How to Replace Obamacare

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When the Patient Protection and Affordable Care Act (commonly known as “Obamacare”) was signed into law in the spring of 2010, congressional opponents vowed that the fight was not over. The most disastrous features of the new law would not take effect until 2014, leaving time for a concerted campaign to avert catastrophe. The way to spend that time, these opponents argued, was working to “repeal and replace” the law that Congress had just enacted.

The “repeal and replace” formulation quickly caught on, but it was not without its critics. That Obamacare should be “repealed” was obvious, given how strenuously conservatives and many independents objected to the new law. But “replace”? Hammering out the details of a new health-care law might easily stir controversy and sow discord, thereby undermining the push for “repeal.”

This concern is not unfounded. But repeal will not be enough, for a simple reason: Although Obamacare would worsen many of the problems with our system of health-care financing, that system clearly does call out for serious reform. Despite the widespread public antipathy toward the new health-care law, simply reverting to the pre-Obamacare status quo would be viewed by many Americans, perhaps even most, as unacceptable. After all, a repeal-only approach would leave many of the most grievous flaws in our system of financing health care unaddressed. Chief among them would be steadily rising health-care costs, driven by the same misguided government policies that so evidently demand reform.

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If the problems that are today obvious to the public had been addressed by market-oriented policies over the past few decades, there would have been no political opening through which to ram Obamacare. Instead, these problems were allowed to fester; by 2009, they had become so acute that there was strong sentiment, even among some business-oriented conservatives, that “something had to be done.” And as the 2010 congressional debate over Obamacare reached its climax, this sentiment—that some action, even an imperfect one, would be better than nothing—likely played a large role in enabling the health-care law to pass.

This history suggests that, now that Obamacare is with us, the law cannot be reversed without a credible proposal for what should take its place. Those reforms must account for both the strengths and the weaknesses of our health-care system, and must solve the problems that contributed to the demand for Obamacare in the first place. There is room for debate about the particulars of these reforms, and different components of our health-care system will call for different kinds of fixes. What any effective solution must involve, however, is the creation of a true market in health coverage—one that drives efficiency through competition, and places health-care decisions in the hands of consumers and taxpayers, where they belong.

WHAT NEEDS FIXING

America’s health-care system has important strengths that must not be overlooked. Most notable among these are an openness to medical innovation that is absent from more centrally planned systems and a network of clinics and hospitals capable of offering the most advanced care found anywhere in the world. The vast majority of Americans (almost 80%) have ready access to this high level of care through third-party insurance arrangements, obtaining coverage from their employers or from federal programs like Medicare and Medicaid. Another 10% have individually purchased coverage.

But for all its considerable strengths, the system suffers from pervasive weaknesses as well. The most serious of these is rapidly rising costs. According to the Congressional Budget Office, between 1975 and 2005, annual per-person health spending in the United States rose, on average, 2 percentage points faster than per-person economic growth. In other words, the escalation of health costs has far outpaced the rise in our
national income. This has left more and more people unable to afford insurance, and it now poses significant problems for government budgets: Both federal and state governments spend an enormous amount on health care, but government’s revenue base for taxation grows along with the economy, not with health-care costs. So as government spending on health care has surged, tax collection has not kept pace — yielding the primary driver of today’s deficits and mounting debt.

Of course, government health-care programs and policies are largely responsible for these rising costs in the first place. To begin, the design of Medicare is terribly flawed: Because the program pays providers of care based on the volume of their services, it creates a massive incentive for inefficiency and overuse. And because Medicare is the biggest payer in most health-care markets in America, that incentive badly distorts the economics of the entire sector. Furthermore, the Medicaid program inflates costs by (among other policies) having states control how the program is run while the federal government pays most of the bills. The result is that neither party has both the incentive and ability to keep costs in check.

The third driver is the tax exclusion for employer-provided insurance: The federal government does not count the amount that employers spend on health insurance for their employees toward workers’ taxable income. This tax exclusion inflates costs by effectively rewarding higher-premium plans and by encouraging employer-purchased insurance, thereby preventing a real consumer market in coverage. The people who use the insurance (workers) are not the people who buy it (employers); many Americans thus have no idea how much is spent for the health care they receive. As a result, there is no clear relationship between cost and value, without which there can be no real prices, no real incentives for efficiency and quality, and thus no limitations on the growth of costs.

But while the cost explosion is clearly the greatest problem with America’s health-care system (and the cause of most of its other problems), costs are not always the focus of the public debate. The most politically salient problem is often the lack of secure insurance coverage for many millions of Americans, and the related problem of insuring Americans with pre-existing and expensive medical conditions. This concern — that if these Americans lost their insurance they might not be able to find affordable coverage again — is of course related to the
high cost of care, which has made it more difficult to provide affordable coverage for everyone, including the sickest among us. But the problem of providing stable insurance to people with pre-existing conditions is also driven by factors unrelated to costs. Foremost among these is the heavy reliance on employer-sponsored insurance that is not owned by workers, and therefore not portable when workers move from job to job or leave the work force.

Proponents of Obamacare like to create the impression that there are tens of millions of Americans trapped by their pre-existing conditions, sick and stuck with lousy insurance and no options. In truth, the vast majority of working Americans have good and secure coverage today, including many millions of people with expensive health conditions. Thanks in part to protections enacted into federal law in 1996 (through the Health Insurance Portability and Accountability Act, or HIPAA), a person who remains continuously insured as he moves from job to job is protected against inflated premiums and coverage exclusions stemming from a health condition. Thus only a very small percentage of Americans face the pre-existing condition dilemma.

But a small percentage of our large population is still a lot of people. There is no denying that cracks in the system exist, and that many Americans fall through them. This is particularly true of people who need to move from job-based coverage into the individual market. Here the 1996 law is entirely inadequate: People who leave the work force and need to buy insurance on their own can face sky-high premiums for weak coverage just because they happen to suffer from a health condition over which they often have little control. Though the number of families in such circumstances is relatively small, it is large enough that many Americans are personally acquainted with people facing these unpleasant realities. This experience is enough to shape public opinion; surveys show that roughly four out of five Americans support provisions in Obamacare that require insurers to sell their products to all comers at the same rates without regard to health status.

The Obama administration is trying to channel this desire to fix the problem of covering pre-existing conditions into a case for retaining the entire Obamacare edifice. Starting in the middle of 2009, the president and his top aides took to calling their plan “insurance reform,” as if the law’s most important elements were simply new rules designed to protect hapless consumers from unscrupulous insurance companies.
This is, of course, a gross mischaracterization of what Obamacare actually does. Among other features, the law implements a massive expansion of taxpayer obligations. It adds two new entitlement programs at an expense of at least $1 trillion over a decade. In that same period, it raises taxes by more than $500 billion. It cuts Medicare payments to those providing medical services by roughly $500 billion, and sets up an unaccountable board — the Independent Payment Advisory Board — to enforce new caps on future Medicare growth through specific payment cuts to Medicare providers. Most egregiously, it puts the federal government in command of the health sector, giving bureaucrats immense new power to decide matters ranging from what services must be covered in every American’s insurance plan to how doctors and hospitals organize themselves and do business.

Obamacare is thus far more than “insurance reform.” But it is revealing that this is how the administration hopes the law will be perceived by average Americans. Obamacare’s opponents should take note of the appeal of this idea: Our nation does need real insurance reform, but it can be implemented in ways that address the problems with our healthcare system instead of exacerbating them.

PILLARS OF REFORM

To be credible, the replacement for Obamacare must address in a plausible way the genuine problems with our system of financing health care. Pre-eminent among these are the explosion in costs, the rising numbers of uninsured, and the challenge of covering Americans with pre-existing conditions.

The good news for Obamacare opponents is that much of the work of building such a plan has already been done. A small but persistent band of reformers and economists has spent many years promoting and refining the elements of a market-based approach to remedying what ails American health care. These ideas have animated scores of plans released by various organizations, including some proposed after Obamacare’s enactment. And while these plans differ in their details, they share a core set of seven principles that should form the basis of any proposal for replacing Obamacare.

The first crucial component of any serious reform must be a “defined contribution” approach to the public financing of health care — the essential prerequisite for a functioning marketplace that imposes cost and
quality discipline. In most sectors of our economy, the normal dynamics of supply and demand keep costs in check and reward suppliers that find innovative ways to deliver more for less. As described above, however, this is not the case in the health-care sector, principally because the federal government has completely distorted consumer incentives.

For market forces to work, consumers must be cost-conscious. Those who decide to consume goods or services must face tradeoffs that require them to prioritize the various uses of their money. In the health sector, there is virtually no cost consciousness on the part of consumers: The vast majority of Americans get their insurance through their employers or through Medicare or Medicaid. In each case, as noted above, the federal subsidy grows as the cost of insurance grows, thereby undermining the incentive to keep costs low. When an employer decides to provide a more generous health-benefit plan to his employees, the U.S. Treasury pays for a good portion of the added costs, because health insurance is a tax-free fringe benefit for workers. When a doctor orders more tests or procedures of dubious clinical value for a patient enrolled in Medicare, it is mainly taxpayers who pick up the tab. And when states pile more people into Medicaid, it is again taxpayers — federal and state — who shoulder the cost. With this kind of subsidy structure, it is not at all surprising that cost escalation throughout the health system has been rapid.

A replacement program for Obamacare must therefore move American health care away from open-ended government subsidies and tax breaks, and toward a defined-contribution system. Under this approach, health coverage would be provided through competing insurance plans; government’s involvement would come through the provision of a fixed financial contribution toward the purchase of insurance by each beneficiary. That subsidy would not vary based on a person’s insurance plan, giving Americans every incentive to shop for good value in their health coverage and to get the most for their defined-contribution dollars.

In the context of employer plans, this approach would mean moving away from the unlimited tax break that is conferred on employer-paid premiums, and instead providing directly to workers a fixed tax credit that would offset the cost of enrollment in the private insurance plans of their choice. Workers selecting more expensive insurance plans would pay for the added premiums out of their own pockets. Those choosing low-premium, high-value plans would pocket the savings, enabling them to offset additional health expenses if they wished to
do so. This system would not only be more efficient: It would also be a far more equitable way to provide health benefits through the tax code. American taxpayers would get a break for health coverage as individuals, irrespective of their employment status or the generosity of the health plan provided by their employers.

In the context of Medicare and Medicaid, meanwhile, the government would similarly provide a fixed (though of course far more generous) level of support, sometimes called “premium support,” that would guarantee insurance coverage to beneficiaries but would allow them to choose among competing options and encourage them to seek out the best value for their money (as discussed at greater length below).

The second pillar of reform should be personal responsibility and continuous-coverage protection. Obamacare attempts to address the challenge of covering people with pre-existing conditions with heavy-handed mandates, especially the requirement that all Americans enroll in government-approved insurance plans (the so-called “individual mandate”). A replacement program for Obamacare should come at the problem from the opposite direction, with government forsaking coercion and instead extending a new commitment to the American people: If you stay continuously enrolled in health insurance, with at least catastrophic coverage, you will never again face the prospect of high premiums associated with developing a costly health condition.

For this commitment to become a reality, some changes would have to be made to both federal law and state insurance regulation. (These proposed changes are discussed in more detail in “How to Cover Pre-existing Conditions,” by James Capretta and Tom Miller, published in the Summer 2010 issue of National Affairs.) To begin, the federal government would need to close the gaps in protection that emerge when people move from employer-sponsored plans to the individual market regulated by the states. This problem could be remedied by amending the 1996 HIPAA law to allow workers to move directly from group to individual insurance without first having to pay out of pocket for the (lengthy) extension of their employer-based plans through so-called “COBRA” coverage. In 1985, the Consolidated Omnibus Budget Reconciliation Act (or COBRA) allowed workers who lose their jobs to remain on their employers’ health-insurance plans for months, provided they pay the full premium cost themselves (usually a significant expense). HIPAA then required workers eligible for this COBRA option to exercise it before they could be given
any protection in the individual insurance markets regulated by the states. Since hardly any workers follow this prescribed course, they enter the individual market with no protections from pre-existing condition exclusions. That would change if workers were protected when they moved directly from group to individual insurance plans.

Next, states would need to amend their regulations of the individual and small-business insurance markets to require insurers to sell coverage to customers who have remained continuously covered. These new regulations would also have to require that such coverage be made available at standard rates—that is, at rates that apply without regard to differences in health status (age and geographic adjustments would be permitted).

Because some workers who leave job-based plans for the individual market could be quite sick, a credible Obamacare replacement plan would also need to include a new approach to covering the high insurance costs for these Americans. Different proposals have offered different mechanisms, but all would move the burden away from the sick patients themselves to a larger and broader pool of people, either through regulation or through a direct government program such as a high-risk pool. For people who have not been continuously insured, these protections generally would not apply. States could continue to allow insurers to charge higher premiums to these individuals based on their respective health risks. There would thus be a very strong incentive for all Americans to remain continuously covered. (At the time of enactment, it would make sense to give those Americans who were not in continuous coverage the opportunity to come into the new system without penalty and to secure this new protection.)

This approach would achieve the goal of providing realistic and affordable options for people with pre-existing conditions, but without imposing the misguided, overbearing, and counter-productive architecture of Obamacare—and in a way that encourages a competitive insurance market and an innovative health sector rather than undermining them.

The third pillar of reform must be a genuine partnership with the states. Under Obamacare, states are treated as mere functionaries in a new centrally planned and federally managed system. The law gives state officials a take-it-or-leave-it choice: They can implement and administer the new policies under Obamacare—such as state-level insurance exchanges—to the letter, without any deviation or adjustment, incurring the extra costs of these new programs along the way. Or state governments
can refuse this managerial responsibility and instead have the federal government come in and operate the exchanges and other new components of the law on the states’ behalf. But in neither case are the states afforded any independence or flexibility, any room to adapt the requirements imposed by Obamacare to the particular circumstances of their populations, or to innovate to achieve greater quality or efficiency.

A replacement plan must be true to the Constitution and reflect a genuine federalist philosophy. Any program to address the problems in American health care will entail some degree of national policy, but it can still leave ample room for state initiative and encourage state-level solutions. There is good reason to allow such discretion: States vary significantly in their demographics, their economic profiles, their infrastructure, their levels of employment and poverty, their Medicaid enrollments, and their numbers of uninsured. There is wide disparity among states in the costs of uncompensated care, the scope of employment-based health insurance, and the condition of individual health-insurance markets. States differ markedly in the range of their health-care problems and in their capacities to cope with them.

Moreover, states can be powerful engines of policy innovation and experimentation in health-care reform, insurance-market reform, and tort and medical-malpractice reform, as well as in the financing and delivery of care in safety-net programs. In recent decades, a number of states have attempted their own solutions to our health-care financing crisis. But because that financing crisis is driven by deformed federal policies, all that these states have been able to do is try to mitigate the effects of Washington’s mistakes. A reform that addressed those mistakes directly at the national level could then free the states to address the problems of health-care financing in the ways that best suit their needs.

To respect federalism and reap its benefits, nothing in an Obamacare replacement agenda should compel state adoption, instead leaving the participation of state governments completely voluntary. Those states that do participate in any federal initiative should be given meaningful control over the most important components of regulation, especially the power to design and operate their own health-insurance markets (within minimal federal standards). Such deference to state authority would mean allowing states to retain full control over matters like what coverage to require in health insurance and how to facilitate consumer enrollment in qualified plans. Crucially, no Obamacare replacement program
should include a federal requirement that states set up health-insurance exchanges that could later become instruments of excessive regulatory control. Rather, states should be given two tasks: informing consumers of their insurance options, and easing their enrollment into the plans they choose by cooperating with the federal government to facilitate the payment of credits and vouchers directly to private insurers. How states perform these critical tasks should be left entirely up to them.

Defined-contribution financial support, protection for Americans who remain continuously enrolled in insurance plans, and genuine federalism are the essential overall concepts that must define any serious health-care reform. But policymakers will also need to apply these principles to the transformation of today’s funding and financing mechanisms: the tax exclusion for employer-provided health coverage, and the Medicaid and Medicare systems.

**TAX REFORM AND HEALTH REFORM**

The fourth pillar of a real reform agenda would therefore address the tax treatment of employer-sponsored plans. Today’s arrangement is somewhat counterintuitive: Because the tax exclusion for health-care premiums is open-ended, workers and employers have an incentive to make health benefits a disproportionately large share of total compensation. And because employers obtain and manage health plans for their workers, there is far too much distance between those who purchase care and those who consume it. The key decisions in American health care thus rest not with patients and doctors, but rather with employers, managed-care executives, and government officials—a structure that has prevented the emergence of a properly functioning marketplace. Individuals and families rarely have a property right in their health-insurance policies and rarely control the terms and conditions of coverage (as they do with auto, life, or home owner’s insurance). Health insurance is rarely portable in any real sense of the term, as workers cannot remain enrolled in the same insurance plans when they switch jobs.

Federal tax policy is at the root of these market malfunctions, and has caused a host of related problems. These include higher health-care costs, the absence of continuous and secure coverage, a lack of transparency in health-care financing, discrimination against lower-income workers and favoritism toward higher-income workers, and a playing field tilted decidedly in favor of group health insurance and against
individually purchased coverage. Among economists, including some of President Obama’s advisors, there is an overwhelming consensus that reform of health-insurance markets must begin with a major change in the federal tax treatment of health insurance.

The most plausible way to implement such a change would be to transform today’s tax exclusion for employer-provided insurance into a standard tax credit that would extend to all Americans, regardless of employment status, which they could then use to purchase the private coverage of their choice. As to how such a consumer-controlled federal tax credit would be designed, policymakers have a variety of options from which to choose. For instance, in its 2011 “Saving the American Dream” plan, the Heritage Foundation proposed replacing today’s unlimited tax break with a new, non-refundable tax credit that would be phased out for the wealthiest citizens. Another approach would be to limit the credit to some pre-determined level of insurance coverage. Because the credit amount would not be increased for workers selecting more expensive insurance plans, those choosing such plans would pay the difference while those opting for plans with lower premiums would not be penalized (with a diminished tax benefit) for economizing.

One such proposal was offered during the 2008 presidential campaign by Senator John McCain, who suggested a universal program of refundable tax credits that would be payable to all households. In 2007, President George W. Bush proposed replacing today’s tax treatment of insurance with a universal deduction for health-insurance premiums that would be available to people in employer-sponsored plans, as well as to those in the individual market. In both cases, the value of these credits and deductions would increase over time by some measure of inflation—ensuring that they would keep pace with fluctuations in the cost of living, while also ensuring that government’s costs would remain predictable and manageable.

In all of these formulations, the essential common element is a move toward consumer control. Individuals would become active, cost-conscious consumers looking for value in the health-care marketplace. This shift would, in turn, create tremendous incentives for those delivering medical services to find better and less expensive ways of caring for patients and keeping them well.

For the purposes of implementing tax-based health-care reform, it would make sense to bifurcate the market for employer-based coverage into small and large employers. For smaller employers (for
instance, those with fewer than 200 employees), there is reason to move quickly to change the tax treatment of job-based insurance: Many small businesses do not even offer coverage today, so a reform that substituted tax credits for today’s tax preference would immediately help millions of working Americans get better coverage than they now have. Indeed, the availability of a credit or deduction would likely reduce the number of uninsured Americans by a significant measure. Consumers wouldn’t want to leave the credit money on the table, and insurers would be eager to provide them with ways to spend it. Insurance companies would thus have every reason to design minimal plans (including, at the very least, catastrophic coverage) with prices roughly equal to the amount of the credit or deduction, and consumers who might otherwise not buy coverage would have every reason to purchase those plans. Moreover, the insurance marketplace for small-business workers tends to be volatile, with workers passing in and out of coverage frequently as they change jobs or leave the work force. Moving toward a tax-credit system would give these workers the chance to sign up for insurance that they would own and keep, even as their life circumstances changed.

On the other hand, many tens of millions of Americans are now signed up with good and stable large-employer plans. Although these workers see a need for reform, they do not want to lose the coverage they have today. For both political and practical reasons, it would make sense to leave these people where they are, in their large-employer plans, as the reforms in the other parts of the marketplace are implemented and refined. The advantages of these changes— including the expansion of personal and portable health insurance, lower-cost health coverage, and higher take-home pay— would, over time, become evident to workers in large-employer plans. The key, however, is that the decision to change coverage would rest not with government but with workers and employers, who would be under no obligation to change the terms of employees’ benefit plans. The only modification that should be pursued immediately is the placement of an upper limit on the amount of employer-paid premiums eligible for the existing federal tax break; this would level the playing field somewhat between the existing tax benefit and the new tax credit. Under this proposal, premiums paid by employers above the upper limit would be counted as taxable compensation to workers. This would give both employers and employees a stronger incentive than they have today to move toward low-premium, high-value plans.
An important additional detail of such a reform plan would apply to people who are eligible for a federal tax credit (or perhaps a Medicaid voucher) and yet still do not sign up for coverage. For these people, one option would be to establish an automatic-enrollment program in which states assign people on a random basis to a series of state-approved private plans. The insurers offering these default options would be allowed to adjust the up-front deductibles as necessary to ensure that the premiums for the insurance plans do not exceed the credits enrollees are eligible to receive. The aim would be to make sure that people who are placed in an insurance plan by default pay no additional premiums out of their own pockets. Those automatically enrolled could switch out of their default plans into other insurance plans at any time (subject to state rules governing enrollment periods); if they had moral or other reasons for not carrying insurance coverage, they would be free to drop out of insurance enrollment altogether.

Such a default enrollment program could be an important feature of a credible replacement plan, allowing millions of Americans to leave the ranks of the uninsured and to secure continuous-coverage protection without the coercion of Obamacare’s mandates. This flexibility would likely be a very attractive selling point for a consensus replacement proposal.

**Improving Health Care for the Vulnerable**

The fifth key component of a genuine health-care reform plan must be an overhaul of Medicaid. Medicaid is actually three separate programs: health insurance for lower-income working-age adults and their children, health and long-term care for the non-elderly with severe disabilities, and long-term care for the frail elderly. For the purposes of replacing Obamacare, the relevant program to change is insurance coverage for working-age adults and children; the other parts will need reform as well, but should be addressed in a separate legislative effort.

Medicaid coverage for working-age adults and children has its roots in welfare. Starting in 1965, women with low incomes, along with their dependent children, were given cash support through a federal-state program (known as Aid to Families with Dependent Children until 1996, and then transformed into the Temporary Assistance for Needy Families program), and provided with medical coverage through Medicaid. Over the years, Medicaid has been modified many times by federal and state
statutes, but the program still retains its welfare-based characteristics. Most troubling among these is the program’s tendency to discourage recipients from securing better-paying jobs, since Medicaid coverage is not integrated with our employment-based system of insurance. For instance, if a woman on Medicaid were to accept a higher-paying job, she might lose her Medicaid insurance without being offered insurance through her place of employment. The result could therefore be a net reduction in her overall financial well-being.

Furthermore, because Medicaid pays exceedingly low fees to care providers, the program does not always offer high-quality coverage. Not surprisingly, as states have pushed physician-reimbursement levels well below the actual costs of caring for Medicaid patients, many doctors have responded by severely restricting the number of Medicaid patients they will see. The result for people on Medicaid is often a lack of accessible quality health care, precisely what the program is supposed to provide.

In replacing Obamcare, policymakers should move lower-income people out of the limited sphere of Medicaid options and into the same private health-insurance markets in which their fellow citizens purchase coverage. This change would afford these patients greater access to doctors and specialists, and would reduce the disincentive to higher-paying work.

There is more than one way to accomplish this objective. In the Heritage Foundation proposal noted above, for instance, existing financing for acute care provided through Medicaid and the State Children’s Health Insurance Program would be transformed into a large pool of funding to be re-allocated to current beneficiaries and other low-income Americans in the form of a federal health-care subsidy (the equivalent of a “refundable tax credit”) for private insurance. If they wished, state governments could provide their own support on top of this federal aid. Benefits under such a plan would be means-tested, with the lowest-income Americans receiving the most generous level of assistance and subsidies being gradually reduced for those with higher incomes as they became eligible for federal tax credits for coverage. (Because the credit in the Heritage plan is non-refundable, people would not be eligible for it until they earned enough to pay federal income taxes.)

A similar approach would give Medicaid recipients the same federal tax credit that workers would receive in a reformed marketplace for health insurance. The federal government could then convert Medicaid into a
per-person allotment to the states, funded through a block grant, that would supplement the base credit for a state’s low-income residents. The federal allotment to the states would be set so that, when combined with the federal support for the base tax credits or vouchers for the Medicaid-eligible population, total federal spending on the Medicaid population in a state would equal the amount that would have been spent under pre-Obamacare Medicaid. After the first year, the federal allotment to the states could be set to grow commensurate with the economy or some other reasonable measure of inflation. States would not be required to reform Medicaid in this manner; if they did, though, they would have far greater freedom to run the program according to their own priorities instead of in response to federal dictates.

The same move toward market incentives and efficiency should characterize our approach to Medicare reform in the wake of Obamacare’s repeal. The sixth pillar of a replacement plan must therefore be a premium-support reform of Medicare.

It is hard to overstate the importance of such a reform to the larger goals of controlling costs and improving quality and access to coverage. Of all the changes that are necessary to bring more cost discipline to health care, moving Medicare toward a defined-contribution structure, and away from today’s open-ended defined-benefit structure, is certainly the most vital. Medicare is the largest payer for services in most markets; the system of hospital and physician care in most communities has been built up around Medicare’s financial incentives.

Today, the program’s dominant fee-for-service structure provides all the wrong incentives. All of the various suppliers of medical services for Medicare patients—the diagnostic labs, the physicians, the hospitals, the outpatient clinics, the nursing homes, and many others—can bill the program separately whenever they render a service to a patient. Absent Medicare’s incentives, they might well consolidate and coordinate to reduce overhead and streamline care, providing higher-quality services at lower cost. Thanks to Medicare, however, these organizations can sustain themselves financially without having to affiliate with any of the other service providers. The result is extreme fragmentation and lack of coordination, which permeates the entire health-care system to the detriment of patient care.

As long as Medicare continues to operate as it does today, the way doctors and hospitals are organized will not change and will, in most
markets, remain excessively costly and inefficient. This will soon prove disastrous for the federal budget: The first wave of the huge Baby Boom generation, 77 million strong, is beginning to retire. Between 2010 and 2030, Medicare’s enrollment is projected to increase from 47 million to more than 80 million beneficiaries, while the ratio of workers to beneficiaries will decline from 3.7-to-1 today to 2.4-to-1 in 2030.

Obamacare’s “solution” for Medicare will exacerbate the problem, not solve it. The law claims to yield $575 billion in savings over ten years through Medicare payment cuts, but those cuts won’t bring more efficiency to the program. They are simply across-the-board price controls that will shift costs off of the federal balance sheets and onto non-Medicare patients (whose costs would rise to make up the difference), while also driving willing suppliers out of the marketplace. Moreover, Obamacare has imposed, for the first time in Medicare’s history, a hard cap on the growth of Medicare spending, tying it to the rate of inflation and subsequently to growth in the general economy. This would, in effect, amount to a global budget for Medicare, analogous in some ways to the tough budgetary caps characteristic of single-payer health programs. To make matters worse, this cap would be enforced in accordance with the decisions of a new Independent Payment Advisory Board—a group of 15 appointed experts whose decisions would be automatically implemented unless Congress actively rejected them.

It is worth noting that, under the statute, the IPAB’s authority is confined to selective Medicare payment reductions (that is, to reducing the fees paid per service in an otherwise unreformed system), and would not extend to any changes in benefit design, beneficiary payment, or the structure of the program itself. Thus there is no prospect that the IPAB will implement reforms capable of making Medicare more efficient. The board can enforce the hard cap on Medicare spending only in the same way budget cuts have always been imposed by Congress in Medicare: through price controls that exacerbate the inefficiencies in how health care is delivered to patients.

The alternative to this disastrous, top-down, micromanaged approach is to convert Medicare into a premium-support program. While such a reform should try to capture the bulk of the huge Baby Boom generation, it should also be carefully phased in, applying only to future enrollees. A transition to a new premium-support model should exempt from the changes people who are currently in the Medicare program and those very
close to retiring. (For instance, the plan offered by Republican congressman Paul Ryan and Democratic senator Ron Wyden would start with Americans who are 55 today, and so will enter the program in ten years.)

In lieu of today’s open-ended benefit, a premium-support system would allow new beneficiaries (after the transition) to decide how to use a fixed-dollar contribution provided by Medicare. Each beneficiary would choose from a menu of approved insurance plans. If a beneficiary’s premium for his chosen plan was higher than the Medicare contribution, he would pay the difference out of his own pocket. If he chose a less expensive plan, he would pay lower premiums and keep the savings. This structure would provide a powerful incentive for the program’s participants to find high-value plans that charge low premiums for quality care, and therefore for insurers to offer such plans.

With cost-conscious consumers looking for the best value for their money, cost-cutting innovations would be rewarded, not punished as they are today. Physicians and hospitals would have strong financial incentives to re-organize themselves to increase productivity and efficiency in order to capture a larger share of what would become a highly competitive marketplace. This is the only way to slow the growth of health-care costs without harming the quality of care.

While Medicare reform is absolutely essential to restraining cost escalation and to improving the affordability of health care for all Americans, it need not be enacted in the same legislation as an Obamacare replacement program. This is true especially because a replacement program would be focused primarily on providing an alternative vision of insurance coverage for working-age Americans, not retirees. Still, the reform of Medicare suggested here is entirely consistent with, and in fact reinforces, the rest of the reforms proposed above. It is up to the sponsors of replacement legislation to decide whether moving one or two pieces of health-care legislation through Congress at a time would be more likely to result in enactment.

**Fiscal Responsibility, for a Change**

Finally, as a key criticism of Obamacare is the danger it poses to federal finances, the seventh pillar of a serious health-care reform plan must be the full offset of all new costs through spending cuts.

If past experience is any guide, Obamacare’s new entitlement and massive expansions of Medicaid could cost several times more than the official estimate (about $1 trillion over a decade). Moreover, Obamacare’s
sponsors resorted to a series of gimmicks and budgetary sleights of hand to make it seem as if the legislation would actually improve, rather than worsen, the long-term budget outlook. But while repealing Obamacare would avert these costs, a credible replacement program would certainly entail some expenses of its own. These would result especially from the subsidization of coverage—whether through the tax credit for the purchase of private insurance, the additional support for many lower-wage workers, or the support for Americans who enter the insurance pool with pre-existing conditions.

To be sure, some of the new costs from a replacement program would be offset by the savings reaped from other components of the reform package. For example, placing an upper limit on the tax break for employer-paid premiums in the large-employer market would generate substantial revenue, partially offsetting the cost of extending credits to Americans in the small-business and individual marketplaces. The reforms of Medicaid, too, would help, ensuring that future federal costs would grow at a more moderate pace than is expected under current law.

Even so, additional spending reductions will be necessary to fully offset the added budgetary burden of replacement legislation. The spending reductions chosen should be real cuts, not budget gimmicks, and should be of sufficient magnitude to ensure that the legislation results in a net decline in federal spending, taxes, and future budget deficits.

The first place to look for such cuts is within existing health-entitlement spending. For instance, both Medicare and Medicaid subsidize hospitals for caring for the uninsured and underinsured. These subsidies could be cut back substantially or eliminated altogether in a replacement program, since that program would extend insurance protection to millions of uninsured people, thus allowing tens of billions of dollars in savings from these indirect means of support. In addition, the Medicare fee-for-service program should be modified to reduce costs even during the window that precedes the full transition to a premium-support program for new entrants. Such changes could include gradually increasing the retirement age, as well as adjusting the rules for supplementary insurance coverage so that seniors have an incentive to responsibly restrain their health-care spending. Policymakers might also consider using some type of means test, adjusting the level of Medicare subsidies or premiums based on income, in order to ensure that taxpayer dollars are not providing needlessly generous benefits to the very wealthy.
A HISTORIC OPPORTUNITY

The enactment of Obamacare has created a political opening for a credible alternative to the health-care status quo. But it would be foolish to assume that this opening will last very long; once it has closed, it is not likely to appear again.

Obamacare is deeply unpopular because it is based on a bureaucratic, government-centered vision of American health care. The entire program is rooted in an expansion of federal power and everything that entails: massive new entitlements, additional dependence on government, tax hikes that hinder economic growth, and federal micro-management of health care that produces a sharp decline in the quality of American medicine. This is exactly what voters do not want in a proposal to reform the nation’s health-care system.

But voters do want a better system, with more security and with affordable and reliable coverage and care. Conservatives thus have a rare opportunity to advance their vision of reform. It will entail some controversy and political risk, which cannot be avoided in a policy arena as complex as health care. But the policy and political upsides are well worth the effort. A market-driven alternative can beat Obamacare on every metric that matters. It will be less costly to taxpayers, more flexible in meeting the diverse needs of citizens, less bureaucratic, and consistent with the Constitution and our values.

Some might observe that if this kind of program had been advanced by conservatives ten years ago, Obamacare might have been avoided in the first place. Perhaps. But it is still not too late to avert disaster: Americans are hungry for a credible alternative to Obamacare, one that carries much less risk for future taxpayers and does not give government control over the delivery of medical care. Now is the time to offer it to them.