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How to Replace Obamacare

Conservatives should articulate a vision for Patient Power.

Stephen Moore & Peter Ferrara from the July - Aug 2012 issue

A COMMON LIBERAL REFRAIN is that conservatives have no real health care agenda of their own— other than, of course, opposing Obamacare. For instance, in the midst of debate over the president's signature health "reform" bill, one progressive Florida congressman famously told the House that the GOP's plan was for sick Americans to "die quickly."

Baloney. Conservatives could probably stand to put more emphasis on the latter part of "repeal and replace," but the fact is that many free-market health care reforms enjoy broad consensus on the right.

The Supreme Court is expected to rule on the constitutionality of Obamacare in late June—after this magazine hits the press. But while the court's decision could be explosive politically, it will not change the need for conservatives to articulate a strong alternative to state-centered health care. The answer is patient power.

EXPLODING HEALTH CARE COSTS in America stem ultimately from what is known as the thirdparty payment problem—that is to say, the great majority of health costs are not paid by the patients themselves. There is almost always some third party, whether it be an insurance company, an HMO, or the government, footing the bills. Indeed, in 2008, 84 percent of health expenses were paid for by private health insurance or government programs such as Medicare, Medicaid, or CHIP.

Consequently, the consumer has no incentive to control costs. To put it in formal economic terms, the consumer has an incentive to spend until the marginal benefit of additional spending is zero. For instance, if a $1,000 procedure costs you nothing, it's worth doing—at least in economic terms—for just $1 Of benefit. In an efficient market, consumers spend until the marginal benefit is equal to the marginal cost. That $1,000 procedure should only really be worth it for $1,001 of benefit.

In more colloquial terms, the problem is that consumers have an incentive to spend on health care until it hurts, and they have no incentive to shop around. Even worse, doctors and specialists not only have no incentive to control costs, but they actually have a direct financial interest in spending more. Health care

providers have no incentive to compete on price, so they compete primarily on quality and secondarily on convenience.

That explains why the American health care system produces far and away the highest quality care in the world: The rewards go to he who creates the best new innovations and most effective new treatments. It also explains why new technology— which drives down costs in every other field—actually *increases* costs in medicine.

The only solution is to unite the decision over what health care services to purchase with the economic responsibility to pay for them, so costs can be weighed against benefits. And there are only two ways to do that: either the third-party payer (the government or insurance company) is given the power to decide what treatments the patient is allowed to consume, or the patient is given market incentives to consider the full costs of his health care.

Obamacare (and most foreign systems like Britain's National Health Service) effectively impose the first alternative. With 159 new bureaucracies, boards, agencies, commissions, and programs to govern American health care, plus the individual and employer mandates that require specific health insurance policies, Obamacare could be rightly Labeled "government-centered health care." The government takes primary responsibility for paying health expenses. The government takes primary responsibility for deciding what health care services its citizens are allowed to consume. The government, then, decides whether each individual's health care is worth the price. This is why the concept of the government "death panel" expresses a fundamental truth about Obamacare.

WHAT AMERICA NEEDS NOW is the opposite, a patient-centered alternative that maximizes consumer power, choice, and control over health care and its financing. The intellectual godfather of this approach is John Goodman, president of the National Center for Policy Analysis (NCPA) in Dallas and author of the 1991 book *Patient Power* published by the Cato Institute.

Central to this concept are Health Savings Accounts (HSAs), which were first proposed in 1981. HSAs include an insurance policy with a high annual deductible, in the range of $2,000 to $6,000 (the higher the better). Such high deductibles reduce the cost of the insurance so much that the savings would mostly cover the deductible in the first year. The HSA funds earn interest tax-free and roll over year after year. After one healthy year with few or no medical expenses, the patient has enough money in the account to cover all expenses below the deductible.

This transforms the incentives of third-party payment. For all but the most catastrophic health expenses, the patient is essentially using his own money. Whatever he doesn't spend he can keep for later health expenses or for retirement. The patient, then, will try to avoid unnecessary care and will look for the best prices for routine visits or services.

In turn, since patients are then concerned about controlling costs, doctors, hospitals, and other health providers compete not just to maximize quality, but also to lower prices, as in all normal markets. (This competition will become more intense and effective the more widespread HSAs become.) These incentives would flow all the way through to the developers of new technologies, who would compete to develop technologies that both improve quality and reduce costs.

Federal legislation providing for HSAs was adopted by the Republican congressional majorities in the 1990s and has improved over the years. These HSAs have been proven to cut the growth in health spending by as much as 50 percent. Participation in HSAs and similar high-deductible plans has soared in recent years and may now exceed HMO enrollment.

PATIENT POWER REFORMS replacing Obamacare would expand HSAs throughout the health care system. Workers should be allowed the freedom to choose them in place of employer-provided coverage, the poor to choose them for their Medicaid coverage, and seniors to choose them for Medicare.

These reforms should be complemented by the Consumer Choice Tax Credit, which would effectively level the playing field and give everyone the same tax relief enjoyed by employer-provided health plans. Anyone could use the refundable credit to help pay for insurance coverage. Paul Ryan proposed $2,300 for individuals and $5,700 for families.

Workers would then be free to choose the health insurance coverage they prefer, using the credit to help pay for it, rather than being stuck with the insurance chosen for them by their employers. Their policies would be their own property, and therefore would be completely portable, so the worker would not lose health coverage if he changes jobs or becomes unemployed. The credit could be financed on a revenueneutral basis by replacing the Obamacare tax credits for the purchase of health insurance.

Allowing consumers to buy health insurance across state lines would maximize consumer choice and competition, which would further reduce costs. Unnecessary regulations should be repealed. That includes the thousands of state special-interest benefit mandates, guaranteed issue and community rating, and rules that prevent new health providers from entering markets, such as requirements for a “certificate of need.” Tort reform, of course, would also reduce health costs.

PATIENT POWER CAN BE EXTENDED to provide a complete safety net, ensuring that no one will suffer lack of essential health care, for just a small fraction of the cost of Obamacare. Moreover, this can and should be accomplished with no individual mandate or employer mandate. Obamacare, by contrast, for all of its trillions in future taxes and spending, and both its individual and employer mandates, still leaves millions of Americans uninsured.

Conservatives should begin by giving Medicaid block grants back to the states, as we discussed in the June issue. Each state could then tailor its plan. Some might use the money to provide vouchers that the poor could use to purchase private health insurance, liberating them from the Medicaid ghetto.

A second step necessary to ensure a complete safety net is to allow each state to use part of its Medicaid block grant to set up a high-risk pool. Those among the uninsured who become too sick to purchase health insurance in the market, perhaps because they have contracted cancer or heart disease, for example, could receive guaranteed coverage through the high-risk pool. They would be charged a premium for this coverage based on their ability to pay. Federal and state funding would cover remaining costs. Such high-risk pools already exist in more than 30 states, and for the most part they work well at relatively low cost, because few people actually become truly uninsurable.

The law already provides that insurers cannot cut off existing policy holders or impose discriminatory rate increases because people become sick while covered. That would be like a fire insurer cutting off coverage for an already burning house. If this law needs to be modernized, it should be.

With these reforms, those who have insurance can keep it; those who can't afford it are given the necessary help to buy it; and those who still remain uninsured and then become too sick to buy it have a backup safety net in the high-risk pools. Everyone can be assured that they will get essential health care when they need it—no individual or employer mandate necessary.

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