, that's before factoring in Obamacare's expensive taxpayer-funded subsidies. However, the typical middle-class American would fare much better under the tax credits proposed in this alternative than under the Obamacare subsidies—as those subsidies aren't remotely geared toward the middle class (see the chart in Part 1)—even if the PPACA weren't driving up costs.

The key to lowering health costs is to inject new life into the individual market, which has long labored under a huge government-created disadvantage. The tax credits proposed herein would have the effect of taking the government's foot off the scale—more or less equalizing the tax treatment of individual and employer-based plans—and the individual market would flourish as a result. In addition, however, this proposal would liberalize rules regarding contributions to, and spending from, health savings accounts (HSAs).

To encourage the use of HSAs, and to help people cover the day-to-day costs of care, this alternative would offer a one-time tax credit of \$1,000 per person for anyone who opens an HSA for the first time in the individual market, as well as for anyone who has already opened an HSA in the individual market but has never claimed this tax credit. (The tax credit would continue to be offered in subsequent years, but no person could claim it more than once, and its value would

not increase over time.) The tax credit would be deposited directly into the HSA that the person has established, and the result would be that anyone in America who opens an HSA would effectively start with \$1,000 in it (or \$2,000 for a couple, or \$4,000 for a family of four). At relatively minimal cost (since it's a one-time tax credit, per person), this would incentivize the use of HSAs, which encourage people to take control of their own health-care dollars and allow them to spend those dollars tax-free. It would also help to rebut the inevitable criticism from Obamacare supporters that some people cannot afford to cover the out-of-pocket costs for their care. In these ways, such a one-time tax credit would complement the tax credit for purchasing health insurance on the open market.

This alternative would also lower costs by having Congress free up the interstate purchase of health insurance. There is no good reason why a couple in New Jersey, for example, should be prevented from purchasing a health insurance plan that originates in Texas and meets Texas's rules (rather than New Jersey's) regarding what things the policy must cover, any limitations on insurance pricing, and the like. As such, this alternative would replicate various proposals, by allowing people to shop for and purchase health insurance across state lines.

While encouraging Americans to maintain more control over their own health-care dollars and giving them more opportunity to shop for value, it is also important to move away from the open-ended subsidizing of health insurance that undermines such cost-consciousness. Thus, this proposal would cap the now-limitless tax exemption for employer-sponsored health insurance. To be clear, *the tax treatment of the typical employer-based plan wouldn't be affected one iota*. But in place of the open-ended exemption for employer-sponsored insurance, the maximum exemption would instead be \$8,000 per individual or \$20,000 per family (amounts that would subsequently increase 3 percent per year). If a family plan costs, say, \$22,000, then those with that plan would continue to get their full tax break on the first \$20,000; they simply wouldn't get a tax break on the last \$2,000.

Closing this tax loophole, which incentivizes people to spend more on health insurance than they would if it weren't tax-free, would not only help equalize the tax treatment of employer-sponsored and individual-market insurance—while providing revenue to help offset the new and overdue tax break in the individual market—but would also help lower health costs. In the example provided above, the family in question might decide to buy a plan that's \$2,000 less expensive and spend that extra \$2,000 on something else, and their slightly cheaper insurance plan—being a bit less like prepaid health care and bit more like genuine insurance that protects against unforeseen costs—would likely give them a bit more opportunity and incentive to shop for value. The more people are shopping for value (and not just having their expenses covered by a middleman), the more health costs will drop across the board.

This alternative would also let people reap the rewards if their lifestyles minimize their risk of needing costly care. Obamacare gives insurers little to no leeway to reward such healthy behavior and in fact generally bans them from doing so. But as Rep. Paul Ryan, Sen. Tom Coburn, Sen. Richard Burr, and Rep. Devin Nunes noted in their 2010 bill, the Patient's Choice Act, "five preventable chronic conditions consume 75 percent of our health spending and cause two-thirds of American deaths." The 2009 House Republican health-care bill would have allowed health insurers to vary the price of premiums by as much as 50 percent, contingent upon the policyholder's participation in a wellness program. This proposal would allow insurers to go even

further, by removing any barriers that keep insurers from encouraging healthier lifestyles and from pricing policies accordingly.

Yet another contributor to high health costs that Obamacare ignores is frivolous medical malpractice lawsuits. Doctors seeking to protect themselves from legal action often feel compelled to assign extra tests or treatments, which inconvenience patients and greatly increase premiums and out-of-pocket costs. To reduce such wasteful spending, states should implement creative policies that will cut back on the number of frivolous medical malpractice suits and expedite the resolution of credible suits.

The combination of these provisions would lower health costs substantially in relation to the pre-Obamacare status quo—and all the more in relation to Obamacare.

Conclusion

This “three legged” proposal is as intelligibly simple as Obamacare is unintelligibly complex. It represents the sort of real reform for which the American people have long been thirsting. The vast majority of Americans, and particularly younger Americans and the middle class, would personally come out far better under this proposal than under Obamacare, even before factoring in how much they would save in taxes—or gain in freedom.

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