NATIONAL REVIEW

Replace Obamacare, Stat

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The American people realize that Obamacare is a very bad policy. But more and more conservatives agree that we need to offer a solid alternative before voters reject Obamacare root and branch. Recently, three prominent Republican senators — Richard Burr (N.C.), Tom Coburn (Okla.), and Orrin Hatch (Utah) — unveiled an alternative proposal. In this article, I would like to outline my own.

The proposal I suggest would achieve four remarkable things: It would be more progressive than Obamacare, because it would involve more distribution from higher- to lower-income households. It would provide genuine protection for people who have a preexisting condition, as opposed to the bait-and-switch promises of Obamacare. It would provide genuine access to care for everyone, as opposed to leaving 30 million uninsured, as Obamacare does. And it would work in practice, primarily because it would confine the role of government to setting a few simple rules of the game, leaving individual choice and the marketplace to do the heavy lifting.

I call this reform a "consensus reform" because it draws not just on such right-of-center think tanks as the Heritage Foundation, the Cato Institute, and the American Enterprise Institute but also on such left-of-center think tanks as the Brookings Institution and the Urban Institute, and various scholars including President Obama's former and current economic advisers, Peter Orszag and Jason Furman. It takes the best ideas these folks have offered and combines them with an important principle: No plan designed by those at the top can ever work unless people at the bottom have an economic incentive to make it work.

Further, the ideas presented here are consistent with the health-care plan John McCain endorsed when he ran for president and with health-care-reform legislation introduced by Senator Tom Coburn, Representative Paul Ryan (Wis.), and other Republican members of Congress. So it could easily be adopted as the Republican alternative to Obamacare.

Here are the essential elements.

Choice. People should be able to choose a health-care plan that fits their individual and family needs, rather than a plan designed by bureaucrats in Washington. This means no mandate. Men shouldn't have to buy maternity coverage; women shouldn't have to buy coverage for prostate-cancer tests; teetotalers shouldn't have to buy substance-abuse insurance; etc. And no one should

have to buy coverage for preventive procedures that health researchers have known for years are not cost-effective.

It is commonly believed that, without a mandate, people will game the system — waiting until they get sick to enroll. But we have found a way to handle this problem in Medicare Part B, Medicare Part C, and Medigap insurance without any mandate. In all three cases, the insurance is guaranteed-issue (no one can be turned down) and community-rated (no one can be charged a higher premium because of a health condition). But people are not permitted to game the system. If you don't enroll when you are first eligible, you will be charged a penalty, and, in the Medigap market, you may be charged a premium that does reflect your health status.

Had we accepted the principle of choice in designing a health-care reform, we would not face the prospect of up to 10 million individual policyholders' losing insurance they were promised they could keep. We would also not face the prospect of millions of additional people's fearing the loss of their employer plans.

Fairness. Everyone at the same income level should get the same help from government when obtaining private insurance. Obamacare flagrantly violates this principle. For example, a family at 138 percent of the poverty line is able to enroll in Medicaid in about half the states and obtain insurance worth about $8,000. Since the coverage is completely free, that's an $8,000 gift. If they earn one dollar more, they will be entitled to enter a health-insurance exchange and obtain a private plan that costs, say, 50 percent more in return for an out-of-pocket premium of about $900. That's a gift of more than $11,000. But because the subsidies in the exchanges are not available in the workplace, the employees of a hotel earning pretty much the same wage will be forced to buy an expensive family plan, and they and their employer will get no new help from the government. After calculating the value of employers' ability to pay premiums with pre-tax dollars, let's call that a newly created $10,000 burden. This is only one of scores of ways in which Obamacare's treatment of people is arbitrary and unfair.

Fairness means that if government subsidizes health insurance though refundable tax credits, the credit should be the same for everyone at the same income level. Should those credits vary by income, age, geography, or other factors? There are good arguments for a variable credit. But there is a counterargument I find persuasive: simplicity. Suppose we offer every adult an annual tax credit worth $2,500 and every child a credit worth $1,500. People would get this subsidy so long as they obtained credible private health insurance, no matter where they obtained it — at work, in the marketplace, or in an exchange.

Think of how many problems we are currently having that would vanish.

Since a person's income would no longer be relevant, the exchanges would not have to link to the IRS, the Social Security Administration, and other federal agencies (which is the main technical reason the exchanges aren't working). It wouldn't matter whether you were offered "affordable coverage" at work. It wouldn't matter whether you were eligible for Medicaid. If you show up at the exchange and buy private insurance, you get the credit. Period.

With a uniform tax credit, 90 percent of the problems the Obamacare exchanges are now having would go away in a flash. Signing up for insurance would be easy. Insurance companies and brokers would be able to sign people up outside the exchanges without asking privacy-invading questions about their income and assets.

If a goal of health-care reform is to insure millions of uninsured people, enrollment has to be easy. The more complicated the process, the lower will be the success rate and the more likely that only the sick will persevere — causing the insurance pools to experience "death spirals," in which the premiums needed to cover medical costs increase until no one can afford to pay them.

Jobs. A uniform health-insurance tax credit combined with the absence of a mandate would also get rid of all the chaos Obamacare is creating in the labor market. Businesses would no longer have an incentive to stay small (avoiding the mandate by hiring fewer than 50 full-time employees). Nor would they have an incentive to shift employees to part-time work (avoiding the mandate with work weeks that are less than 30 hours). With a universal credit, they would no longer have an incentive to drop coverage for their active employees or end their post-retirement plans because of more generous subsidies available in an exchange. Health-care reform should be neutral with respect to the number of hours you work and the number of people you work with.

Further, with a tax-credit approach, employers and employees would no longer face perverse incentives to buy wasteful insurance. (Under the current system, the more costly the insurance, the greater the tax benefit.) Instead, they could buy insurance that meets their core needs and increase take-home pay with the savings, with no tax penalty. This would lower the cost of employment and encourage hiring.

Universality. Experts predict that, after all the havoc Obamacare will cause, most of the uninsured will still be uninsured. In fact, since millions of people are having their insurance canceled, we may end 2014 with more people uninsured than a year earlier. Along the way, Obamacare will reduce federal spending on the very safety-net institutions that deliver care to uninsured people. There's a better way.

There will always be some people who will turn down the offer of a tax credit. But instead of having the Treasury keep the value of those unclaimed credits, the money should be sent to safety-net institutions in the communities where the uninsured live. (The money needs to go to the places where they seek care, and the number varies from place to place.) Uninsured patients will probably be asked to pay their medical bills, but if they cannot, the safety-net institutions will have a source of cash to pay for "uncompensated care."

Under this idea, money follows people. The federal government promises a credit to every man, woman, and child in the country. If they all buy private insurance, the funds subsidize premiums. If they all decide to be uninsured, the funds go to safety-net institutions. This is a way of ensuring universal access to health care. (There will still be a wait for care through many of these institutions, just as there is a wait in Britain and Canada. But this proposal would provide just as much access to care as those countries do.)

There is something else we could do to promote universal health insurance: We could allow everyone — regardless of income — to enroll in Medicaid, and at the same time allow everyone on Medicaid to leave the program, claim the tax credit, and buy private insurance. This, of course, is the "public option" that the Left has been clamoring for. It's hard to understand why conservatives are so resistant to it: If a private insurer can't outperform Medicaid, it doesn't deserve to be in the market.

The specific tax-credit levels I am proposing are the Congressional Budget Office estimates of the cost of enrolling new people in Medicaid. Under my proposal, people who are already eligible could use their tax credit to buy in, no questions asked, but people with higher incomes might have to pay a premium on top of their tax credit if they have higher-than-average expected costs. Health status wouldn't be considered, but age and other factors would be. To prevent gaming of the system, no one would be able to move from one plan to another at a premium that is way below his total expected costs. (See below.)

This proposal may appear to be unconservative, but in fact it is consistent with minimizing the role of government. Medicaid would be an insurer of last resort, but, beyond their uniform tax credit, people who are not poor but enroll in Medicaid would not be getting an entitlement. They would have to pay their own way.

Portability. In most states today, it is illegal for employers to buy for their employees what they most want and need — insurance that travels with them from job to job and in and out of the labor market. Employers can buy group insurance with pre-tax dollars, but they can't buy individually owned insurance (they could buy it with after-tax dollars, but this probably never happens). This means that people lose their insurance when they leave their employer, and that is the primary reason preexisting conditions are a problem for the uninsured in this country.

This policy needs to be reversed. Employers should be encouraged to provide insurance for their employees that is portable in the same way as 401(k) plans and employer-paid life insurance. NFL football players and United Mine Workers members already have portable insurance, with premiums paid by their employers, because of special federal legislation. It's time to extend this opportunity to everyone else.

Employers, by the way, can be very effective portals into the insurance system, solving problems that are hard for individuals to solve on their own. We should encourage, rather than discourage, their participation.

Patient Power. Health savings accounts (HSAs) and health reimbursement arrangements (HRAs) are very effective ways to eliminate waste and to control costs. That's why 30 million people now have these accounts. The RAND Corporation estimates that more widespread use of these consumer-directed health-care plans would make savings of up to 30 percent possible. (Ironically, even though many Democrats regard HSAs as a Republican idea, Obamacare is likely to result in a large expansion of HSA-compatible plans — because so many plans sold on the exchanges have high deductibles.)

In addition to their incentive effects on buyers of health care, these accounts are also having a big impact on the providers of care. Walk-in clinics, mail-order pharmacies, and Walmart's $4 generic drugs are just some of the ways that the supply side of the market is responding to patients who control their own health-care dollars.

Still, we are not taking full advantage of the opportunities here. Instead of the rigid restrictions under current law, continued under Obamacare, HSAs should be completely flexible — and allowed to partner with third-party insurance in innovative ways. Then the market should determine the appropriate division between third-party insurance and individual self-insurance by means of an HSA. The private sector also needs the ability to create special accounts for the chronically ill. A model is the highly successful Cash and Counseling program, under which disabled Medicaid recipients have managed their own health-care dollars.

Real Insurance. Here is the greatest irony about Obamacare: The prime motive behind health-care reform was to give everyone access to care. But the way things are panning out, millions of people are losing insurance that offers very reasonable access to providers and are being forced into an exchange where the typical plan excludes the best doctors and the best hospitals. In some areas, these plans are dubbed "Medicaid Plus." In Massachusetts, it appears that patients with subsidized private insurance have worse access to care than do people on Medicaid.

The reason people are losing access to care is that we are creating a market in which insurers have to compete with one another in light of very perverse incentives. With community rating and guaranteed issue, insurers are not allowed to charge actuarially fair premiums, reflecting each enrollee's expected health-care costs. But since this means that healthy enrollees will be profitable and sicker enrollees will cause losses, every insurer will go to great lengths to attract the healthy and avoid the sick. The insurers are convinced that the healthy buy on price and thus look for cheap plans, and that only the sick care about networks, so they are keeping premiums down by creating networks that include only those providers who agree to accept rock-bottom fees.

How could things be different?

We don't have to look far. One out of every four seniors (including about 40 percent of younger, i.e., newly eligible seniors) has enrolled in a private insurance plan through the Medicare Advantage program. You can think of this program as an exchange in which insurers have to community-rate and take all comers. However, the actual premiums the plans receive are not community-rated. Through a complex formula, Medicare adjusts the payments based on the expected health-care expenses of the enrollee. As a result, the private Medicare Advantage plans do not run from the sick — they compete to enroll them. There are even "special needs" plans that specialize in catering to seniors whose average annual cost is about $60,000. They compete for these patients because Medicare pays them a premium of more than $60,000.

One of the complaints about Medicare Advantage is that it is too political: Because of special-interest politics, the government overpays some plans. Congress even dictates what Medicare has to pay these plans in various counties around the country.

An alternative to having government manage the risk adjustment is to let the market do it. The idea is that no insurer should ever be allowed to dump its costliest enrollees onto another insurer without paying the full cost of the transfer. So if an expensive-to-treat patient moves from Plan A to Plan B, the former has to compensate the latter for any above-average expected costs — just the way Medicare compensates private plans.

Right now, Obamacare is destroying the market for individual insurance. It's allowing state risk pools to dump high-cost patients into the exchanges and get off scot-free. The federal government is about to do the same thing with the risk pools it manages. So is Detroit. Cities and counties across the country that have promised post-retirement benefits they can't pay for, and even many private companies, are poised to drop their high-cost problems right into the lap of the Obamacare exchanges. The Obama administration has decided that hospitals can sign up patients for exchange insurance and pay the premiums for them even from their hospital beds (thus shifting the hospitals' bad debt to an unsuspecting insurance company). And there are countless ways in which the employer community will be able to game the system by keeping employees out of the exchanges when they are healthy and sending them to the exchanges if they get sick.

This is worse than bad public policy. It is unconscionable.

Some of the problems we are dealing with are social problems, and any reasonable solution should therefore spread its cost over the entire population. Instead, Obamacare is heaping all the costs on an insurance market that is serving less than 10 percent of people with private insurance.

Untangling the disastrous mess in which we are about to find ourselves will be extremely difficult. However it is done, there are two points we should remember. First, the president's promise that you won't be denied coverage because of a preexisting condition was a bait and switch. As insurers run from anyone who has an expensive-to-treat health problem, those patients will find that the only affordable policies they have access to are little better than Medicaid. Second, real protection against the cost of developing a preexisting condition requires a market for insurance in which insurers find it in their self-interest to solve the problems of the sick.

How much would this alternative to Obamacare cost? Starting from where we are now, it's almost a free lunch. If we take all of the current subsidies for employer-provided insurance and add all of the subsidies Obamacare is providing, we will have more than enough money for reasonable reform. In fact, we have enough money to buy off resistance to reform by giving large companies and labor unions a choice of tax regimes: They can continue with the current system of tax subsidies, or they can switch to the tax-credit system. My bet: Very few will choose to stay in the old system.

However, there will never be enough money to fix things if we do not stop the red-ink hemorrhaging that is about to occur. We must act as quickly as possible to prevent the states, the cities and counties, and the private companies from dumping their high-cost patients into the individual market with impunity.

There is an urgent need to reform Obamacare. We really can't wait until 2017, when we will get a new president.

— *John C. Goodman is the president of the National Center for Policy Analysis and the author of Priceless: Curing the Healthcare Crisis. This article originally appeared in the March 24, 2014, issue of* National Review.