NATIONAL CENTER FOR POLICY ANALYSIS

Health Care for All without the Affordable Care Act

Issue Brief No. 116 by John C. Goodman and Peter Ferrara October 2012

The National Center for Policy Analysis has developed a proposal to provide essential health care for all. We can do this with the money that is already in the system. Unlike the Affordable Care Act ("ObamaCare"), it will require no new taxes, no new spending, no individual mandate and no employer mandate. This proposal would provide patients, health care providers and insurers with the tools necessary to control costs and improve the quality of health care — without rationing by health care bureaucracies.

Dallas Headquarters:
12770 Coit Road, Suite 800
Dallas, TX 75251-1339
972.386.6272

www.ncpa.org

Washington Office:
601 Pennsylvania Avenue NW,
Suite 900, South Building
Washington, DC 20004
202.220.3082

This can be accomplished without the 159 new boards, agencies, commissions and programs of ObamaCare, without a government takeover of health care, and without any new entitlement programs.

Repealing ObamaCare and implementing the reforms discussed below would reduce federal spending over the next 10 years by almost $1.8 trillion, possibly more.[1] Moreover, while the president's health reform law would leave millions of Americans uninsured, and most of the newly insured with inferior government health coverage through Medicaid, these reforms can achieve the goal of universal coverage by utilizing the strengths of the private marketplace — competition, incentives and innovation — which would improve health quality while controlling costs.

Inequities and Inefficiencies in the Current System and under ObamaCare

Most people who obtain private insurance today benefit from federal tax subsidies that total about $300 billion a year.[2] But the system is arbitrary and unfair. The amount of tax subsidy an individual receives depends upon whether the insurance is obtained through an employer, what options the employer offers, the family's tax bracket, and other factors. Consider a middle-income family facing a 25 percent federal income tax rate, a 15.3 percent payroll (FICA) tax and a 5 percent average state income tax rate.[3] The ability of an employer to pay health insurance premiums for this family with pretax dollars is a subsidy worth 45.3 percent. Government is effectively paying almost half the cost of the family's health insurance. [See Figure I.]

Unfortunately, if the family does not get insurance from an employer and must purchase the insurance directly there is almost no tax relief. Moreover, because most of the uninsured do not have access to employer-provided coverage, they get little or no tax subsidy when they obtain insurance.

Among those who get a tax subsidy, the system is highly regressive. Because the amount of the subsidy depends on the employee's tax bracket, the largest subsidies are given to people who need them least. Households earning more than $150,000 per year receive an average subsidy of $4,436,

while those earning between $10,000 and $20,000 receive only about $285 in tax benefits.[4] To make matters worse, the subsidy is open-ended. The more expensive the health insurance, the more subsidy people get. In this way, the system encourages waste.

Our system for taking care of the uninsured is also arbitrary and unfair. Although no one knows the exact number, it appears the uninsured pay a little over one-third of the cost of the health care they receive from their own resources, leaving nearly two-thirds as unpaid bills.[5] Yet how much help people get depends on where they live, how many other uninsured patients are also seeking care and how much money hospitals get from federal, state and local governments.

Under ObamaCare, tax and spending subsidies for private health insurance will become even more arbitrary and unfair. For example, a family earning just over $30,000 a year will get no additional tax relief for employer-provided insurance. Yet the government will pay as much as 95 percent of the premium if that family gets insurance through a health insurance exchange set up under the Affordable Care Act. In the exchange, the family can receive $12,000 more help from the government in some cases.[6]

As a candidate for president, Barack Obama endorsed universal health coverage, but opposed forcing individuals to buy their own insurance. As president, he signed into law a program that violates both promises: it isn't universal, but it requires individuals to purchase insurance. The law also violates another campaign promise that "if you're in a plan you like, you can keep it."

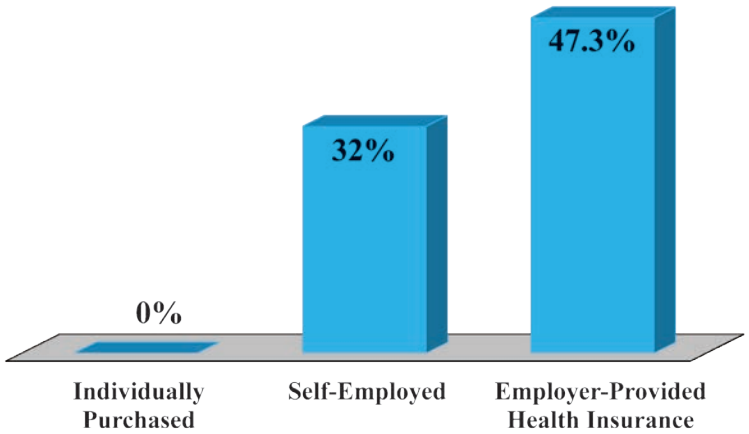
Ultimately, the Affordable Care Act will give the federal government the authority to tell every American what insurance they must have, where they will get it and what they will pay for it. But the latest estimate from the Congressional Budget Office (CBO) is that after the new health reform law is fully implemented 30 million will remain uninsured — almost half of all the uninsured.[7]

Now that the Supreme Court has declared the mandate constitutional, what is next? Mitt Romney says "repeal and replace." But what should we replace it with? Republicans on Capitol Hill are being far too timid. They are endorsing only modest reforms that will not solve the fundamental problems of cost, quality and access to care.

Here is our suggestion: Return to the two original ideas Obama said he was for — universal coverage and no mandate. Replace ObamaCare with a fair, efficient system of health insurance subsidies coupled with a health care safety net that will provide assistance to those who need it.

Figure I

Federal and State Tax Subsidies for Private Insurance



Note: Assumes taxpayer is in the 25 percent federal income tax bracket, faces a 15.3 percent payroll (FICA) tax, and a 7 percent state and local income tax.

Source: John C. Goodman and Devon M. Herrick, "The Case against John Kerry's Health Plan," National Center for Policy Analysis, Policy Report No. 269, September 2004.

Tax Fairness

The complex tax subsidies embedded in the current system and ObamaCare should be replaced by a very simple, equitable alternative. The government should offer every individual the same, uniform, fixed-dollar subsidy, whether used for employer-provided or individual insurance. For everyone with private health insurance, the subsidy would be realized in the form of lower taxes by way of a tax credit. The credit would be refundable, so that it would be available to individuals with no tax liability.

Tax Credits for Health Insurance. The amount of the subsidy should be what we expect to spend from public and private sources on free care for each person on average when he or she is uninsured. If that is $2,000, we should be willing to offer $2,000 for every individual who obtains private insurance.[8]

That would equal $8,000 for a family of four.[9] Failure to subsidize private insurance as generously as we subsidize free care encourages people to choose the latter over the former.

Where would the federal government get the money to fund this proposal?

We could begin with the $300 billion in tax subsidies the government already "spends" to subsidize private insurance. Add to that the money federal, state and local governments are spending on indigent care. For the remainder, the federal government could make certain tax benefits conditional on proof of insurance. For example, the $1,000 child tax credit could be made conditional on proof of insurance for a child.[10] For middle-income families, a portion of the standard deduction could be made conditional on proof of insurance for adults. For lower-income families, part of the Earned Income Tax Credit could be conditioned on obtaining health coverage.

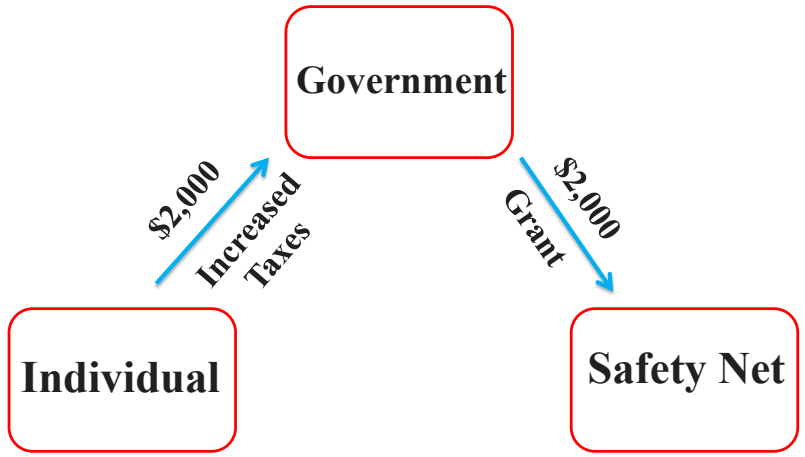
Is an $8,000 refundable tax credit for families adequate? The typical employer plan these days costs twice that amount.[11] But in almost everyone's estimation the typical employer plan buys a lot of wasteful and unnecessary care. The $8,000 would pay for the core, catastrophic insurance that we want everyone to have. Any additional coverage purchased by employees and their employers would be made with after-tax dollars.

Every dollar spent on additional insurance would be an unsubsidized dollar. It would be a dollar that would otherwise be take-home pay. Given this new subsidy structure, it is highly likely that insurers would begin offering plans that cost $8,000 or close to it. Of course, these lower cost plans would have fewer options than the typical employer plan today.

A Health Care Safety Net. If the individual chose to be uninsured, the unclaimed tax relief would be sent to a safety net agency providing health care to the indigent in the community where the person lives, so that it would be available there in case he generates medical bills he cannot pay from his own resources. The result would be a system under which the uninsured as a group effectively pay for their own care, without any individual or employer mandate. By the very act of turning down the tax credit for health insurance in choosing not to insure, uninsured individuals would pay extra taxes equal to the average amount of the free care given annually to the uninsured. The subsidies for the insurance purchased by the insured would then effectively be funded by the reduction in expected free care the insured would have consumed if uninsured. [See Figures II and III.]

Figure II

An Insured Individual Becomes Uninsured



Source: John C. Goodman.

Under this approach, money follows people. If everyone in Dallas County opts to obtain private insurance, there would be no need to fund a safety net and all the government's support would be in the form of tax credits for health insurance premiums. On the other hand, if everyone in Dallas County opts to be uninsured, all the unclaimed tax credits would go to safety net institutions in Dallas.

This is an easy reform to implement, even if peoples' insurance status changes often over the course of a year. All the federal government needs to know is how many people live in each community. If the tax credits claimed on income tax returns fall short of their potential for the community as a whole, the balance would be provided in the form of a block grant to be spent at the local level.

Block Grant Medicaid to the States

Medicaid, the health care program for the poor, now costs roughly $500 billion a year in federal and state spending, and is growing like Jack's beanstalk. Medicaid is

jointly financed by the states and the federal government, with the federal contribution determined by a formula under which it pays about 60 percent of the costs on average. The National Association of State Budget Officers reports that states already spend more on Medicaid than on any other program — including K-12 education.[12] The U.S. Centers for Medicare and Medicaid Services projects that total annual federal and state costs for Medicaid will be over $800 billion by 2019.[13] President Obama's latest budget projects federal Medicaid costs alone will total nearly $4.4 trillion over the next 10 years.[14]

Roughly 60 million Americans are on Medicaid today.[15] Under ObamaCare, the total will grow to 85 million, and to nearly 100 million by 2021, according to the CBO. These numbers will change some under the recent Supreme Court ruling, which empowers states to refuse the expansion of Medicaid mandated by ObamaCare.

Despite all the dollars spent, Medicaid pays doctors and hospitals only 60 percent or less of costs for their health services to the poor. Consequently, the poor on Medicaid face grave difficulties obtaining timely and essential health care, and suffer worse health outcomes as a result. For example, as Scott Gottlieb of the New York University School of Medicine points out:[16]

- A 2010 study of throat cancer "found that Medicaid patients and people lacking any health insurance were both 50 percent more likely to die when compared with privately insured patients."[17]
- A 2011 study of heart patients "found that people with Medicaid who underwent coronary angioplasty were 59 percent more likely to have…strokes and heart attacks, compared with privately insured patients. "[18]
- The same study found that Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn't have health insurance.[19]
- Furthermore, a 2010 study of major surgical procedures "found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death."[20] [See Figure IV.]

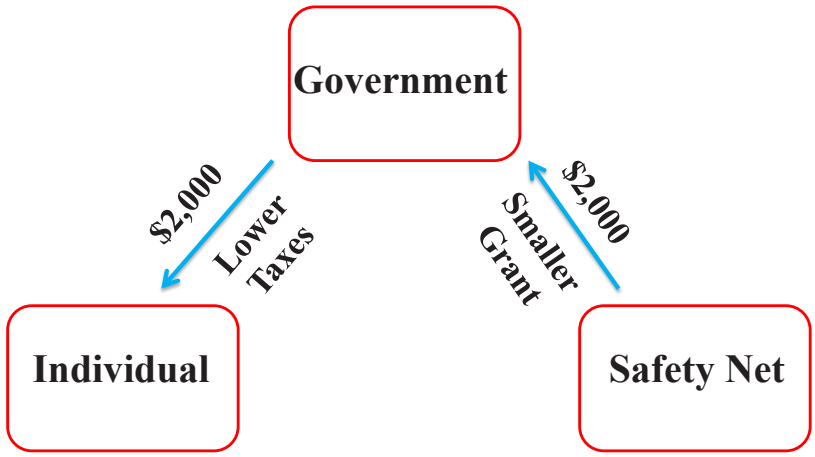
Health economist Austin Frakt takes issue with these studies, claiming that Medicaid and non-Medicaid populations are fundamentally different.[21] Frakt points to some studies finding that Medicaid makes a positive difference over being uninsured.[22] But the results would probably have been just as good or better if we spent the money giving free care to vulnerable populations. Moreover, even with their Medicaid cards, enrollees turn to emergency rooms for their care twice as often as the privately insured and the uninsured.[23]

The problem posed by lack of access to timely care in Medicaid can be illustrated by the case of Deamonte Driver, a12-year-old from a poor Maryland family. When Deamonte complained of a toothache, his mother tried to find a dentist who would take Medicaid. But only 900 out of 5,500 dentists in Maryland do. By the time she found one, and got the boy to the appointment, his tooth had abscessed and the infection had spread to his brain. Now she needed to find a brain specialist who took Medicaid. Before she could find one, the boy was rushed to Children's Hospital for emergency surgery. He called his mother from his hospital room one night to say, "Make sure you pray before you go to sleep." In the morning, he was dead.[24]

The poor would ultimately greatly benefit by extending to Medicaid the enormously successful, bipartisan 1996 reforms of Aid to Families with Dependent Children (AFDC) program. Like Medicaid, federal AFDC funding was previously based on a matching formula, with the

Figure III

An Uninsured Individual Becomes Insured

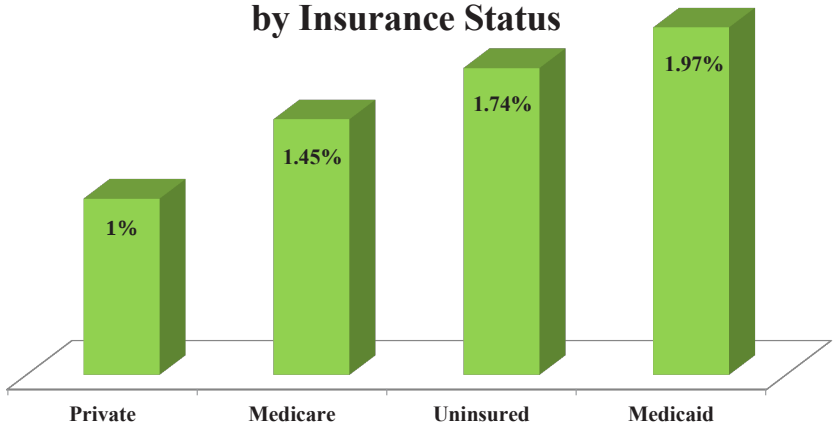


Source: John C. Goodman.

federal government giving more to each state the more it spent on the program, effectively paying the states to spend more. The reform returned the federal share of spending on AFDC to each state in the form of a "block grant" for a new welfare program designed by the state based on mandatory work for the able bodied. The key to the 1996 reforms was that the block grants to each state were finite, not matching, thus, the federal funding did not vary with the amount the state spent. If a state's new program cost more, the state had to pay the extra cost. If the program cost less, the state could keep the savings.

The reform was shockingly successful, with two-thirds leaving the program for work within 10 years. Their incomes consequently increased by 25 percent, while costs to taxpayers were 50 percent less after 10 years than they would have been otherwise.[25]

Figure IV
In-Hospital Surgical Patient Death Rate by Insurance Status



Source: Damien J. LaPar et al., "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Volume 252, Number 3, September 2010, pages 544-551.

What the states could do with Medicaid block grants has been shown by Rhode Island, which received a broad waiver from federal Medicaid requirements in 2008 in return for a fixed cap on federal financing for 5 years. The state turned to managed care, competitive bidding by health care providers, and comprehensive case management by private insurers for those on Medicaid. It shifted more long term care out of nursing homes to home and community-based care.

The Lewin Group, a well-known health care consulting firm, concluded that the Rhode Island reforms were "highly effective in controlling Medicaid costs" while improving "access to more appropriate services."[26] According to one of the program's designers, the state's costs fell nearly 30 percent in the first 18 months. Although his successor said the savings could not be verified, it is indisputable that the poor enjoy greater access to care because the program assigned them providers to ensure they received essential care.[27]

The poor would be best served if each state used its Medicaid funds to help them buy the private health insurance of their choice. The voters of each state would decide how much assistance to give each family at different income levels to ensure the poor were able to obtain adequate health insurance. This would vary with the different income and cost levels of each state. The poor would then be free to choose the private health insurance they preferred, including Health Savings Accounts, liberating them from the Medicaid ghetto.

As a result, the poor would enjoy the same health care as the middle class because they would have the same health insurance as the middle class — paying market rates to doctors and hospitals for health care.

With such a reform, if an individual or family is too poor to buy health insurance, the government would give them the additional funds to buy it. This could quite possibly be done with a net reduction overall in Medicaid spending, given the experience with the 1996 AFDC reforms and the Rhode Island Medicaid waiver. For instance, the CBO estimates the Medicaid block grant proposed by House Budget Committee Chairman Paul Ryan would save close to $1 trillion over 10 years.

Guaranteed Renewability

At a New Hampshire townhall in 2009, President Obama said that under his health plan,

> "[I]nsurance companies…will not be able to drop your coverage if you get sick. They will not be able to water down your coverage when you need it. Your health insurance should be there for you when it counts — not just when you're paying premiums, but when you actually get sick. And it will be when we pass this plan."[28]

In making the above argument, President Obama was trying to take credit for solving a problem that had already been largely solved. It has long been illegal in America to drop or water down health insurance coverage for individuals after they become sick. Indeed, the prohibition was enacted nationally in the landmark, bipartisan Health Insurance Portability and Accountability Act (HIPAA) in 1996, and had already been law in the states. HIPPA even provides that if an individual loses employer-sponsored health insurance coverage for any reason (changing jobs, layoffs, employer goes out of business, divorce) any private insurer to whom the person applies within two months must take them, regardless of health condition. That is workable because such individuals are not trying to game the system, waiting until they are sick before they buy guaranteed coverage, but are actually trying to responsibly maintain continuous coverage.

Before ObamaCare, the law did allow insurers to cancel coverage if an applicant for insurance lied about his or her medical condition or history — involving fraud by the individual. But the alternative safety net discussed here would still cover them, through state high-risk pools and Medicaid health insurance premium assistance.

The law in America has long provided for guaranteed renewability, which means that as long as an individual continues to pay the premiums, an insurance company cannot cut them off because they get sick, nor can it impose discriminatory premium increases any greater than for anyone else in the original risk pool.

Health Status Insurance

Guaranteed renewability should be extended to a new standard provision that can be included in health policies: protection specifically against the development of pre-existing conditions. Not only could someone who becomes sick while insured keep his policy at standard rates: if he or she decides to choose a new insurer after becoming sick, the previous insurer would be obligated to make payments to the new insurer to cover the likely added costs of the pre-existing condition. The cost of that expanded coverage would be included in the premiums to be paid for the policy.

Health status insurance to cover the development of costly conditions would begin a trend toward higher risk-adjusted premium payments to insurers of the sick with costly chronic conditions.[29] That could and should be extended by risk-adjusting Medicaid premium payments for the private insurance chosen by the poor.

Risk-adjusted premium payments would effectively create a market for the sickest patients, because the sick would be just as desirable as the healthy to every health plan. This would foster the development of health plans that specialize in managing care for the sick with costly chronic diseases. A successful model for such plans already exists as an alternative to traditional Medicare. Private insurers offer Medicare Advantage plans — which provide more comprehensive benefits than traditional Medicare — and have enrolled about a quarter of seniors. There are Medicare Advantage plans that actively compete to cover the sickest Medicare beneficiaries with special needs.

And there would be active, entrepreneurial efforts to find low-cost ways to solve health problems — in order to lower costs for both the insured and their insurers.[30] This would further expand access to the highest quality care for the sickest Americans.

A further solution to the problem of pre-existing conditions would be to allow employers to purchase individually owned, portable insurance for their employees. Health insurance coverage prior to the development of pre-existing conditions could be further expanded by eliminating cost-increasing government mandated benefits, freeing workers to choose their own coverage. Studies show that as many as one out of every four uninsured Americans have been priced out of the market for health insurance by those government imposed cost increases.[31] Freeing insurers to sell insurance across state lines nationwide would further expand coverage through competition further reducing insurance costs.

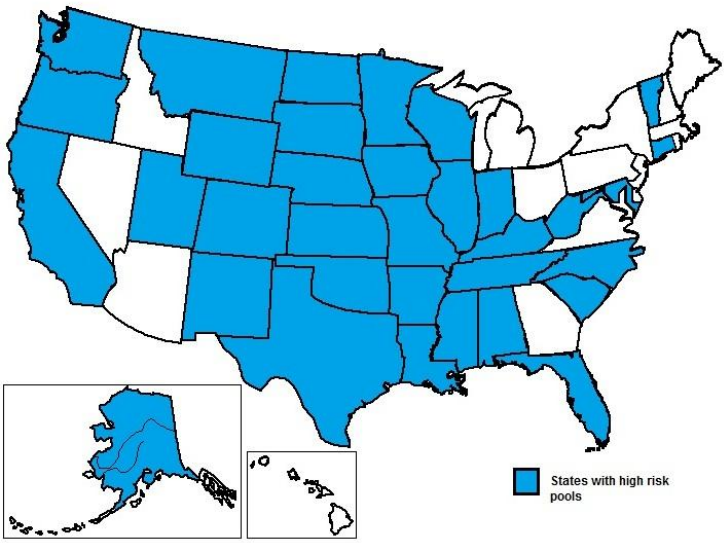
Portability

For the working age population, one of the biggest problems in the U.S. health care system is that health insurance is not portable. In general, when an individual leaves an employer, they must eventually lose the health insurance plan the employer provided. Almost all the problems people have with pre-existing conditions arise because of a transition from employer-provided insurance to individually purchased insurance. The problems arise because the employee does not own employer-based insurance.

Portability allows a long-lasting relationship with a health plan, which in turn allows a long-lasting relationship with providers of care. This means that people who switch jobs frequently can still have continuity of care — which is often a prerequisite for high-quality care. Moreover, people who have portable insurance will not be locked into jobs solely because their benefits are not portable. Portable benefits are consistent with a mobile labor market, which is a necessary component of a dynamic, competitive economy. Finally, a system of portable benefits is one in which the employer's role is financial rather than administrative. Employers, therefore, can specialize in what they do best, leaving health insurance to insurance firms.

Figure V

States with High-Risk Pools



Source: Statehealthfacts.org, Kaiser Family Foundation

We do not have portable insurance today because federal tax law generously subsidizes employer-provided insurance, but offers very little tax relief to those who must purchase insurance on their own. In addition, state laws often discourage or do not allow employers to pay premiums for workers' individual insurance — so-called "list-billing."[32]

The health insurance tax credit mentioned previously would solve the problem of health insurance portability. Workers could use the tax credit to buy their own health insurance that they own and take with them from job to job. Employers could also use the credit or its equivalent to buy portable health insurance for their workers. That would be a fringe benefit preferred by workers — much better than health insurance tied to one job. It would also be better for employers, allowing them to just make a financial contribution to health insurance, and leave the administration of the insurance to insurance companies expert in the field.

Most employers, and certainly all small business owners, would prefer not to be in the health insurance business. In a world of portable insurance, they would not have to be. Rather than offering health insurance as a defined benefit, employers should be able to offer health insurance as a defined contribution. This would allow them to make a monetary contribution to the health insurance premiums of each employee, each pay period. The 401(k) retirement plan is a model. New employees would know not only their salary, but also how much the employer is willing to pay toward the cost of insurance. In this way, the employer's role in health insurance would be made purely financial. In fact, employers would have no more involvement in the employee's health plans than they have in their employee's 401(k) portfolio.

Transitional Step: High-Risk Pools for the Uninsurable

Temporary adjustments to the current system are needed for the transition to a fully market-based system.

After a market-based system is established, most individuals and families will be insured from birth, and changes in their health status can be covered by health status insurance. However, in the meantime, a step necessary to ensure a complete safety net during this transition is for each state to use part of its Medicaid block grant to set up a high risk pool. Those who become too sick while uninsured to purchase health insurance in the market — perhaps because they have contracted cancer or heart disease, for example — would be guaranteed coverage through the risk pool. They would be charged a premium based on their ability to pay, ensuring that they would not be asked to pay more than they could afford. Federal and state funding would cover remaining costs.

Similar risk pools already exist in over 30 states [see Figure V]. In general, they work well at relatively little cost to the taxpayers because few people actually become truly uninsurable in the private market — only about 1 to 2 percent.[33] Trying to force the uninsured who cannot obtain private coverage on their own into the same insurance market as everyone else, through such regulations as guaranteed issue and community rating, raises the cost of health insurance for the general public, sharply increasing the number of people who choose to go without insurance. For this reason, providing a separate pool for the uninsured who become uninsurable is a much better policy.

We have made it so easy for people to get insurance after they get sick that the need for a risk pool is not great. Only 82,000 have enrolled and they do not cost much.[34] It would be best, however, to tighten the requirements a bit to discourage gaming: in addition to a six-months-without-insurance requirement, people should be penalized based on their income, their assets and the length of time they have been willfully uninsured.[35]

High-risk pools would allow individuals to obtain health insurance without excluding pre-existing conditions. Most insurers limit coverage for pre-existing conditions for only a few months. But each state's high-risk pool could provide coverage for pre-existing conditions during those excluded months, or for however long is necessary to get coverage for that condition.

A Comprehensive Health Care Safety Net

With these reforms, those who have insurance plans they like could keep them, those who could not afford insurance would be given the necessary help to buy it, and those who nevertheless remain uninsured and then become too sick to buy it would have a back-up safety net in the high-risk pools. Further avenues would be provided for those in need to obtain health care from safety-net community health clinics. Everyone would be able to get essential health care when they need it, with no individual or employer mandate.

Moreover, new solutions for pre-existing conditions would be provided through the high-risk pools, the new health status insurance coverage and the development of portable insurance. The development of extensive risk-adjusted premium payments for those with costly chronic illnesses would further extend access to the highest quality care for the sickest Americans.

Moreover, all of this would be accomplished while *shrinking* entitlement burdens and averting the massive expansion of taxes and government spending involved in ObamaCare. In replacing ObamaCare, these reforms would reduce federal spending under that wasteful and unnecessary program by at least the $1.76 trillion over the next 10 years. Yet the universal access to essential health care provided by the above safety net reforms will not be achieved by ObamaCare. The block grant to the states of Medicaid would further reduce the growth of government spending on that program, as CBO scores current Medicaid block grant proposals.

John C. Goodman is president and CEO of the National Center for Policy Analysis, a Research Fellow with The Independent Institute and author of Priceless: Curing the Healthcare Crisis. *Peter Ferrara is a senior fellow at the National Center for Policy Analysis, director of entitlement and budget policy at the Heartland Institute, and a senior adviser on entitlement reform and budget policy for the National Tax Limitation Foundation.*

References and sources can be found in the online version at www.ncpa.org/pub/ib116.

About the NCPA

The National Center for Policy Analysis (NCPA) is a nonprofit, nonpartisan public policy research organization, established in 1983. Our goal is to develop and promote private, free-market alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. We bring together the best and brightest minds to tackle the country's most difficult public policy problems — in health care, taxes, retirement, small business, and the environment. In doing so, we propose reforms that liberate consumers, workers, entrepreneurs and the power of the marketplace.