

Replacing the Affordable Care Act the Right Way

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On the basis of campaign promises in the 2016 election, Americans can reasonably expect significant parts of the Affordable Care Act (ACA) to be repealed and replaced over the next two years. The incoming Trump administration and the US Congress—both Democrats and Republicans—will have a rare and important opportunity to enact substantive reforms that can improve the nation’s healthcare system. To ensure that the opportunity is not squandered, lawmakers should focus on addressing long-standing problems in government policies that have led to a proliferation of relatively low-value healthcare spending.

Reform, if done correctly, will simultaneously improve quality and put downward pressure on prices. The only surefire way to achieve these goals is by replacing the ACA’s government-centric approach with a consumer-centric approach that realigns incentives, unleashes market forces, and increases competition. I begin this paper with a brief overview of why the ACA failed and what lessons must be learned from its failure. I then propose a vision for reform and six key steps for the ACA replacement plan: (1) realigning incentives so consumers focus on value, (2) sensibly addressing the preexisting condition problem, (3) promoting portable, longer-term insurance, (4) providing financial assistance for lower-income people to purchase health care, (5) capping the exclusion for employer-sponsored insurance (ESI), and (6) fundamentally reforming Medicaid.

THE FAILURE OF THE ACA

As a result of government policy, most Americans had comprehensive health insurance before the ACA was enacted. Because premiums for ESI are not taxed, employers have an incentive to offer comprehensive coverage. Today, nearly half of all Americans receive coverage through the workplace. In addition, the Medicare and Medicaid programs, which collectively cover more than one-third of Americans, mandate comprehensive coverage for enrollees.

Comprehensive insurance is expensive, but the costs—forgone wages, government borrowing, and higher taxes—are largely invisible. Comprehensive insurance also produces moral hazard, leading many people to consume medical services that cost much more than the corresponding benefits. Moreover, comprehensive insurance also carries large administrative costs from insurers serving as the intermediaries between providers and consumers.

With limited exceptions, the ACA mandated that all Americans purchase comprehensive insurance. Virtually all plans must meet the law's requirements on benefit packages, actuarial value standards, and pricing. Although plans offered by large employers typically satisfied most of the new requirements, most plans available in the individual and small-group markets did not do so. The available choices for individual market plans have declined markedly. Plan variation now largely consists of the size of cost-sharing amounts, including deductibles, and the scope of provider networks. As plans became standardized after enactment of the ACA, premiums and cost sharing increased, and provider networks shrank as insurers tried to stem losses.

Premiums increased the most for the young and healthy. Those individuals' participation was essential for the law's regulatory structure to work, however, so the ACA contained a mixture of sweeteners and coercion to induce them to purchase coverage. The sweeteners were subsidies that were most generous for people with income below 200 percent of the federal poverty line (FPL).¹ The coercion was the tax penalty for failing to purchase the required coverage. The subsidies have been largely responsible for the makeup of the risk pool as two-thirds of all exchange enrollees have income below 200 percent of the FPL.² Overall individual-market enrollment is significantly below expectations. About 19 million people will be enrolled in the individual market in 2016³—12 million

1. Two hundred percent of the FPL is about \$24,000 for a single person. The ACA authorized premium tax credits for people enrolling in an exchange plan who generally have income between 100 and 400 percent of the FPL and are not eligible for another government healthcare program or for insurance through the workplace. The law also authorized cost-sharing reduction payments, which lower plan deductibles and other cost-sharing amounts, for certain people with income below 250 percent of the FPL.

2. US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016.

3. According to Mark Farrah Associates, 20.5 million people were enrolled in individual market plans at the end of March 2016. Given the large attrition in exchange enrollment over the course of 2016, it is most likely that there will be about 19 million individual market enrollees, on average, in 2016. Mark Farrah Associates, "The Latest Health Insurance Market Trends," June 22, 2016.

fewer than the Congressional Budget Office (CBO) projected would be enrolled in its April 2014 estimate.⁴

Because the exchanges—with their complex web of mandates, subsidies, and regulations—did not produce nearly the coverage gain expected, most of the reduction of the uninsured population occurred because the ACA also expanded Medicaid.⁵ Medicaid expansion was controversial for many reasons, including relatively poor health outcomes for enrollees,⁶ large crowd-out of private coverage,⁷ reduced incentives to work,⁸ and the crowd-out of other state priorities such as education, infrastructure, and adequate funding of public sector pensions.⁹ Moreover, states receive a much higher reimbursement rate for Medicaid expansion enrollees than for traditional Medicaid enrollees such as lower-income children, pregnant women, senior citizens, and the disabled. Therefore, the ACA created a major bias in federal policy in favor of the expansion population at the expense of traditional Medicaid populations who would face greater competition from new enrollees for access to medical care. Despite these concerns, 31 states and the District of Columbia have adopted the ACA's Medicaid expansion. As of August

4. In April 2014, CBO projected that 24 million people would be enrolled in the exchanges in 2016 with 7 million people buying individual market coverage off the exchange. Congressional Budget Office (CBO), *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014.

5. From 2014 through 2016, the federal government has reimbursed 100 percent of the amount of state spending on newly eligible enrollees—nondisabled, working-age adults with income between the state's previous eligibility threshold and 138 percent of the FPL. The reimbursement rate is scheduled to phase down in 2017 until it reaches 90 percent in 2020, where it is scheduled to remain indefinitely.

6. Many observational studies show that Medicaid is associated with poor health outcomes. One example is a study of nearly 900,000 procedures from 2003 to 2007, which controlled for a multitude of patients and hospital characteristics and found that Medicaid enrollees were significantly more likely than others to experience complications, to spend additional time in the hospital, and to die in the hospital. Damien J. LaPar et al., "Primary Pay Status Affects Mortality for Major Surgical Operations," *Annals of Surgery* 252, no. 3 (September 2010): 544–51. After reviewing this study and several others, I concluded in a 2011 paper that Medicaid enrollees frequently receive inferior medical treatment, are often assigned to less-skilled surgeons, and tend to receive poorer postoperative instructions. See Brian Blase, "Medicaid Provides Poor Quality Care: What the Research Shows" (Backgrounder No. 2553, Heritage Foundation, Washington, DC, May 5, 2011).

7. Gruber and Simon estimated Medicaid crowd-out at 60 percent for expansions between 1996 and 2002. Jonathan Gruber and Kosali Simon, "Crowd-Out 10 Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?," *Journal of Health Economics* 27 (2008): 201–17.

8. One study estimated that pre-ACA Medicaid expansions led to a 1–2 percent reduction in labor supply from women and a 2–4 percent reduction in labor supply from men. Cathy J. Bradley, Chun-Chieh Hu, and Lindsay M. Sabik, "Medicaid Expansions and Labor Supply among Low-Income Childless Adults: Evidence from 2000–2013" (paper presented at a meeting of the American Society of Health Economists, Philadelphia, PA, June 13, 2016).

9. Marc D. Joffe, "Long-Term Trends in Medicaid Spending by the States" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, September 2015).

2016, 15.7 million more people were enrolled in Medicaid than had been enrolled in the late summer of 2013—a 27 percent increase.¹⁰

The Medicaid expansion has proved much more expensive than expected. Total federal spending on the expansion in 2015 was at least 50 percent above CBO’s April 2014 projection of \$42 billion.¹¹ Part of the reason for this unanticipated expense is that states are paying insurers much higher rates than the government projected; in fact, spending per newly eligible enrollee was 49 percent higher in 2015 than was expected by the Obama administration in a 2014 report.¹²

New Medicaid enrollment has also greatly exceeded projections; in many states, enrollment is more than twice the projected number.¹³ Moreover, calculations based on a recent study coauthored by economist Jonathan Gruber show that about two-thirds of new Medicaid enrollees in 2014 were eligible for the program under previous state eligibility criteria.¹⁴ Although those people may not have had an insurance card before the ACA, they were not really uninsured because they could generally enroll in Medicaid as soon as they needed medical care. CBO’s expectation was that only about one-sixth of new Medicaid enrollees would have been eligible under previous state criteria.¹⁵

Evidence from Oregon’s unique Medicaid expansion suggests that the ACA’s Medicaid expansion is a poor use of taxpayer dollars.¹⁶ Despite a significant increase in healthcare use, Oregon expansion enrollees did not show discernible improvements in any of the three physical health metrics evaluated:

10. Centers for Medicare & Medicaid Services (CMS), *Medicaid & CHIP: August 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*, November 3, 2016.

11. Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO’s April 2014 Baseline*, April 2014; Brian Blase, “Commentary: Cost of Medicaid Expansion Far Exceeds Initial Estimates,” *Philadelphia Inquirer*, August 15, 2016.

12. In its 2014 Medicaid actuarial report, CMS estimated that the 2015 cost per newly eligible enrollee would be \$4,281. The actual cost, however, was approximately \$6,366. CMS, *2015 Actuarial Report on the Financial Outlook for Medicaid*, June 2016.

13. Jonathan Ingram and Nicholas Horton, “ObamaCare Expansion Enrollment Is Shattering Projections: Taxpayers and the Truly Needy Will Pay the Price” (Foundation for Government Accountability, Naples, FL, November 16, 2016).

14. Using Census Bureau data, the authors apportion the newly insured in 2014 as 37 percent from exchange subsidies, 19 percent as newly eligible Medicaid enrollees, and 44 percent as new Medicaid enrollees who were eligible under pre-ACA criteria. Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, “Disentangling the ACA’s Coverage Effects—Lessons for Policymakers,” *New England Journal of Medicine* 375, no. 17 (October 2016): 1605–8.

15. CBO, *Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016 to 2026*, March 2016.

16. In 2008, Oregon was able to expand its Medicaid program to include a limited number of low-income, nondisabled, working-age adults. The state decided to assign those slots using a lottery; people who won the lottery and submitted their paperwork got Medicaid coverage. Therefore, Oregon’s Medicaid expansion produced a randomized experiment that enabled researchers to better study the effects of Medicaid.

blood pressure, cholesterol, or blood sugar.¹⁷ Perhaps most importantly, the researchers estimated that expansion enrollees placed between 20 and 40 cents of value on each dollar of Medicaid spending on their behalf—an estimate that suggests a major opportunity for policy improvement.¹⁸

NEED TO REDUCE GOVERNMENT BIAS TOWARD COMPREHENSIVE COVERAGE

This past year, Americans spent \$3.2 trillion on health care—an amount equal to nearly \$10,000 for each American.¹⁹ Only a relatively small share of this spending is controlled by consumers, however. Nearly 90 percent comes from third-party payers (mainly health insurers), with the bulk of the financing coming from the government and employers. Health policy expert Devon Herrick notes that “health care is the only major sector of our economy where consumers typically do not make decisions based on comparison shopping.”²⁰

The key to bringing about better health care at lower prices is to start chipping away at government policies that bias people’s purchasing decisions toward comprehensive insurance. In a 2009 *Atlantic* essay titled “How American Health Care Killed My Father,” GSN president and CEO David Goldhill put it this way:

The most important single step we can take toward truly reforming our system is to move away from comprehensive health insurance as the single model for financing care. And a guiding principle of any reform should be to put the consumer, not the insurer or the government, at the center of the system. . . .

A more consumer-centered healthcare system would not rely on a single form of financing for healthcare purchases; it would make use of different sorts of financing for different elements of care, with routine care funded largely out of our incomes, (2) major, predictable expenses (including much end-

17. The study did find that Medicaid lowered medical debt and the prevalence of depression. Katherine Baicker et al., “The Oregon Experiment—Effects of Medicaid on Clinical Outcomes,” *New England Journal of Medicine* 368, no. 18 (May 2, 2013): 1713–22.

18. Amy Finkelstein, Nathaniel Hendren, and Erzo F. P. Luttmer, “The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment” (NBER Working Paper No. 21308, National Bureau of Economic Research, Cambridge, MA, June 2015).

19. Anne B. Martin et al., “National Health Spending: Faster Growth in 2015 as Coverage Expands and Utilization Increases,” *Health Affairs* 36, no. 1 (January 2017).

20. Devon M. Herrick, “The Market for Medical Care Should Work Like Cosmetic Surgery” (Policy Report No. 349 National Center for Policy Analysis, Dallas, TX, May 2013).

of-life care) funded by savings and credit, and (3) massive, unpredictable expenses funded by insurance.²¹

Experience shows that healthcare quality improves and prices fall when comprehensive insurance is not the intermediary between providers and consumers. For example, the price of medical care grew at double the rate of inflation between 1992 and 2012, but the price of cosmetic surgery—which consumers pay almost exclusively out of pocket—grew at less than half the rate of inflation.²² As ophthalmologists competed for consumer dollars, the price of LASIK eye surgery declined by 25 percent between 1999 and 2011, even as quality markedly improved.²³

The case against government bias toward comprehensive insurance is bolstered by numerous studies suggesting that medical care is a small relative determinant of overall health. This result also indicates that it may make more sense to allocate public-health dollars to alter behavior (e.g., to fund antismoking campaigns) and to support efforts that will cause faster economic growth and boost incomes—and thus improve living conditions.

In 2016, researchers with the Determinants of Health project modeled the factors correlated with health outcomes.²⁴ They estimated that medical care determines only about 11 percent of health—far less than individual behavior (38 percent), social circumstances (23 percent), or genetics and biology (21 percent).²⁵ (Physical environment determines the remaining 7 percent.)²⁶ These estimates are similar to those of several other studies. For example, J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman looked at the determinants of early death, estimating that behavior (40 percent), genetics (30 percent), and social circumstances (15 percent) were more important than medical care (10 percent).²⁷ In addition to those estimates, the only two health insurance experiments—the Oregon Medicaid experiment discussed previously and the Rand Health Insurance Experiment—have not found a beneficial effect on physical health from people receiving comprehensive insurance.²⁸

21. David Goldhill, “How American Health Care Killed My Father,” *Atlantic*, September 2009.

22. Herrick, “Market for Medical Care Should Work Like Cosmetic Surgery.”

23. *Ibid.*

24. Edwin Choi et al., “Determinants of Health,” Goinvo, accessed December 8, 2016, <http://www.goinvo.com/features/determinants-of-health/>.

25. *Ibid.*

26. *Ibid.*

27. J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, “The Case for More Active Policy Attention to Health Promotion,” *Health Affairs* 21, no. 2 (March 2002): 78–93.

28. In a 2007 essay for *Cato Unbound*, economist Robin Hanson discussed numerous studies that show that variations in medical spending usually have no statistically significant effect on health.

Although medical care is beneficial in many instances, it is often unnecessary and can be harmful. In 2012, the Institute of Medicine estimated that 30 percent of health care is unnecessary.²⁹ In a 2015 piece in the *New Yorker*, Atul Gawande, a surgeon and a prolific health policy writer, observed that providers and patients often underestimate the costs of medicine.³⁰ He cites three examples: proliferation of antibiotics for viral infections; the downsides from tests, such as increased radiation and false positives; and overdiagnosis, or positive diagnosis for conditions that develop extremely slowly and are unlikely ever to cause a patient problems.³¹

THE AIMS OF THE ACA REPLACEMENT PLAN

The ACA replacement plan should aim to (1) realign incentives so that consumers focus on value, (2) sensibly address the preexisting condition problem, (3) promote portable, longer-term insurance, (4) provide financial assistance for lower-income people to purchase health care, (5) cap the ESI exclusion, and (6) fundamentally reform Medicaid.

Realigning Incentives for Focus on Value

To better allow market forces to work, federal and state governments should place few, if any, coverage mandates on health insurance. Assessments of the value of extra coverage should be made by the people who are best positioned to

Hanson also discusses the Rand experiment in depth, in which the researchers randomly divided experiment participants into four groups on the basis of the generosity of health insurance coverage. The main result: “For the five general health measures, we could detect no significant positive effect of free care for persons who differed by income . . . and by initial health status.” Robin Hanson, “Cut Medicine in Half,” *Cato Unbound*, September 10, 2007; see also Robert H. Brook et al., “The Effect of Coinsurance on the Health of Adults: Results from the RAND Health Insurance Experiment” (Rand report, Rand Corporation, Santa Monica, CA, December 1984).

29. According to the Institute of Medicine, unnecessary spending includes use beyond evidence-established levels, discretionary use beyond benchmarks, unnecessary choice of higher-cost services or providers, errors, care fragmentation, excessive administrative costs, excessively high prices, missed prevention opportunities, and fraud. Mark Smith et al., eds., *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America* (Washington, DC: National Academies Press, 2012).

30. Atul Gawande, “Overkill,” *New Yorker*, May 11, 2015.

31. As an example, Gawande wrote, “Over the past two decades, we’ve tripled the number of thyroid cancers we detect and remove in the United States, but we haven’t reduced the death rate at all. In South Korea, widespread ultrasound screening has led to a fifteen-fold increase in detection of small thyroid cancers. Thyroid cancer is now the No. 1 cancer diagnosed and treated in that country. But . . . the death rate hasn’t dropped one iota there, either. (Meanwhile, the number of people with permanent complications from thyroid surgery has skyrocketed.) It’s all over-diagnosis. We’re just catching turtles,” conditions that develop extremely slowly and are unlikely to ever cause a patient problems. *Ibid.*

make decisions about the tradeoffs involved. For example, economists estimate that the ACA requirement that companies offer dependent coverage through the age of 26 results in a wage reduction of \$1,200 for all workers regardless of whether they have dependents.³² Rather than the federal government imposing this tradeoff, firms and their workers should decide whether the coverage is worth the wage reduction. While the ACA represented an unprecedented increase in federal health insurance mandates, the National Conference of State Legislatures estimates that there are also 2,000 state insurance mandates—for healthcare services that must be covered, categories of healthcare providers that must be covered, and people, such as dependent children, who must be covered.³³

One excellent way to improve incentives would be to expand health savings accounts (HSAs). That expansion would likely significantly improve healthcare markets and increase consumers' focus on value and the price of services. HSAs allow people to self-insure rather than rely on government transfer programs, as people will tend to accumulate money in their HSAs well into middle age and then make expenditures from those accounts when they are older. A Rand Corporation study indicates that cost sharing reduces use of healthcare services without significantly affecting the quality of care and without adverse effects on health.³⁴ The ACA replacement plan should increase the current limits on what people can place in HSAs, which will be \$3,400 for self-only plans and \$6,750 for family plans in 2017, and should disconnect HSAs from the purchase of high-deductible health plans.

Sensibly Addressing Preexisting Conditions

Health reform must protect people with preexisting conditions who have behaved responsibly as well as people with coverage who develop an expensive condition.³⁵

32. Gopi Shah Goda, Monica Farid, and Jay Bhattacharya, "The Incidence of Mandated Health Insurance: Evidence from the Affordable Care Act Dependent Care Mandate" (NBER Working Paper No. 21846, National Bureau of Economic Research, Cambridge, MA, January 2016).

33. National Conference of State Legislatures (NCSL), *State Insurance Mandates and the ACA Essential Benefits Provisions* (Washington, DC: NCSL, August 30, 2016). If five states had a particular mandate, such as chiropractic coverage, it would count as five total mandates.

34. Rand Corporation, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate" (Rand Health Research Highlights, Rand Corporation, Santa Monica, CA, 2006).

35. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 generally requires that group health plans cannot deny coverage to people who had maintained creditable coverage in the recent past without any significant breaks. HIPAA does not dictate the premiums that insurers charge, although the plans may not ask a worker to "pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual."

This protection must be established without creating the incentive—as the ACA did—for people to wait until they need medical care before purchasing coverage.³⁶

First, it is important to put this problem in perspective. Most people either have insurance or do not have an expensive medical condition that prevents them from obtaining insurance. A 2003 CBO study estimated that only 3.5 percent of people were uninsured because their health was too poor to be offered an insurance plan.³⁷ The relatively small number of people who enrolled in a federally funded high-risk pool created by the ACA—the Pre-existing Condition Insurance Plan (PCIP)—provides some evidence that the problem of preexisting conditions was not nearly as large as ACA advocates suggested.

PCIP was open to people who had been without coverage for at least six months and who either had a preexisting condition or had been denied coverage. In April 2010, CMS projected that 375,000 people would gain coverage through the PCIP program in 2010 and that the \$5 billion in funding would be exhausted by 2012.³⁸ CBO projected that 400,000 people would enroll by the end of 2011.³⁹ However, only 48,879 people had enrolled in PCIP as of December 31, 2011, and more than half of the funding remained by the end of 2012.⁴⁰ The PCIP experience suggests that addressing the preexisting condition problem will not be nearly as expensive as previously thought and that the problem certainly did not require the ACA.

Before the ACA, 35 states operated high-risk pools; those pools covered 226,615 people by the end of 2011.⁴¹ With the enactment of the ACA, these high-risk pools have closed, and enrollees have largely migrated to the exchanges. If the ACA is repealed, states will be free to reinstate high-risk pools to help people with expensive health conditions. Congress could provide federal funding for these pools.

Focusing on Longer-Term Portable Insurance

Just as high-risk pools can provide assistance for people with preexisting conditions who do not have a secure source of coverage, longer-term health insurance

36. Paul Demko, “Gaming Obamacare,” *Politico*, January 12, 2016.

37. CBO, *How Many People Lack Health Insurance and for How Long?*, May 2003.

38. Richard S. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” CMS Office of the Actuary, April 22, 2010.

39. Douglas W. Elmendorf to the Honorable Michael B. Enzi, CBO, June 21, 2010, http://cbo.gov/sites/default/files/cbofiles/ftpdocs/115xx/doc11572/06-21-high-risk_insurance_pools.pdf.

40. Karen Pollitz, “High-Risk Pools for Uninsurable Individuals,” Kaiser Family Foundation, August 1, 2016.

41. *Ibid.*

products (similar to term life insurance) can protect people from the possibility of developing an expensive condition and facing steep premium increases or a loss of coverage. A central problem with the ACA is the focus on short-term insurance products, along with constant disruption caused by insurers exiting the market. As stated previously, most people receive coverage through their workplace, and their coverage is disrupted when employment ends.⁴² A better model, which would also address the fact that most employees receive only a limited number of insurance plan options,⁴³ would be to allow employers to contribute fixed amounts that their workers could use to purchase coverage on the market.⁴⁴ People would be free to choose longer-term insurance products that would accompany them when they move or change jobs—thus increasing the portability of health insurance.

University of Chicago economist John Cochrane recommends that people buy policies that the insurer must renew without raising premiums.⁴⁵ Because the guaranteed renewable product provides extra protection, it would have a somewhat higher price than a one-year policy. Health economists Mark Pauly and Bradley Herring found that more than three-quarters of individual-market insurance plans in the 1980s already had implicit, if not explicit, guaranteed renewability at premiums whose rate of increase was based only on average growth in expenses.⁴⁶ A person with a long-term guaranteed renewable product

42. In the event that a covered employee is terminated for reasons other than gross misconduct, the employer is federally required to offer the employee continuation in that coverage for 18 months. Employee Benefits Security Administration, US Department of Labor, *An Employer's Guide to Group Health Continuation Coverage under COBRA*, September 2015.

43. Eighty-three percent of firms offering insurance in 2016 offered only one type of plan, although larger firms are more likely to offer at least one type of plan. Kaiser Family Foundation, "Types of Plans Offered," in *2016 Employer Health Benefits Survey* (Menlo Park, CA: Kaiser Family Foundation, 2016).

44. For an in-depth discussion of the defined contribution model, see James C. Capretta and Thomas P. Miller, "The Defined Contribution Route to Health Care Choice and Competition" ("Beyond Repeal and Replace" report, American Enterprise Institute, Washington, DC, December 2010).

45. In a 2009 *Wall Street Journal* column, Cochrane wrote, "A truly effective insurance policy would combine coverage for this year's expenses with the right to buy insurance in the future at a set price. Today, employer-based group coverage provides the former but, crucially, not the latter. A 'guaranteed renewable' individual insurance contract is the simplest way to deliver both. Once you sign up, you can keep insurance for life, and your premiums do not rise if you get sicker. Term life insurance, for example, is fully guaranteed renewable. Individual health insurance is mostly so. And insurers are getting more creative. UnitedHealth now lets you buy the right to future insurance—insurance against developing a pre-existing condition. . . . These market solutions can be refined. Insurance policies could separate current insurance and the right to buy future insurance. Then, if you are temporarily covered by an employer, you could keep the pre-existing-condition protection." John H. Cochrane, "What to Do about Pre-existing Conditions," *Wall Street Journal*, August 14, 2009.

46. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington, DC: American Enterprise Institute, 1999), 18.

would be free to choose a plan from a different insurer, with the old insurer paying the new one a fair price for any change in the person’s health status.⁴⁷ This protection from premium increases provides a natural incentive for people to remain continuously insured.

Assisting Lower-Income People with Healthcare Expenses

Government subsidies for healthcare consumption should be redirected as much as possible to people instead of through insurance companies or providers. Direct subsidies give people ownership of the money and create incentives for them to shop for the best value. Expanding HSAs, as recommended previously, allows young and healthy people to accumulate wealth and finance expenses as they age or need medical care.

Lower-income people are less able to finance HSAs. One idea would be for the federal government to make payments into those individuals’ HSAs and allow them to finance health insurance premiums out of their HSAs. Policymakers could decide the parameters of the proposal—the overall budget, the amount of payments, how to decrease the payment amounts as income increases, and which group of people to make eligible. But conceptually, this approach sends subsidies directly to the people and provides them with an additional reason to be cost-conscious consumers seeking value from the healthcare system. This alternative again emphasizes the overarching need for stronger, sustainable economic growth that raises incomes across the entire income distribution.

Capping the ESI Tax Exclusion

A 40 percent excise tax on health insurance with costs exceeding a specified amount—dubbed the “Cadillac tax”—was inserted into the ACA to address the open-ended ESI tax exclusion that disproportionately benefits higher-income workers and depresses wages.⁴⁸ A central aim of this tax was to incentivize employers to offer less costly coverage. Adding a cap on the ESI exclusion would be a simpler and fairer policy than the Cadillac tax, while tackling the same problem.

47. For more detail on how free-market risk adjustment would work, see “Turning the Exchanges into Real Markets” (Brief Analysis No. 106, Goodman Institute, Dallas, TX, April 6, 2016).

48. The ACA set a threshold at \$10,200 for individual coverage and \$27,200 for family coverage beginning in 2018. The tax would only apply to amounts above the threshold.

Reforming Medicaid

Medicaid needs fundamental reform with the goals of dramatically reducing the number of people enrolled in the program and providing a higher-quality program for remaining enrollees. The root of many of Medicaid’s problems is the uncapped federal reimbursement of program spending—a feature that encourages states to draw down as much federal money as possible without enough focus on value to either taxpayers or enrollees. Another significant problem is that stringent federal rules severely limit what states can do. Fundamental Medicaid reform would eliminate the open-ended reimbursement of state spending by providing states with fixed amounts of money while freeing them from restrictive federal rules. For lower-income enrollees as well as high-cost populations, states could provide greater assistance—either adding to the HSA deposits or providing grants to local communities for services such as health clinics or drug rehabilitation centers.

THE ROLE OF STATES IN FREEING HEALTHCARE MARKETS

State policymakers can take several actions to substantially free their healthcare markets from excessive federal rules. If the ACA is repealed and states are once again the primary regulators of health insurance, they should reduce the bias toward comprehensive insurance by eliminating insurance benefit mandates.⁴⁹ Although states would be free to impose rules such as guaranteed issue or community rating, they should not do so; instead, they should allow premiums to reflect people’s expected expenditures and address high-cost enrollees with high-risk pools or state-financed subsidies.

Much of the Mercatus Center’s state-level health policy work focuses on state regulations that hinder competition and innovation.⁵⁰ As discussed by Robert Graboyes, these regulations tend to favor large, established companies. Graboyes notes several productive actions states can take, including the following:

- Abolishing certificate-of-need requirements
- Expanding provider licensing reciprocity agreements with other states
- Allowing nurse practitioners to practice independently of physicians

49. In November 2009, CBO estimated that the ACA’s requirements to make insurance more comprehensive would increase premiums in the individual market by 27–30 percent on average. Douglas W. Elmendorf to the Honorable Evan Bayh, CBO, November 30, 2009, <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>.

50. Robert F. Graboyes, “Fortress and Frontier in American Health Care” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, October 2014).

- Allowing nurse practitioners and other physician extenders broader scope of practice
- Allowing pharmacists to write certain prescriptions independently of physicians
- Reducing restrictions on telemedicine
- Reforming malpractice laws⁵¹

CONCLUSION

The ACA has failed to meet its central goals. The law's mandates and tax increases have raised the price of insurance and significantly reduced people's choices. The exchanges have enrolled less than half the number of people expected. Many insurers have abandoned the exchanges, and most of those that remain have hiked their premiums considerably. The exchanges in most states appear to be far along in a death spiral, and markets in some states may not survive past 2017. The Medicaid expansion is costing much more than expected, with a recent study suggesting that many, if not most, new enrollees were already eligible for the program under pre-ACA rules.

As Congress and the incoming Trump administration consider how to replace the ACA, they should aim to (1) reduce the government bias in favor of comprehensive insurance, (2) fundamentally reform Medicaid by better aligning incentives of states to be concerned about the value of spending, and (3) expand market-oriented reforms such as HSAs. States should support these efforts by reducing insurance mandates and eliminating state rules that restrict competition and innovation. The next year presents a unique opportunity to replace the ACA's government-centric approach with a consumer-centric approach, and it must not be wasted.

51. Ibid.

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