The Heritage Foundation

BACKGROUNDER

No. 2970 | OCTOBER 30, 2014

A Fresh Start for Health Care Reform

Edmund F. Haislmaier, Robert E. Moffit, PhD, Nina Owcharenko, and Alyene Senger

Abstract

The need for health care reform has never been questioned by health care policy analysts on either side of the political spectrum. Furthermore, the broad goals of controlling costs, improving quality, and expanding access are widely shared. Yet, while both sides agree that reform is necessary, the policy solutions differ dramatically, most importantly on the question of who controls the key decisions in health care. During the public campaign in support of President Obama's health plan, the President made numerous promises to the American people about the law's effect on everyday Americans. Four years into its implementation, it is growing ever apparent that these promises have all but vanished. Four Heritage Foundation health policy experts detail the five main promises that President Obama broke, and present a fresh way for sustainable and patient-centered, market-based health care reform.

Despite President Barack Obama's insistence that the national health care debate is over, and that he will not "re-litigate" the misnamed Patient Protection and Affordable Care Act (PPACA), the practical concerns, aggravated by implementation glitches and policy failures, guarantee that the debate over the PPACA is far from over.[1]

In the next phase of the health care debate, supporters of the PPACA will undoubtedly attempt to fix or tweak the weaknesses and failures of the law. Such an approach would be based on preserving and expanding the government's role in health care. Indeed, some analysts have already proposed policies that would further strengthen the government's hand in managing and regulating the health care system.[2]

Those who reject the notion of increasing government control in health care can pursue an alternative path—a path based on the

This paper, in its entirety, can be found at **http://report.heritage.org/bg2970**

The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002
(202) 546-4400 | heritage.org

Key Points

- Despite President Obama's insistence that the debate on the misnamed Patient Protection and Affordable Care Act (PPACA) is over, the practical concerns, aggravated by implementation glitches and policy failures, have kept the debate alive, and it has intensified.
- While both sides in the debate agree that health reform is necessary, their policy solutions differ dramatically, most importantly over the question of who controls the key decisions in health care.
- Policymakers who reject increasing government control in health care can pursue an alternative path—based on the principles of patient-centered, market-based health care reforms. Such a path empowers individuals, gives them greater choice and control, and allows them to make their own health care decisions.
- Congress should focus on balancing the tax treatment of health insurance, devolving health insurance regulation back to the states, and reforming Medicare and Medicaid based on the principles of choice and competition.

principles of patient-centered, market-based health care reforms. That alternative path not only gives individuals greater choice, but also empowers them to make their own health care decisions.

Better Solutions. The need for health care reform has never been questioned by health care policy analysts on either side of the political spectrum. Furthermore, the broad goals of controlling costs, improving quality, and expanding access are widely shared. Yet, while both sides agree that reform is necessary, their policy solutions differ dramatically, most importantly on the question of who controls the key decisions in health care.

For the Obama Administration and defenders of the PPACA, the common conviction is that for major issues in health care, government officials should be the key decision makers. Those government decisions are imposed through detailed federal rules and regulations. The PPACA epitomizes this approach, and the course of its regulatory implementation—strewn with the broken promises of the President—provides an excellent guide to the consequences and inherent challenges of such an approach.

In contrast, those who believe in a patient-centered, market-based approach to reform trust individuals, not the government, to be the key decision makers in the financing of health care. To achieve this goal, Congress should embark on a reform agenda that is grounded in the following policy cornerstones: (1) reforming the tax treatment of health insurance so that individuals choose the health care coverage that best fits their needs (not the government's dictates); (2) restoring commonsense regulation of health insurance by devolving it back to the states; and modernizing (3) Medicare and (4) Medicaid by adopting policies that harness the powerful free-market forces of choice and competition.

The PPACA: Broken Promises

During the public campaign in support of President Obama's health plan, the President made numerous promises to the American people about the law's effect on everyday Americans. Four years into its implementation, it is growing ever more apparent that these promises have all but vanished.

Promise #1: "If you like your health care plan, you'll be able to keep your health care plan, period."[3]

Reality: Millions of Americans have already lost, and more will likely lose, their coverage due to the PPACA. The PPACA has significantly disrupted the market for those who buy coverage on their own by imposing new coverage and benefit mandates, causing a reported 4.7 million health insurance cancelations in 32 states in 2013.[4]

The same is true for those with employer-sponsored insurance. During the first half of 2014, Heritage Foundation analysis of the market enrollment data found that net enrollment in employer-group coverage declined by almost 4 million individuals, offsetting the gains in individual-purchased coverage by 61 percent.[5]

Promise #2: "If you like your doctor, you will be able to keep your doctor, period."[6]

1. Heritage Foundation analysts and others predicted this from the very beginning of the PPACA's implementation. See Stuart M. Butler, "Why the Health Reform Wars Have Only Just Begun," Heritage Foundation *Lecture* No. 1158, July 6, 2010, http://www.heritage.org/research/lecture/why-the-health-reform-wars-have-only-just-begun; Robert E. Moffit, "The Prospects for Ending Obamacare: Learning from Health Policy History," Heritage Foundation *Backgrounder* No. 2424, June 21, 2010, http://www.heritage.org/Research/Reports/2010/06/The-Prospects-for-Ending-Obamacare-Learning-from-Health-Policy-History; and Grace-Marie Turner, James C. Capretta, Thomas P. Miller, and Robert E. Moffit, *Why Obamacare is Wrong for America* (New York: Harper Collins, 2011).
2. For a discussion of expanding government interventions in the exchanges, see Henry Aaron and Kevin Lucia, "Only the Beginning—What's Next at the Health Insurance Exchanges," *New England Journal of Medicine*, September 4, 2013, http://www.nejm.org/doi/full/10.1056/NEJMsb1205901 (accessed October 6, 2014). For a discussion on expanding the role of the Independent Payment Advisory Board in Medicare, see Michael Ettlinger, Michael Linden, and Seth Hanlon, "Budgeting for Growth and Prosperity," Center for American Progress, May 2011, p. 26, http://cdn.americanprogress.org/wp-content/uploads/issues/2011/05/pdf/budget_for_growth.pdf (accessed October 6, 2014).
3. News release, "Remarks by the President at the Annual Conference of the American Medical Association," The White House, June 15, 2009, http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-american-medical-association (accessed September 17, 2014).
4. "Policy Notifications and Current Status, by State," Associated Press, December 26, 2013, http://news.yahoo.com/policy-notifications-current-status-state-204701399.html (accessed September 17, 2014).
5. Edmund F. Haislmaier and Drew Gonshorowski, "Obamacare's Enrollment Data: Mainly a Medicaid Expansion," Heritage Foundation *Backgrounder* No. 2967 October 22, 2014, http://www.heritage.org/research/reports/2014/10/obamacares-enrollment-increase-mainly-due-to-medicaid-expansion.
6. News release, "Remarks by the President at the Annual Conference of the American Medical Association."

Reality: Many Americans have not been able to keep their doctors as insurers try to offset the added costs of the PPACA by limiting the number of providers in their networks. In many of the PPACA's exchange plans, access to providers is limited; nationwide, 48 percent of all exchange plan provider networks are deemed to be "narrowed" and of those narrowed networks, nearly 40 percent are classified as "ultra-narrow."[7] Likewise, due to significant payment reductions in the PPACA, some seniors with Medicare Advantage plans are being forced to find new doctors. UnitedHealth, the largest provider of these plans, has recently reduced its provider networks in at least 14 states.[8]

In addition to these network access issues, there is the impact of the PPACA on the health care workforce, in particular its effects on workforce shortages and greater administrative burdens.[9]

Promise #3: "In an Obama Administration, we'll lower premiums by up to $2,500 for a typical family per year."[10]

Reality: Premiums for those who purchase coverage in the individual market have significantly increased in a majority of states, and premiums in the group market also continue to rise. In 2014, PPACA coverage in the exchanges was more expensive than comparable 2013 coverage in the pre-PPACA individual market in 42 states.[11] For Americans with employer-sponsored coverage, premium costs also continue to increase. Family premiums for employer-sponsored coverage have increased by an average of $3,459 since 2009.[12]

Although 2015 premium rates have not been finalized, an initial analysis of 19 states with available data shows that 28 percent of Silver-level exchange plans will have premium increases greater than 10 percent, while only 14 percent of Silver-level exchange plans will have rate decreases of more than 10 percent.[13]

Promise #4: "Under my plan, no family making less than $250,000 a year will see any form of tax increase."[14]

Reality: The PPACA contains 18 separate tax increases, fees, and penalties, many of which heavily impact the middle class. Altogether, the PPACA's taxes and penalties will collect more than $770 billion in new federal government revenues over 10 years.[15] The individual mandate, the medical

7. McKinsey Center for U.S. Health System Reform, "Hospital Networks: Updated National View of Configurations on the Exchanges," June 2014, http://healthcare.mckinsey.com/sites/default/files/McK%20Reform%20Center%20-%20Hospital%20networks%20national%20update%20%28June%202014%29_0.pdf (accessed September 17, 2014).
8. Melinda Beck, "UnitedHealth Culls Doctors from Medicare Advantage Plans: Physicians in 10 States Notified," *The Wall Street Journal*, November 16, 2013, http://online.wsj.com/news/articles/SB10001424052702303559504579200190614501838 (accessed October 7, 2014).
9. Amy Anderson, "The Impact of the Affordable Care Act on the Health Care Workforce," Heritage Foundation *Backgrounder* No. 2887, March 18, 2014, http://www.heritage.org/research/reports/2014/03/the-impact-of-the-affordable-care-act-on-the-health-care-workforce.
10. Barack Obama, "Remarks of Senator Barack Obama: Health Care Town Hall," June 5, 2008, http://votesmart.org/public-statement/346763/remarks-of-senator-barack-obama-health-care-town-hall/?search=$2,500#.UqtV5sRDt8E (accessed September 17, 2014).
11. Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief*, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.
12. Kaiser Family Foundation, "Employer Health Benefits: 2014 Annual Survey," p. 27, Exhibit 1.11, http://kaiserfamilyfoundation.files.wordpress.com/2014/09/8625-employer-health-benefits-2014-annual-survey4.pdf (accessed September 16, 2014).
13. McKinsey and Company, "2015 Individual Exchange Filings as of September 5, 2014," http://healthcare.mckinsey.com/sites/default/files/McKinsey_2015%20individual%20rate%20filings_%20%20September%208%20linked.pdf (accessed September 17, 2014). Obamacare standardizes health insurance plans based on the concept of "actuarial value." A plan's actuarial value is the average share of total expenses for the covered benefits that the plan pays. So, an actuarial value of 70 percent means that the plan, on average, pays 70 percent of the total expense for the covered benefits. The enrollee is responsible for paying the remaining costs, according to the plan's schedule of deductibles and co-pays. The four plan categories specified in Obamacare are: Bronze (60 percent actuarial value); Silver (70 percent actuarial value); Gold (80 percent actuarial value); and Platinum (90 percent actuarial value). See Public Law 111-148 §1302(d).
14. Senator Barack Obama, "Remarks in Dover, New Hampshire," September 12, 2008, http://www.presidency.ucsb.edu/ws/?pid=78612 (accessed September 17, 2014).
15. Joint Committee on Taxation, "Estimated Revenue Effects of a Proposal to Repeal Certain Tax Provisions Contained in the Affordable Care Act (ACA)," June 15, 2012, and Congressional Budget Office, "Table 2: CBO's May 2013 Estimate." The total amount of tax revenue collected from the individual mandate, employer mandate, and 40 percent excise tax on high-cost health plans comes from the CBO's May 2013 estimate. For all other taxes, the amount of tax revenue totaled comes from the Joint Committee on Taxation's June 2012 estimation.

device tax, the federal health insurer tax, and new penalties and limits on health savings accounts and flexible spending accounts are just a few of the taxes that affect middle class Americans.[16]

Promise #5: "I will protect Medicare."[17]

Reality: The PPACA cuts Medicare to offset new health care spending. The PPACA makes unprecedented and unrealistic payment reductions to Medicare providers and Medicare Advantage plans in order to finance the law's new spending on subsidized coverage for the non-Medicare population. The cuts amount to over $700 billion from 2013 to 2022.[18] If these draconian reductions take place as scheduled, they will significantly impact seniors' ability to access treatments and the quality of their care.[19]

With such a lackluster record, it is not surprising that public opposition to the law remains strong and consistent. As a matter of fact, when all polls are averaged, the level of public opposition to the PPACA has always been higher than the level of public support.[20]

Principles of Patient-Centered, Market-Based Health Care Reform

Traditionally, terms such as "patient-centered" or "market-based" have been used to contrast an alternative approach to greater government control in health care. However, the vocabulary of health care policy is often elastic, and different people sometimes use the same terms to express significantly different concepts. For example, the Obama Administration recently changed its description of the government-run health exchange to "marketplace."

The linguistic elasticity adds to the general confusion among the public and policymakers that seems to plague this already complex area of public policy. Consequentially, clarifying the rationale, objectives, and principles of patient-centered health care reform is important for properly understanding the concepts and implications of this approach.[21] Specifically, truly patient-centered, market-based health reform means that:

- **Individuals are the key decision makers in the health care system.** That would be a major departure from most current arrangements under which governments or employers determine the type and scope of health care benefits and how those benefits are financed. In normal markets, consumers drive the system through their choices of products and services, reflecting their personal needs and preferences. In response, the providers of goods and services compete to meet consumer demands and preferences by supplying products that offer consumers better value in terms of price, quality, and features. The only way to achieve the same results in health care is by putting basic decision-making authority into the hands of consumers and patients.

- **Individuals buy and own their own health insurance coverage.** In a normal market, when individuals exchange money for a good or service, they acquire a property right in that good or service, but in today's system, individuals and fami-

16. For a detailed explanation of the impact of the PPACA's taxes, see Curtis S. Dubay, "Obamacare and New Taxes: Destroying Jobs and the Economy," Heritage Foundation *WebMemo* No. 3100, January 20, 2011, http://www.heritage.org/research/reports/2011/01/obamacare-and-new-taxes-destroying-jobs-and-the-economy.
17. News release, "Remarks by the President to a Joint Session of Congress on Health Care."
18. Douglas W. Elmendorf, director, Congressional Budget Office, letter to Speaker John Boehner (R–OH), U.S. House of Representatives, July 24, 2012, pp. 13–14, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf (accessed September 17, 2014). The letter estimates the cost of repealing Obamacare, which would increase Medicare spending due to the absence of Obamacare's Medicare cuts. If Obamacare were repealed, the CBO states, "[w]ithin Medicare, net increases in spending for the services covered by Part A (Hospital Insurance) and Part B (Medical Insurance) would total $517 billion and $247 billion, respectively. Those increases would be partially offset by a $48 billion reduction in net spending for Part D."
19. Alyene Senger, "Obamacare's Impact on Seniors: An Update," Heritage Foundation *Issue Brief* No. 4019, August 20, 2013, http://www.heritage.org/research/reports/2013/08/obamacares-impact-on-seniors-an-update.
20. Real Clear Politics, "Public Approval of Health Care Law," http://www.realclearpolitics.com/epolls/other/obama_and_democrats_health_care_plan-1130.html (accessed September 17, 2014).
21. Edmund F. Haislmaier, "Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market," Heritage Foundation *Backgrounder* No. 2128, April 23, 2008, http://www.heritage.org/research/reports/2008/04/health-care-reform-design-principles-for-a-patient-centered-consumer-based-market.

lies rarely have property rights in their health insurance coverage. The policy is owned and controlled by a third party—either the employer or government bureaucrats. In a reformed system, individuals would own their health insurance, just as they own virtually every other type of insurance or virtually any other product in other sectors of the economy.

- **Individuals are able to choose from a wide range of options.** Individuals, not employers or government officials, would choose their own health plan and level of coverage. Having a choice among health plans is particularly important because, of necessity, it incorporates a whole set of other implicit choices—such as what the plan will pay for versus what the consumer will purchase directly from providers, how and from whom the patient will receive care, and any informational tools or services the plan provides to assist patients in deciding among competing providers and treatment options. The corollary is that suppliers of medical goods and services, including health plans, must have the necessary flexibility to offer consumers and patients innovative and better-value solutions. That means that government rules and regulations should be limited to those that are necessary to ensure safety and a level playing field. Laws and regulations that favor particular providers, suppliers, business models, or plan designs over others, or that create unreasonable barriers to market entry by new competitors, are inherently anti-consumer.

The challenge for policymakers is to undertake the reforms needed to transform the present system into one that rewards the search for and creation of better value. As other economic sectors show, health care need not be a zero-sum game in which costs can be controlled only by limiting benefits and benefits can be expanded only by increasing costs. Rather, a value-maximizing system would simultaneously demand and reward continuous benefit improvements accompanied by continuous cost reductions.

Such a value-maximizing result can be achieved in health care only if the system is restructured to make the consumer the key decision maker. When individual consumers decide how the money is spent, either directly for medical care or indirectly through their health insurance choices, the incentives will be aligned throughout the system to generate better value—in other words, to produce more for less.

A Fresh Start to Health Care Reform: The Right Policy

As it stands, the PPACA is burdened by practical infirmities that render it unworkable and unfair. Its policy prescriptions are unaffordable. This combination of bad policy and inherently flawed management has had, and will have, consequences that render the law persistently unpopular.

Congress should start fresh. It should repeal the PPACA and focus on the fundamentals: reform of the tax treatment of health care; devolving health insurance regulation back to the states; and reform of the major health care entitlement programs of Medicare and Medicaid.

Time to Reform the Tax Treatment of Health Care

The current tax treatment of health insurance is largely a relic of World War II wage and price controls. While those laws regulated cash wages, they exempted "insurance and pension benefits" of a "reasonable amount" from the definition of "wages" and "salaries," to which the controls were applied.[22] Faced with labor shortages (as working-age men joined the armed forces) employers used that loophole to effectively skirt the wage controls by offering increased compensation in the form of employer-paid health insurance.

This distinction between cash wages and certain non-cash employee benefits also raised the issue of how the value of such benefits should be treated for tax purposes. When Congress enacted a major revision of the federal tax code in 1954 it explicitly excluded from the calculation of gross income any employer payments for a worker's medical care or health insurance.[23] Moreover, this exclusion applies to both federal income and payroll (Social Security and Medicare) taxes. Thus, the tax exclusion for employer-sponsored health insurance meant that working families could fund their medical care with income that was completely tax-free.

22. Stabilization Act of 1942, Public Law 77-729 § 10.
23. Internal Revenue Act of 1954, Public Law 83-591.

Furthermore, unlike the case with most other tax breaks, Congress did not set a limit on the amount of income that could be diverted into paying for employer-sponsored health benefits on a pre-tax basis. Thus, having more of their compensation paid in the form of tax-free health benefits, and less in the form of taxable wages, became particularly attractive to workers in periods of higher inflation and higher marginal tax rates, such as during the 1970s.

The aggregate value of this federal tax preference in 2014 is about $250 billion per year, with reductions in federal personal income tax accounting for about $175 billion of that figure and reductions in payroll taxes accounting for the other $75 billion.[24]

The principal effect of this policy was the widespread adoption of employer-sponsored health benefits as the dominant form of health coverage for American workers and their families. The share of the non-elderly population covered by employer-sponsored health insurance peaked at an estimated 71.4 percent in 1980.[25] Even though the share has gradually declined since then, in 2012, an estimated 58.5 percent of the non-elderly population was still covered under such plans.[26]

Yet that decline reveals some of the major drawbacks of this tax policy. Back in the 1950s and 1960s, it was fairly common for a worker to spend his entire career with the same employer. Yet the American workforce has become far more mobile since then. For instance, a Department of Labor survey of workers born between 1957 and 1964, found that they had an average of 11 jobs between the ages of 18 and 46.[27] Obviously, a tax policy that links health insurance to the place of work means that each time a worker changes employers, he must change his health plan.

This tax policy also produces what economists call "horizontal inequity," meaning that if two individuals have the same income, but one has employer-sponsored health benefits while the other buys his own health insurance, the first individual receives a larger tax break than the second. At the same time, this tax policy also creates "vertical inequity." If two individuals work for the same employer and participate in the same health plan with the same cost, but have different incomes, the tax benefit each receives will vary based on their different marginal tax rates. That is so because the value of the tax exclusion for employer-sponsored coverage is equal to an individual's combined marginal tax rates for both income and payroll taxes, with the consequence that the size of the tax relief provided by the tax exclusion varies according to the different marginal tax rates imposed at different income levels.

Yet, the biggest problem with the tax exclusion from the health policy perspective is that while it offers workers substantial tax relief, it does so only if the workers let their employers decide how that portion of their compensation is spent. That translates to less choice and competition in health insurance, reduced consumer awareness of the true costs and value of medical care, and incentives to tailor health plans more toward meeting the interests of employers than to the preferences of the workers and their families.

The PPACA and the Tax Treatment of Health Care. Not only does the PPACA fail to correct these flaws in long-standing health care tax policy, it layers new complexity and distortions onto the existing system. It provides new, and substantial, subsidies for buying health insurance, but only to those individuals who have incomes between 100 percent and 400 percent of the federal poverty level (FPL) and purchase their coverage through government-run exchanges. Furthermore, it denies those new subsidies to individuals with access to employer-sponsored coverage, while at the same time imposing fines on employers with 50 or more full-time workers if they do not offer coverage.

Indeed, the only helpful change to health care tax policy that the PPACA makes is to limit the amount of employer-provided coverage that may be excluded from taxation. However, Congress did

24. Congressional Budget Office, "The Distribution of Major Tax Expenditures in the Individual Income Tax System," May 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43768_DistributionTaxExpenditures.pdf (accessed October 7, 2014).
25. Robin A. Cohen et al., "Health Insurance Coverage Trends, 1959–2007: Estimates from the National Health Interview Survey," Centers for Disease Control *National Health Statistics Reports* No. 17, July 1, 2009, http://www.cdc.gov/nchs/data/nhsr/nhsr017.pdf (accessed October 7, 2014).
26. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 390, September, 2013, http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources1.pdf (accessed October 7, 2014).
27. Bureau of Labor Statistics, "Number of Jobs Held, Labor Market Activity, and Earnings Growth Among the Youngest Baby Boomers: Results from a Longitudinal Survey," U.S. Department of Labor, July 25, 2012, http://www.bls.gov/news.release/pdf/nlsoy.pdf (accessed October 7, 2014).

even that in a convoluted fashion. Rather than simply setting a limit—as Congress previously did with the tax exclusion for contributions to retirement plans—the PPACA imposes a punitive excise tax on any employer health plan whose value exceeds specified amounts.

A Better Approach. The proper goals for a true reform of the tax treatment of health insurance should be to make the system simpler and fairer for individuals, while also ensuring that it is neutral both with respect to how an individual obtains coverage (whether directly or through an employer or an association) as well as with respect to an individual's choice of plan design (such as a health-maintenance organization (HMO), a preferred-provider organization (PPO), a high-deductible plan, or another arrangement).

Various proposals for health care tax reform have been offered over the years. Most would repeal the tax exclusion and replace it with a new, universal tax deduction or tax credit for health expenses.

Replacing the current tax treatment of health benefits with a new design for health care tax relief that is both revenue and budget neutral (based on pre-PPACA levels) is the first step in transforming the American health system into one that is more patient-centered, market-based, and value-focused. No amount of government regulation or micromanagement of the system—such as tinkering with provider reimbursement rates or payment arrangements—can produce better value. That desired result will only be achieved by giving consumers more control over how to spend their health care dollars, thus forcing health insurers and medical providers to respond to consumer demand by offering better quality and prices for their products and services.

Even so, there is the practical concern that simply replacing the tax exclusion with a new design for health care tax relief would be an abrupt and major change in tax policy—resulting in further dislocation, at least initially, to the existing health care financing arrangements of millions of Americans. One way to avoid that problem is by including a transitional mechanism in the design, as follows:

First, instead of eliminating the tax exclusion, convert the existing limitation on high-cost employer health plans into a straightforward cap on the value of the exclusion.

Second, replace all the other narrower health care tax breaks (such as the tax deduction for coverage purchased by the self-employed, the Trade Adjustment Assistance health care tax credit for dislocated workers, and the itemized deduction for medical expenses) with an alternative health care tax relief option available to all taxpayers, regardless of income or source of coverage.

Third, permit individuals with access to employer-sponsored coverage to choose whether the tax exclusion, or the new tax relief option, should be applied to the value of their employer-sponsored benefits. Each worker would simply instruct his employer, on his W-4 form, which type of health care tax relief to apply in calculating his tax withholding.

Fourth, index the cap on the amount of the exclusion to decrease as needed in future years, so as to maintain at a baseline level the aggregate amount of tax relief provided by both the new option and the exclusion. For years in which the combined aggregate amount of tax relief provided by the alternative tax relief option and the exclusion exceeded the baseline level, the Treasury Department would be required to apply the indexing adjustment to lower the exclusion cap for the following year to make up the difference.

Under this approach there would be no abrupt dislocation of existing coverage arrangements. Those with employer-sponsored coverage could stay in their plans. The only difference would be that each worker could choose the form of the tax treatment to be applied. In general, most lower-wage workers would likely benefit more under the new tax option than the exclusion, while most higher-wage workers would likely find that they are better off continuing to claim the tax exclusion.

This arrangement would not only avoid the PPACA's problem of creating incentives for employers to discontinue coverage, but might actually result in more lower-wage workers enrolling in employer-sponsored coverage. That is because employer coverage would become more affordable to those workers if they opted to apply the new tax relief option, instead of the tax exclusion, to that coverage.

Over time, the indexing of the cap on the exclusion would eventually bring the value of the tax exclusion into parity with the value of the new tax relief option. However, that would occur gradually—not abruptly—and as a byproduct of individual workers exercising their personal preferences.

Commonsense Insurance-Market Reforms

Beyond reforming health care tax policy, the next step in creating a more patient-centered, market-based health system is to reform the regulation of health insurance to make coverage more competitive and value-focused. It is necessary not only for consumers to have incentives to seek better value, but also for insurers to have sufficient scope to innovate in offering better value products.

America's private health insurance market consists of two basic subgroups: the employer-group market, and the individual insurance market. Plans purchased from commercial insurers—whether individual or employer-group policies—are primarily regulated by state insurance laws.

There are, however, instances where federal regulations apply. The Employee Retirement and Income Security Act (ERISA), for example, establishes federal protections for the arrangements that an employer makes for providing benefits to his workers. The state, however, still regulates the commercial products that the employer might choose to purchase.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). That act, among other policy changes, set in place basic market rules for employer-group coverage and individual-market coverage. For employer plans, HIPAA included policies on a number of issues relating to guarantee issue, guarantee renewability, limitations on pre-exclusions, and prohibition on discrimination based on health status. For individual plans, HIPAA was limited to guarantee renewability and rules in the case of workers who lost their group coverage.[28]

The PPACA and Insurance Regulation. While there were certainly some problems with insurance market regulation prior to the PPACA, those relatively modest problems could easily have been remedied with a few thoughtful and limited reforms. Instead, Congress enacted in the PPACA a raft of new regulations on insurers and health plans that standardize coverage, restrict innovation in plan design, and increase premiums for many Americans. Consequently, many of the new requirements imposed on insurers by the PPACA—such as the new federal benefit mandates that standardize coverage[29] and the rating rules that artificially increase premiums for younger adults[30]—are counterproductive and lead to the need for the widely despised individual mandate to offset their destabilizing effects.

A Better Approach. State governments have performed the basic function of regulating insurance reasonably well for over a century, and there is no need for the federal government to supplant these efforts as it is now doing under the PPACA. Therefore, Congress should immediately devolve the regulation of health insurance back to the states.

From there, states should initiate a policy agenda that aims to stabilize the market while expanding choice and competition by reducing burdensome and costly rating rules and benefit mandates. State lawmakers should also pursue policies to achieve greater harmonization among the states. For instance, reciprocity agreements between states would permit residents in one state to buy coverage that is issued and regulated in another state. In 2011, Maine included such a reciprocity provision in its broader health insurance reform law.[31] Enacting such policies would expand the choices available to consumers, increase competition among insurers, and help clear the way for potential federal interstate purchase legislation. Finally, states should advance medical liability reforms to help improve access and bring down the cost of practicing medicine.

To address the outstanding concern over protections for those individuals with pre-existing conditions, Congress could solve this issue in a rela-

28. For a more detailed account, see Edmund F. Haislmaier, "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms," Heritage Foundation *Backgrounder* No. 2703, June 22, 2012, http://www.heritage.org/research/reports/2012/06/saving-the-american-dream-the-us-needs-commonsense-health-insurance-reforms.
29. Edmund F. Haislmaier, "Obamacare and Insurance Benefit Mandates: Raising Premiums and Reducing Patient Choice," Heritage Foundation *WebMemo* No. 3110, January 20, 2011, http://www.heritage.org/research/reports/2011/01/obamacare-and-insurance-benefit-mandates-raising-premiums-and-reducing-patient-choice.
30. Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011, http://www.heritage.org/research/reports/2011/01/obamacare-and-insurance-rating-rules-increasing-costs-and-destabilizing-markets.
31. Tarren Bragdon and Joel Allumbaugh, "Health Care Reform in Maine: Reversing 'Obamacare Lite,'" Heritage Foundation *Backgrounder* No. 2582, July 19, 2011, p. 9, http://www.heritage.org/research/reports/2011/07/health-care-reform-in-maine-reversing-obamacare-lite.

tively simple fashion without resorting to the kind of sweeping and complex regulation enacted in the PPACA.

Dating back to the 1996 HIPAA law, Congress enacted a set of modest and reasonable rules for employer-group coverage that specified that individuals switching from one group plan to another (or from group coverage to an individual plan) could not be denied new coverage, be subjected to pre-existing-condition exclusions, or be charged higher premiums because of their health status.[32] Thus, in the group market, pre-existing-condition exclusions could only be applied to those without prior coverage, or to those who wait until they need medical care to enroll in their employer's plan. Furthermore, there were limits even in those cases. Such individuals could still obtain the group coverage, and any pre-existing medical condition could not be excluded from that coverage for more than 12 months.

Under these employer group rules, individuals who received and kept coverage are rewarded, and individuals who wait until they are sick to enroll in coverage are penalized, but the penalties were neither unreasonable nor severe. That was also why those rules worked without needing to mandate that individuals purchase coverage, as required by the PPACA.

The problem, however, is that the same kind of rules did not apply to the individual market. Thus, an individual could have purchased non-group health insurance for many years, and still be denied coverage or face pre-existing-condition exclusions when he needed or wanted to pick a different plan. Not only was that unfair to those individuals who had bought insurance while they were healthy, it also did little to encourage other healthy individuals to purchase coverage before they needed it.

Thus, the obvious, modest, and sensible reform would be to apply a set of rules to the individual-health-insurance market similar to the ones that already govern the employer-group-coverage market.[33]

Reforming Medicare

Established in 1965, Medicare is the huge government health program for seniors over the age of 65, as well as for some disabled populations. It faces monumental challenges. The $583 billion Medicare program covering 52 million aged and disabled citizens is the most powerful force driving entitlement spending, and will generate a long-term unfunded liability (an "off-budget" debt) at an estimated $28 trillion to $35 trillion.[34]

Medicare is also structurally complex.[35] Each of Medicare's four parts (A, B, C, and D) is financed differently. The Medicare fee-for-service (FFS) (Parts A and B) program, or traditional Medicare, is the main component of the Medicare entitlement and has been slow to change. The reason: It is governed by an old-fashioned system of central planning and price controls that produce cost shifting and over-regulation, undercutting both economic efficiency and innovation. The program also fails the most basic test of insurance: It does not guarantee patient protection for the financial devastation of catastrophic illness. Not surprisingly, that and other antiquated elements of the program's benefit design fuel demand for private supplemental insurance to fill traditional Medicare's notorious coverage gaps. Approximately 90 percent of seniors thus depend on such supplemental coverage. Because these supplemental plans routinely provide "first dollar" coverage, this current arrangement drives excessive use of services and drives up costs for both taxpayers and beneficiaries.[36]

Medicare must also cope with an enormous demographic challenge.[37] America's aging population is steadily growing, but their Medicare coverage

32. Health Insurance Portability and Accountability Act of 1996, Public Law 104–191.
33. Haislmaier, "Saving the American Dream."
34. Robert E. Moffit, "The Medicare Funding Problem Threatening Medicare's Future," The Daily Signal, July 30, 2014, http://dailysignal.com/2014/07/30/medicare-funding-problem-threatening-medicares-future/.
35. For a discussion of the structural problems of the Medicare program, see Robert E. Moffit and Alyene Senger, "Medicare's Outdated Structure—and The Urgent Need for Reform," Heritage Foundation *Backgrounder* No. 2777, March 22, 2013, http://www.heritage.org/research/reports/2013/03/medicares-outdated-structureand-the-urgent-need-for-reform.
36. Walton J. Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP* (Washington, DC: The AEI Press, 2009), pp. 26–27.
37. For an account of this demographic challenge, see Robert E. Moffit and Alyene Senger, "Medicare's Demographic Challenge—and the Urgent Need for Reform," Heritage Foundation *Backgrounder* No. 2778, March 21, 2013, http://www.heritage.org/research/reports/2013/03/medicares-demographic-challenge-and-the-urgent-need-for-reform.

is being funded through taxation on a proportionally smaller working population. Current and future Medicare enrollees are also living, or expected to live, significantly longer than previous generations.

The first wave of the huge baby-boomer generation—those born between 1946 and 1964—are starting to retire and are enrolling in the program. Seventy-seven million strong, the boomers are going to sharply increase the total Medicare population, and trigger a new demand for medical services unlike anything the nation has previously experienced. By 2030, over 80 million seniors will depend on Medicare for their health care. Moreover, the average life expectancy in the United States has increased since Medicare was created—from 70.2 years in 1965 to a predicted 79.5 years in 2020.[38] By 2030, the average life expectancy will be almost 81 years of age, assuming current trends continue.

Meanwhile, the baby boomers have not replaced themselves in sufficient numbers, and the ratio of workers to beneficiaries is projected to decline from 3.2 in 2013 to 2.3 by 2030.[39] Younger Americans' future is thus darkened by the prospect of massive tax increases to sustain Medicare. Alternatively, senior and disabled citizens could face deep benefit cuts, or more likely, reduced access to care. The latter would be the inevitable result of relentless reimbursement reductions for medical professionals, doubling down on the cuts already scheduled under the PPACA.

Medicare, the fastest-growing program in the federal budget, also faces a severe fiscal challenge.[40] That challenge is aggravated by two prevalent myths. First, many seniors today erroneously believe that their Medicare benefits are somehow secure because they are "guaranteed" in statute by the federal government. When politicians talk about Medicare's "guaranteed benefits," this, invariably, is what they mean. But, of course, a congressional provision of entitlement to benefits is not in any sense tantamount to a legal right to those benefits, since Congress can alter, change, or reduce Medicare benefits whenever it deems it necessary or convenient to do so. The more serious problem for seniors is that Congress, as noted, has made promises to provide those benefits to current and future retirees, but those benefit promises are not fully funded. In fact, Medicare's unfunded obligation ranges from $28 trillion to $35 trillion, meaning the government is currently short this amount of dedicated revenue to pay for future benefits over the long term.

The second myth is that Medicare beneficiaries have already paid for their Medicare benefits. Specifically, many seniors erroneously believe that their benefits are secure because they paid for those benefits through the Medicare payroll tax. In fact, for most seniors, this is simply not true. Indeed, most seniors routinely receive more in Medicare benefits than they paid in premiums or payroll taxes. The average two-earner retired couple paid into Medicare $119,000 during their working years, yet now receives over $357,000 in Medicare benefits.[41] Medicare is what is called a pay-as-you-go system, meaning that the benefits of today's seniors are financed by the taxes on today's workers. In any given year, younger workers finance almost nine of every 10 dollars in Medicare benefits.

The PPACA and Medicare. Rather than putting Medicare on more solid financial footing, the PPACA takes a majority of the $716 billion in 10-year "savings" from Medicare to offset the costs of the law's other non-Medicare spending provisions, in particular the costly exchange subsidies and Medicaid expansion. These savings are mostly derived from statutory modifications to Medicare's complex administrative payment updates for providers, or

38. Ibid.

39. Centers for Medicare and Medicaid Services, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 28, 2014, p. 67, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf (accessed October 7, 2014), and see also Robert E. Moffit and Alyene Senger, "The 2014 Medicare Trustees Report: A Dire Future for Seniors and Taxpayers Without Reform," Heritage Foundation *Issue Brief* No. 4256, August 1, 2014, http://www.heritage.org/research/reports/2014/08/the-2014-medicare-trustees-report-a-dire-future-for-seniors-and-taxpayers-without-reform.

40. Robert E. Moffit and Alyene Senger," Medicare's Rising Costs—and the Urgent Need for Reform," Heritage Foundation *Backgrounder* No. 2779, March 22, 2013, http://www.heritage.org/research/reports/2013/03/medicares-rising-costsand-the-urgent-need-for-reform.

41. C. Eugene Steuerle, Richard B. Fisher, and Stephanie Rennane, "How Lifetime Benefits and Contributions Point the Way Toward Reforming Our Senior Entitlement Programs," August 2011, The Urban Institute, p. 2, Figure 1, http://www.urban.org/UploadedPDF/1001553-Reforming-Our-Senior-Entitlement-Programs.pdf (accessed October 7, 2014).

regulatory changes to the conditions under which their services are reimbursed.[42]

The largest chunk of the PPACA's Medicare "savings" are to come from future payment reductions for Part A providers—hospitals, skilled nursing facilities, home health agencies and even hospice programs. The second-biggest item is an estimated $156 billion in payment reductions and other effects on the popular Medicare Advantage program (Medicare Part C) that offers enrollees the ability to get their Medicare coverage from competing private health plans. Medicare Advantage is today seniors' main alternative to enrollment in the FFS program. The object of the law is to ratchet down Medicare Advantage payments to levels approaching the costs of traditional Medicare FFS.

In addition and of greater significance is the law's creation of the Independent Payment Advisory Board (IPAB), and a fast-track process for implementing its recommendations.[43] Through IPAB, the PPACA for the first time in Medicare's history, imposed a hard cap on the growth of Medicare spending, tying it to the growth in inflation and subsequently the growth in the general economy. This, in effect, would amount to a global budget for Medicare. It is worth noting that, under the law, IPAB's authority is confined to selective Medicare payment reductions, and would not extend to any changes in benefit design, beneficiary payment or the structure of the program itself.

Beyond these changes, the law increases Medicare payroll taxes on upper-income persons from 2.9 percent to 3.8 percent, while it authorizes a variety of delivery reforms, such as "pay for performance" for physicians and "value-based purchasing" programs for hospitals. It also resurrects a form of government-sponsored managed care, the newly created accountable care organizations (ACOs), in which providers who are in compliance with government quality standards share in cost savings.

A Better Approach. That the Medicare program must change is not even an option. The program simply cannot and will not continue as it is today. The best path for comprehensive reform is to transition the entire Medicare program from a defined-benefit system to a defined-contribution system ("premium support"), in which the government would make a defined contribution to the health plan of an enrollee's choice. Such a reform has potential for impressive savings.[44]

Congress should act now to sequester any of the 10-year $716 billion of estimated Medicare savings that accrue from the PPACA, along with any other Medicare savings, in a special account as savings *for* Medicare and Medicare alone, rather than using those savings to finance the new PPACA spending programs.

Beyond that necessary earmarking of Medicare savings for the Medicare program, Congress should embark on broader Medicare reform in stages. In the first stage, Congress should adopt some basic reforms to the traditional Medicare program, most of which already attract broad bipartisan support, to smooth the way for Medicare premium support:[45]

1. Congress should increase the age of Medicare eligibility—gradually—to 68, and index it to longevity;

2. Congress should gradually increase the Medicare Parts B and D premiums from 25 percent to 35 percent while retaining existing "hold harmless"

42. Robert E. Moffit, "Obamacare and Medicare Provider Cuts: Jeopardizing Seniors' Access," Heritage Foundation *WebMemo* No. 3105, January 19, 2011, http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Medicare-Provider-Cuts-Jeopardizing-Seniors-Access.

43. Robert E. Moffit, "Obamacare and the Independent Payment Advisory Board: Falling Short of Real Medicare Reform," Heritage Foundation *WebMemo* No. 3102, January 18, 2011, http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-the-Independent-Payment-Advisory-Board-Falling-Short-of-Real-Medicare-Reform.

44. Congressional Budget Office, "A Premium Support System for Medicare: Analysis of Illustrative Options," September 18, 2013, http://www.cbo.gov/publication/44581 (accessed October 7, 2014), and Robert E. Moffit and Rea S. Hederman, Jr.,"CBO Confirms: Medicare Premium Support Means Savings for Taxpayers and Seniors," Heritage Foundation *Backgrounder* No. 2878, February 3, 2014, http://www.heritage.org/research/reports/2014/02/cbo-confirms-medicare-premium-support-means-savings-for-taxpayers-and-seniors.

45. Robert E. Moffit, "The First Stage of Medicare Reform: Fixing the Current Program," Heritage Foundation *Backgrounde*r No. 2611, October 17, 2011, http://www.heritage.org/research/reports/2011/10/the-first-stage-of-medicare-reform-fixing-the-current-program, and Robert E. Moffit and Rea S. Hederman, Jr., "Medicare Savings: 5 Steps to a Down Payment on Structural Reform," Heritage Foundation *Issue Brief* No. 3908, April 11, 2013, http://www.heritage.org/research/reports/2013/04/medicare-savings-5-steps-to-a-downpayment-on-structural-reform.

rules for the poor, and should further reduce taxpayer subsidies for wealthy Medicare recipients;

3. Congress should combine Medicare Parts A and B and replace the existing complex set of cost-sharing arrangements with a simple and unified deductible, a uniform coinsurance rate, and a catastrophic out-of-pocket limit;

4. Congress should establish a Part A premium to be effective in any year that the Medicare HI Trust Fund is running a deficit; and

5. Congress should repeal the statutory restrictions on Medicare private contracting,[46] and allow Medicare beneficiaries to buy and use a health savings account to reimburse physicians and other medical professionals for their medical services.

In conjunction with these basic reforms, Congress should initiate the full transition of Medicare to a premium support program.[47] This transition should take place over a period of no more than five years.[48] Congress should build on the best features of Medicare Part C (Medicare Advantage), which provides comprehensive and integrated health care coverage, and also Medicare Part D, which delivers high-quality prescription drug coverage through competing private health plans.[49]

Under premium support, the government would make a defined contribution to the health plan of the enrollee's choice. The coverage options would include traditional Medicare as well as private health plans—both existing private plans in Medicare Advantage and any future plan offerings. If people wanted to buy a plan that costs less than the government contribution, they could do so and either pocket the savings or deposit those funds in an account for health care. If people wanted to buy more generous coverage than that financed by the government contribution, they could do so and pay the difference in additional premiums. Such an arrangement would guarantee Medicare beneficiaries a wide range of health plans and providers, while reducing costly bureaucracy and red tape and controlling costs for both enrollees and taxpayers.

With respect to governance and consumer protections, the new competitive program would largely resemble the premium support system that exists today in the popular and successful Federal Employees Health Benefits Program (FEHBP), which covers federal workers and retirees.[50] An agency, separate and apart from the Medicare bureaucracy, should have responsibility for administering the new Medicare premium support program, including mechanisms to deal with issues of risk adjustment and adverse selection among competing health plans.

These reforms would preserve Medicare for future generations by ensuring its fiscal and structural stability and by building on the successful models based on choice and competition.

Reforming Medicaid

Medicaid, established alongside Medicare in 1965, is the massive federal and state health care program for the poor. In 2012, an estimated one in

46. In the Balanced Budget Act of 1997, Congress and the Clinton Administration imposed a unique statutory restriction on physicians and patients freely entering into agreements for private care without submitting claims to Medicare. This restriction is insulting to doctors and patients alike. See Robert E. Moffit, "Congress Should End the Confusion Over Medicare Private Contracting," Heritage Foundation *Backgrounder* No. 1347, February 18, 2000, http://www.heritage.org/research/reports/2000/02/congress-shouldend-the-confusion-over-medicare-private-contracting.

47. Robert E. Moffit, "The Second Stage of Medicare Reform: Moving to a Premium Support Program," Heritage Foundation *Backgrounder* No. 2626, November 28, 2011, http://www.heritage.org/research/reports/2011/11/the-second-stage-of-medicare-reform-moving-to-a-premium-support-program.

48. Transition is a prudential matter, but delays, as the CBO and others have noted, reduces the potential savings of the reform. The three-year to five-year period suggested would ensure that a large cohort of the baby-boomer generation is rapidly integrated into the new system.

49. For 2014, out of an estimated 53.9 million Medicare beneficiaries, 40.6 million are to be enrolled in Medicare Part D, and 16.2 million are to be enrolled in private health plans in Medicare Part C. See the *2014 Trustees Report*. In other words, because most Medicare enrollees are already enrolled in a defined-contribution program in one way or another, the transition to a comprehensive premium support program should have a solid foundation. In both areas of Medicare, where private plans are competing, there are also high rates of beneficiary satisfaction.

50. For an overview of this FEHBP experience and its direct relevance for Medicare reform, see Francis, *Putting Medicare Consumers in Charge*; Stuart M. Butler and Robert E. Moffit, "The FEHBP as a Model for a New Medicare Program," *Health Affairs*, Vol. 14, No. 4 (Winter, 1995), pp. 47–61; and Harry P. Cain, "Moving Medicare to the FEHBP Model, or, How to Make An Elephant Fly," *Health Affairs*, Vol. 18, No. 4 (July/August 1999), pp. 25–39.

five Americans was enrolled in Medicaid for at least one month, and combined federal and state spending reached $431 billion.[51] Medicaid provides care to a very diverse group of individuals, including low-income children and pregnant mothers, low-income disabled, and low-income elderly seniors. However, some states have further expanded Medicaid's reach to cover other non-traditional populations. The program provides a broad set of health-related services, including a significant long-term care component. Medicaid is consuming ever-larger shares of federal and state budgets and threatening other budget priorities. Continued growth in enrollment and spending, accelerated by the PPACA, sets the stage for future demographic, fiscal, and structural challenges in Medicaid.

Medicaid enrollment averaged 58.6 million enrollees in 2012 and is expected to climb to 71.3 million in 2015 and reach 80.9 million by 2022.[52] In 2012, there were 28.3 million children in Medicaid, 14.6 million able-bodied adults, 9.7 million disabled, and 5.1 million elderly enrolled.[53] A considerable increase in the number of adults enrolled in Medicaid is expected as a result of the expansion of the program included in the PPACA. It is projected that 27.9 million able-bodied adults will be enrolled in Medicaid in 2022, trailing only slightly behind the 33.1 million children expected to be enrolled in the program.[54] This demographic shift in enrollment changes the traditional makeup of the program where children were by far the largest category.

Spending in Medicaid is also expected to increase significantly over the next decade. In 2012, combined federal and state spending reached $431 billion—$248.8 billion in federal spending and $182.2 billion in state spending. Spending is expected to hit $544.4 billion ($328.4 billion federal/$216 billion state) in 2015 and top $853.6 billion ($511.1 billion federal/$342.5 billion state) by 2022.[55] Medicaid spending as a share of gross domestic product is also rising and is expected to reach 3.3 percent by 2022. At the state level, Medicaid is already consuming over 23 percent of states' budgets,[56] diverting resources from other state priorities, such as education and transportation. Moreover, the greater the spending on Medicaid, the more dependent states become on federal funding.

Although children and adults account for the largest share of enrollment, spending is greatest among the aged and disabled. In 2012, the aged and disabled made up just over 25 percent of enrollment, but accounted for over 65 percent of Medicaid spending—principally payments for long-term care services.[57] Indeed, Medicaid is the largest payer for long-term care services. In the context of total national health care spending, Medicaid paid for 52.7 percent of all health, personal, and residence care, 37.2 percent of home health care, and 30.6 percent of nursing home care.[58]

Growth in enrollment and spending puts pressure on the program in other ways. Medicaid has a history of providing lower quality health care.[59] In addition to reasons such as bureaucratic red tape,

51. U.S Department of Health and Human Services, Center for Medicare and Medicaid Services, Office of the Actuary, *2013 Actuarial Report on the Financial Outlook for Medicaid*, 2013, p. iii, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/medicaidReport2013.pdf (accessed October 9, 2014).
52. Ibid., p. 66.
53. Ibid., p. 63.
54. Ibid.
55. Ibid., p. 24.
56. National Association of State Budget Officers, *State Expenditure Report: Examining Fiscal 2011–2013 State Spending*, November 21, 2013, p. 42, http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report%20%28Fiscal%202011-2013%20Data%29.pdf (accessed October 9, 2014).
57. *2013 Actuarial Report*, p. 16.
58. Ibid., p. 52.
59. Kevin D. Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation *Backgrounder* No. 2740, November 7, 2012, http://www.heritage.org/research/reports/2012/11/studies-show-medicaid-patients-have-worse-access-and-outcomes-than-the-privately-insured.

many physicians decline to participate in Medicaid due to low payment rates in many states.[60] Historically, FFS Medicaid pays physicians two-thirds of what Medicare pays for the same services,[61] while Medicare typically pays less than the private market. Moreover, states continue to depend on various cost-containment measures to keep Medicaid within budget,[62] some of which impact access and quality of care.

The PPACA and Medicaid. Rather than initiating any meaningful reforms that might improve the struggling program and bring spending under control, the PPACA simply fuels further expansion and spending.[63] The PPACA expands eligibility to able-bodied, working age adults—the vast majority of whom do not have dependent children—up the income scale to 138 percent of the federal poverty level. Furthermore, the PPACA fully funds this new expansion population for three years. The federal government assumes 100 percent of the Medicaid benefit costs (but not administrative costs) for this newly designated group in 2014, 2015, and 2016. Thereafter, the federal share will gradually decline until it reaches 90 percent in 2020. However, that does not mean that state spending will be flat. The Heritage Foundation estimates that the vast majority of states will also incur additional costs.[64]

As a result of the Supreme Court decision in *NFIB v. Sebelius*, the Centers for Medicare and Medicaid Services Actuary adjusted its Medicaid spending projections to account for expectation that some states would choose not to expand Medicaid.[65] The Actuary now projects that the PPACA will increase Medicaid spending by $500 billion between 2013 and 2022 relative to what would have been spent without the law. The Actuary also projects that Medicaid enrollment will increase by 18 million individuals as a result of the PPACA.[66]

Likely acknowledging that access to care remains a significant challenge, the PPACA authors also provided new federal dollars to increase reimbursement for primary care physicians. While that extra funding is temporary (two years), there are already efforts underway to retain this enhanced federal funding.[67] This will likely encourage specialty physicians in Medicaid to demand the same treatment, which would overextend taxpayer obligations even further.

A Better Approach. The best solution for low-income individuals and families in need of quality health care is to reform the Medicaid program. Medicaid should be broken down into three discrete programs with tailored policies that best fit the unique needs of each population. As a general principle, such

60. For a discussion on the access and payment, see Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, June 2013, p. 50, https://a7d050c2-a-10078ef1-s-sites.googlegroups.com/a/macpac.gov/macpac/reports/2013-06-15_MACPAC_Report.pdf?attachauth=ANoY7crzVwRhxkgK9TSbL5GYeLzb6qj3DuDVcQM0ywfzD1alU4mvzsgb9WU7U8ptAtkNPBULpqD1ZerZn6yh5bzpLw5pzV2As_RUT8_1wDSKYJS02hzrJdHvgfP0DdqQiM9zwaO32hljFhxf55hMEr-b3WuRJVoGEe1muVbyy_NwieVsIUkclTPEaKb6uxMQAjdZhWYUGLKEo_qpWSTqUpCe6TDxRe_R0QUqTIedZ3aHAXbK0-g9rYs%3D&attredirects=0 (accessed October 9, 2014).

61. Ibid.

62. For a summary of the various state efforts on cost containment, see Vernon K. Smith et al., *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, The Henry J. Kaiser Family Foundation, October 2013, http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/ (accessed October 9, 2014).

63. For a further discussion on the PPACA provisions and Medicaid, see Brian Blase, "Obamacare and Medicaid: Expanding a Broken Entitlement and Busting State Budgets," Heritage Foundation *WebMemo* No. 3107, January 19, 2011, http://www.heritage.org/research/reports/2011/01/obamacare-and-medicaid-expanding-a-broken-entitlement-and-busting-state-budgets, and Edmund F. Haislmaier and Brian Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, http://www.heritage.org/research/reports/2010/07/obamacare-impact-on-states.

64. Drew Gonshorowski, "Medicaid Expansion Will Become More Costly to States," Heritage Foundation *Issue Brief* No. 3709, August 30, 2012, http://www.heritage.org/research/reports/2012/08/medicaid-expansion-will-become-more-costly-to-states.

65. For a discussion of the impact of the Supreme Court decision, see Nina Owcharenko, "The Supreme Court's Medicaid Decision: The Obamacare Mess Just Got Messier," Heritage Foundation *Issue Brief* No. 3663, July 11, 2012, http://www.heritage.org/research/reports/2012/07/obamacare-fallout-from-the-supreme-court-and-medicaid-expansion.

66. *2013 Actuary Report*, p. iv.

67. Sophia Duong, "Congress and States Work to Extend ACA's Medicaid Primary Care Bump," Center for Children and Families Health Blog, Georgetown University, August 7, 2014, http://ccf.georgetown.edu/all/congress-and-states-work-to-extend-acas-medicaid-primary-care-bump (accessed October 9, 2014).

reforms would give enrollees more choices and more control over their health care decisions and in the end deliver better quality and better access to those in need.

Congress should start by taking immediate action to reduce the enhanced funding for the new expansion population provided to the states under the PPACA. Rather than simplifying and stabilizing Medicaid's financing, the PPACA's higher federal funding for the expansion population creates a new layer of complexity in the program, further undermines the future stability of the program, and encourages states to shift attention from the traditional mission of the program—serving indigent children, parents, the elderly and disabled—toward a new group of able-bodied, working age adults.

In addition, like the new tax option for those with employer-based coverage, Congress should allow those currently enrolled in Medicaid—specifically the non-disabled, non-elderly—to opt out of Medicaid and purchase coverage of their choice using existing Medicaid dollars and without the burden of existing restrictions. Enrollees would be able to decide whether to stay in the traditional Medicaid program or to purchase private health insurance outside Medicaid. In a post-PPACA environment, this would provide enrollees with short-term relief that expands their options as Congress tackles more fundamental Medicaid reform.

Long term, Congress, in conjunction with the states, should pursue further structural changes to Medicaid. Congress should restructure the traditional federal funding formula to a per capita amount based on each eligibility group. Meaning, Congress should set a separate funding level for children, a separate funding level for parents, a separate funding level for the elderly, and a separate funding level for the disabled. This would begin transitioning Medicaid into more discrete, focused, and manageable programs while creating more stable and predictable budgets with savings for both federal and state taxpayers.

From there, low-income children and parents should have their federal Medicaid contribution converted into direct assistance to purchase private health insurance. States, of course, would be allowed to supplement the federal contribution as they see fit. Rather than depending on the Medicaid bureaucracy for their care, those low-income families would be able to purchase private health insurance of their choosing, including coverage at the place of work.

Currently, Medicaid also provides "wrap around" coverage to Medicare for the low-income elderly that pays their Medicare premiums, deductibles, and coinsurance. However, under a comprehensive, reformed Medicare premium support program, those funds would be reprogrammed to give those beneficiaries a greater contribution to cover premiums and cost sharing.[68] That way, low-income seniors would still receive the same level of assistance, but it would be provided through one program rather than two.

Finally, yet equally as important, the low-income disabled enrolled in Medicaid, would, under the new financing arrangement, have more access to patient-centered options, such as personal accounts and counseling, to let them to exercise greater control over the direction and management of their care.[69]

These reforms would refocus the Medicaid program, provide budget reliability, better address the unique needs of the different diverse populations currently covered by the program, and provide beneficiaries with better access to medical care by embracing successful models based on patient choice and competition.[70]

Opportunity for a Fresh Start

The debate over reforming America's health care system is far from over. The ongoing implementa-

68. Jonathan Crowe, "How Competitive Private Plans Can Improve Care for Dual-Eligible Beneficiaries of Medicare and Medicaid," Heritage Foundation *Backgrounder* No. 2925, July 10, 2014, http://www.heritage.org/research/reports/2014/07/how-competitive-private-plans-can-improve-care-for-dual-eligible-beneficiaries-of-medicare-and-medicaid.

69. For a description of these types of consumer-based reforms, see "Cash and Counseling," Robert Wood Johnson Foundation, June 11, 2013, http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf406468 (accessed October 17, 2014), and Centers for Medicare and Medicaid Services, "Self Directed Services," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html (accessed October 17, 2014).

70. Nina Owcharenko, "Medicaid Reform: More than a Block Grant Is Needed," Heritage Foundation *Issue Brief* No. 3590, May 4, 2012, http://www.heritage.org/research/reports/2012/05/three-steps-to-medicaid-reform.

tion and technical problems plaguing the PPACA, combined with consistent opposition to the law as a whole, will necessitate another debate over health care reform. That will offer opportunities for Congress to advance a much better alternative. The alternative is one that does not reinforce greater government control as does the PPACA, but rather provides a fresh approach based on patient-centered, market-based principles. Such an approach would address the ongoing challenges associated with the tax treatment of health insurance, the over-regulation of insurance markets, and the pressing need for serious reforms to health care entitlements.

*—**Edmund F. Haislmaier** is Senior Research Fellow; **Robert E. Moffit, PhD,** is Senior Fellow; **Nina Owcharenko** is Preston A. Wells Jr. Fellow and Director; and **Alyene Senger** is a Research Associate, in the Center for Health Policy Studies, of the Institute for Family, Community, and Opportunity, at The Heritage Foundation.*