



## Constructing an Alternative to Obamacare: Key Details for a Practical Replacement Program

By James C. Capretta

*Despite President Obama's successful reelection campaign, opposition to his signature domestic initiative—the health care law passed in 2010, often referred to as “Obamacare”—remains intense. Polls continue to show that more Americans are against Obamacare than for it. But these polls also demonstrate that voters want the pressing problems of the system fixed, just without the massive expansion of governmental power and spending contained in Obamacare. A market-based reform agenda could deliver much more positive results than a federally managed approach like Obamacare. Seven pillars that would support such an effective replacement program are: to build a “defined contribution” approach to the public financing of health care, encourage personal responsibility and mandate continuous coverage protection, establish a genuine partnership with the states, address the tax treatment of employer-sponsored plans, overhaul Medicaid, initiate premium-support reform of Medicare, and, finally, offset all new costs through spending cuts. If successful, this new program could permanently change the national political conversation over health care policy.*

Health care policy has been front and center in the national political conversation ever since President Obama launched his effort to enact a reform plan with a decidedly government-centric focus. Opponents of what has become known as Obamacare have expended much time and energy informing the public of the law's significant dangers to the national economy, federal budget, and quality of American health care. And it is clear that effort has succeeded.

Public opinion has consistently run against the Obamacare framework, both during the debate over its enactment by Congress and in the two and half years that have passed since the president signed it into law. Even after the president's successful reelection effort, opposition to the law remains intense.

But while more Americans are against Obamacare than for it, polls also show that a strong

majority of the electorate want the very real problems in the health system fixed—just without the massive expansion of governmental power and spending that characterize Obamacare. This

### Key points in this Outlook:

- Despite President Obama's successful reelection, opposition to his federally managed health care initiative remains intense.
- Broadly speaking, a successful alternative to Obamacare would be based on market principles, consumer choice, and fiscal discipline.
- More specifically, this replacement program would involve changes to public financing of health care, continuous coverage protection, a federal partnership with the states, addressing the tax treatment of employer-sponsored plans, overhauling Medicaid, reforming Medicare, and making spending cuts.

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strong impulse for a positive reform agenda could undermine a repeal effort if there is no realistic program being readied to replace Obamacare.

Fortunately for Obamacare's opponents, much of the work needed to construct a viable alternative was already done many years ago by a band of economists and health policy experts who have long argued that a market-based approach to reform would deliver far better results than one managed by the federal government, as Obamacare would be.

Robert Moffit and I provided an overview of what a market-based reform plan would look like in the spring 2012 issue of *National Affairs*.<sup>1</sup> The article listed seven key principles for an effective replacement program:

1. **Defined Contribution Health Care.** What health care needs more than anything is the discipline of a functioning marketplace, and a marketplace only exists if consumers are cost-conscious. That will necessarily mean conversion of today's open-ended federal subsidies for insurance into "defined contribution" payments that give consumers strong incentives to seek out the best value with the fixed support they get.
2. **Continuous Coverage Protection.** Today, Americans must switch insurance when they switch jobs. A law passed in 1996 has mainly smoothed out transition problems between job-based plans. Specifically, workers (or their family members) with preexisting conditions cannot be penalized when they sign up with insurance at a new job so long as they have had insurance for a specified period of time. Unfortunately, the law did not adequately extend the same protection for people who transition from job-based coverage to individually purchased insurance. Those gaps need to be filled within a broad commitment to the American people: so long as people remain continuously insured with at least catastrophic insurance, they should never be forced to pay high premiums solely because they develop a costly health condition.
3. **A Genuine Partnership with the States.** Any solution to the problems of American health care will necessarily entail some uniform national policies. But there should also be plenty of room for states to adopt approaches suited to their needs within a federal framework. States should be given the lead role in insurance regulation, Medicaid reform, and ensuring consumers have sufficient information to make informed choices.
4. **Reforming the Tax Treatment of Employer-Paid Premiums.** The favorable tax treatment of employer-sponsored health insurance has made this type of coverage far more attractive than alternatives. But relying so heavily on workplace insurance has stifled the individual market. Moreover, because the tax break has no limit, it fuels cost escalation. Fixing American health care will necessarily require reforming this central feature of today's system.
5. **Medicaid Reform.** Federal rules limit the states' ability to implement cost-saving approaches in Medicaid. Moreover, because it is a matching program with more federal money flowing to the most expensive programs, states have a disincentive for cost-cutting. On average, states need to cut nearly \$2.50 in combined federal and state Medicaid spending to save \$1.00 in state funds, as the first \$1.50 gets returned to the federal government. Reform must give states the freedom to implement sensible, market-based reforms.
6. **Medicare Reform.** Medicare is the largest and most important purchaser of health services in the country. Its dominant fee-for-service insurance option is the primary reason the American system is characterized by fragmented and procedure-driven health care. It will not be possible to improve the efficiency of American health care without Medicare reform. In particular, Medicare must move away from a system of centrally managed price controls and toward a market-driven program with beneficiaries choosing from competing options based on their prices and quality.
7. **Spending Cuts to Improve the Deficit Outlook and Offset Costs.** Obamacare increases taxes by \$1 trillion over a decade to pay for the law's massive new entitlement spending. This is one of the main reasons for the intense public opposition to the law. The alternative to Obamacare must exhibit much more spending discipline and finance any additional outlays with spending cuts, not tax increases. Indeed, overall, the alternative should provide a net reduction in taxes, spending, and projected future deficits.

These principles simply provide what is needed to begin constructing a workable replacement plan for Obamacare. This paper is an attempt to go deeper into the details of some of the more important design features

of a market-based-reform-program plan. The aim is to develop an approach that is both robust enough to solve the very real problems that plague American health care and appealing enough to gain support among a broad coalition of citizens sincerely open to a viable alternative to Obamacare.

## **Targeted Reform of the Tax Treatment of Employer-Paid Health Insurance**

The vast majority of working-age Americans (and their dependents) get their health insurance through their employers. The reason is simple: employer-paid premiums do not count as taxable income to workers for purposes of federal income and payroll taxes, thus making job-based coverage for health insurance far preferable to the alternatives.

From a certain perspective, this policy of encouraging widespread adoption of employer-sponsored insurance has worked remarkably well: some 156 million Americans under the age of 65 get their private-sector health insurance from their employers.<sup>2</sup> And this insurance is generally popular with workers, for good reason. It is why most Americans have ready access to a broad and high-quality network of physician clinics and hospitals.

But the favorable tax treatment of job-based insurance is far from a benign policy. It is one of the most important sources of the significant problems that have plagued American health care for decades.

For starters, because the federal tax break is conferred without limit, it encourages high-cost health care. The most expensive employer plans enjoy the largest federal tax breaks, and workers have an inflated preference for getting paid with health insurance rather than cash because the former is tax exempt while the latter is not.

For middle- and upper-class families, this is no small matter. For a family facing a 40 percent marginal tax rate on income (25 percent for income taxes, and 15 percent for payroll taxes), the implicit value of the federal tax break for health care is worth more than \$5,000 on a \$13,000 employer-sponsored plan. Moreover, the value of the tax break generally rises with salaries because higher-paid workers tend to face higher marginal tax rates—and thus save more when their employer plan is conferred tax-free.

The worst side-effect of exempting employer-paid premiums from taxation is that it has undermined any chance for a vibrant individual health insurance market to emerge in the United States. Workers are so much

better off enrolled in employer plans that they only enter the individual market if they do not work or work at firms that do not sponsor plans. With much smaller numbers of enrollees, the premiums in the subdivided market are highly sensitive to the risk profile of the participants, and therefore more volatile (and sometimes much higher) than the premiums charged for employer coverage.

Heavy reliance on employer-based insurance is also a primary reason for large numbers of uninsured Americans. Workers who are in between jobs often go without insurance until they can find new work (even though they usually have the option to stay on their former employer's plan for up to 18 months). Consequently, very large numbers of Americans experience short spells without insurance—spells that could be eliminated if Americans owned their insurance and retained it even when they were out of work, much as they do today with car insurance.

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This phenomenon of going uninsured for temporary periods of unemployment is so common that it distorts our understanding of the uninsured. When the US Census Bureau reports that there are 50 million uninsured (as it did in 2010), most people tend to think there is a large, permanent class of Americans who go without coverage on a permanent basis.

But this is not true. The uninsured is a very dynamic group that is constantly changing as people move into and out of coverage based on their employment status. A recent study found that the number of uninsured individuals who went without coverage between 2004 and 2007 was just 12 million.<sup>3</sup> It is this group that might be considered the permanently uninsured.

The study also found, however, that a much larger group of people—some 89 million—experienced at least one month without insurance during this four-year period. It is this group that swells the official measures of the uninsured—even though the vast majority of them are just as likely to have had insurance at any given point in time. The large number of Americans who vacillate between having coverage and lacking coverage is an indication that the job-based insurance system does not work for many millions of lower-wage workers who are

employed in industries and firms that may or may not sponsor a health plan.

The problems with excessive reliance on job-based health insurance have been known for many years, but the policy has been extremely hard to change because of the political difficulty of disrupting coverage for so many middle-class and upper-middle-class Americans who are insured through work. For them, job-based insurance is entirely satisfactory and stable. They support the concept of health care reform because they see the problems that plague the broader system. But they are very reluctant to embrace any kind of reform approach that might disrupt their job-based coverage because it provides them with ready access to a broad network of physicians and hospitals.

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A possible solution is reforming the tax treatment of insurance. Instead of attempting wholesale change, such as Senator John McCain's 2008 proposal to eliminate the current tax break altogether and replace it with a universal credit, it would be far easier politically to alter the tax treatment just for the segments of the marketplace that are not being served well by today's arrangements.

This would mean adjusting the tax treatment of health insurance for those who work in smaller firms (perhaps defined as those with less than 50 or 100 workers) and are therefore more likely to experience episodic coverage, or lack of coverage, over time. For these workers, it would be far better to get a refundable tax credit that they can use to buy insurance that they keep even as their life circumstances change.

The value of the credit for these workers should be set at something approximating the current value of the tax preference for an average premium employer plan. For families, this would mean a tax credit in the range of about \$5,000, and for individuals, about \$2,500. After a year, these amounts could be indexed to grow with some measure of inflation, such as the medical consumer price index.

These credits should also be extended to people with no attachment to the workplace at all. This would eliminate the discriminatory feature of today's system that penalizes those who buy insurance outside the employer system.

For workers in larger employer plans, however, the current tax exemption for employer-paid premiums would remain in place so as to minimize disruption of these plans. But, to improve cost discipline in these plans, it would be important to place an upper limit on the value of the tax preference, perhaps at plans priced at the 75th percentile in terms of expense.<sup>4</sup>

This would encourage the continuation of this employer-sponsored insurance, but with new incentives for cost control. Applying this kind of "tax cap" to the tens of millions of workers in large employer plans would have an important effect on the entire health system, as workers who are currently largely indifferent to the cost of their plans would have a newly acquired interest in enrolling in plans with premiums that fall below the "tax cap" threshold.

## **The Role of the States in Facilitating a Functioning Marketplace**

Some suggest that the state-based "exchanges" in Obamacare are a nod toward market-based reform because, in theory at least, the exchanges are supposed to facilitate informed consumer choice of health plans. And it is certainly true that a properly run exchange could aid in the transparency of the marketplace and ease the enrollment and premium-payment process for consumers. These features of a theoretical exchange *might* make local health insurance markets run more smoothly than they otherwise would—but, it is important to keep in mind that the exchanges created in Obamacare will not exist in an apolitical vacuum.

The fundamental struggle is over how to allocate scarce health care resources. Should the federal government do so through regulation, tax collection, and spending programs? Or should consumers call the shots in a functioning marketplace? Every reform idea is judged by whether it pushes the overall system more toward one side or the other of this crucial policy divide.

And so, which is it with the Obamacare exchanges? Are they the foundations for a market-driven system? Or are they new bureaucratic structures that will bring under government control portions of the health system that currently lie outside of the government's reach?

Under the law, the federal government will provide massive new subsidization for health insurance for those

with incomes between 135 and 400 percent of the poverty line—but only if they get their insurance through the Obamacare exchanges. This will provide a powerful incentive for millions of Americans to get their insurance in the exchanges. And when they do, the federal government has the legal discretion to impose any number of different regulatory requirements on insurance plans being offered, including what premiums can be charged. Most importantly, the law allows the federal government—working with the states—to block some insurers from participating in the exchanges. In effect, the federal government has the power to put insurers out of business.

The federal government is currently playing down this immense power and deferring to the states in the hope that they will become more cooperative in building the first iterations of these agencies for the 2014 launch year. But this “hands off” approach will almost certainly end at the first sign of a budget crisis. Then, the government will very likely begin considering the same options to control costs that have been under review in Massachusetts, including imposition of Medicare’s regulated-payment systems on all of the insurance offered and purchased in the exchanges.

This approach to cost control is favored by some politicians because it creates the impression that it is only the “providers”—not the beneficiaries—that will see cuts from the changes. Extending the Medicare payment regulations into the exchanges would represent a very large step toward an “all payer” health system and a similarly large step away from a market-driven system in which pricing must be free to float to send the proper signals to consumers.

By contrast, a genuine market-based reform will set in motion changes that will not be easily hijacked for a government takeover of the health system. Instead of blindly embracing the exchange concept, pro-market reformers should approach the question of the state role in reform from a functional rather than an organizational perspective. In other words, what do states need to do for a thriving, adaptable marketplace to emerge? From this perspective, two critical roles for the states stand out.

First, the states must implement a small number of changes to create what might be called “continuous coverage protection.” The idea is to guarantee that the premiums of all Americans who stay in continuous insurance coverage (defined as having at least catastrophic insurance protection) will not be adjusted based on changes in their health status. This would require states

to change how they regulate insurance for people moving from larger employer plans to the individual or small-group market. Insurers in these markets would be required to offer coverage to people who have stayed continuously insured for the required period of time, without exclusions for preexisting conditions, and at standard rates based on age and residence.

With these changes, more Americans with expensive health costs would be entering the state-regulated insurance markets. Under current rules, states often allow insurers to pass expectations of high costs directly to the higher-risk consumers in the form of higher premiums. This would no longer be allowed under the proposed framework, so states would need to work with the federal government to provide more direct subsidies to the insurance plans from high-risk pools to keep overall premiums from rising precipitously.

Most states have high-risk pools that could be leveraged and enlarged (with federal money) to cover the added expense associated with this change. States would then need to work with insurers to establish a system to identify the truly high-risk cases among the state’s insured population. To prevent abuse, states would need to create disincentives for excessive referrals for high-risk funding, perhaps by penalizing insurers for seeking subsidization for people who are found unqualified.

The second important role for the states would be reducing the burden that citizens eligible for the tax credit will face when they want to find and sign up for coverage. Specifically, states would need to establish a process by which individuals could make their selection of health insurance, and the state would forward those selections to the federal government so that the credits could be paid directly to the insurance plans chosen.

Under Obamacare, this process is assigned to a bureaucracy—the state exchanges. But there is no reason a state could not handle this process without ever building a new bureaucracy. For instance, private vendors already facilitate the choice of health insurance in the private market. States could leverage that capacity to build platforms tailored to tax-credit individuals.

Moreover, states could approach the task of aiding consumer choice by focusing strictly on the transparency and accessibility of the information available to consumers. The states could work with all licensed insurers and brokers to require the standardization of comparison information and then require insurers as well as employers not offering insurance to participate in the broad distribution of that information to the tax-credit-eligible public.

## The Role of Default Insurance

As mentioned, a critical component of a market-based reform plan is the promise of continuous-coverage protection. The idea is to use the principle of the marketplace to provide strong incentives to stay insured. Under this concept, anyone who retained at least catastrophic insurance coverage without significant interruption could not be charged higher premiums based on deteriorating health status. In other words, someone who stayed insured could not be penalized with higher premiums just because he or she got sick.

Today, the law protects people from this kind of problem when they move from one job-based insurance plan to another. But there are cracks in the system when workers leave employer-sponsored plans and try to get insurance in the individual market. The number of people faced with this situation is large enough to resonate politically. Many millions of middle-class Americans have good, secure insurance today, but worry that they too could one day have a preexisting condition and face exorbitant premiums.

Fixing the regulatory portion of this problem is relatively straightforward. The challenge is establishing updated federal rules that allow the continuously insured to go directly from an employer plan to an individually owned product without a preexisting condition being held against them.<sup>5</sup>

Of course, for the marketplace to function properly, it must be the case that someone who *does not* retain continuous insurance protection can face higher premiums based on his or her health risk. Otherwise, the insurance market would suffer from the same problems experienced in those states that required insurers to sell their policies to all comers, including new market entrants. These states experienced severe adverse selection in their insurance systems, with the sick signing up for coverage at high rates and the healthy purchasing insurance only when they knew they would need to use it.<sup>6</sup>

Consequently, a market-based approach not only needs to address the issue of preexisting conditions with sensible protections for the continuously insured, it must also provide a realistic avenue for staying continuously insured, even for low-wage households that are most susceptible to being uninsured.

As mentioned earlier, the reform approach advocated here would address this issue by providing anyone without a large employer health plan with a refundable tax credit that could be used only to secure health

insurance coverage. This policy is, for all intents and purposes, a universal plan for insurance coverage, because every American household would either be in a large employer plan or get the refundable credit.<sup>7</sup> Thus, there would be no reason for anyone to have a break in coverage.

Yet even with a widely available tax credit for insurance, some portion of the population would likely still go uninsured, for a variety of reasons (this is often the case with other programs like Medicaid, in which eligible individuals fail to sign up in large numbers). There are a couple of reasons for this phenomenon: some people are hard to reach in terms of public information campaigns, and others tend not to make significant changes to their life arrangements without a clear need and direct, personal intervention.

It is possible, however, to boost insurance coverage among the hard-to-reach population without resorting to coercive mandates or requirements. Under the framework proposed here, this could be done through what might be called “default insurance.” States would be responsible for designating several insurance plans as default options to which persons who are eligible for a refundable tax credit would be assigned (on a random basis) if they failed to sign up for coverage on their own.

The key to making this concept work is that the premiums for default insurance would need to be set to the value of the tax credit so that persons who were assigned to such plans would not be charged any additional premium. And to keep the premiums equal to the credits, the insurance plans must be given the authority to set their up-front deductibles accordingly so that the cost of the coverage does not exceed the federal credit.

This approach would of course mean that persons assigned to default plans would likely get catastrophic insurance coverage, with a larger-than-normal deductible. Nonetheless, they would have insurance to protect them against high medical expenses, which is the primary need and benefit of health coverage. Most importantly, those who were assigned to a default plan would retain the continuous coverage designation, and thus be protected against getting risk rated later based on their health status.

This approach would not preclude those who are initially assigned to a default plan from later switching to a plan of their choosing, or from dropping out of the insurance system altogether. The default concept is simply a way to approximate universal enrollment in insurance in a voluntary, consumer-driven marketplace.

## A State Option for Medicaid Reform

Today, participants in Medicaid are not integrated into the insurance system through which other working-age Americans get their coverage.<sup>8</sup> This separation of Medicaid from the rest of the insurance marketplace is one of the most serious defects of today's arrangements.

For one thing, it has led to the separation of the Medicaid population from mainstream medical-service delivery systems in many communities. Medicaid pays far below commercial rates and is therefore less attractive to physicians and hospitals. Medicaid participants are thus forced to get their care from a narrow set of willing providers, which leads far too often to substandard care.

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Medicaid's isolation from the rest of commercial insurance for the working-age population also impedes welfare reform. Today, when people with low incomes move up the wage scale, they might reach a point where they earn too much to stay on Medicaid. When this happens, they generally cannot keep the plans they have by paying the premiums themselves. Instead, they have to find new insurance coverage, presumably through their workplace.

But, of course, some employers do not offer coverage, and those that do often offer coverage that is less generous than Medicaid. Thus, not only can getting a better-paying job result in discontinuity in insurance, it can also mean a reduction in the value of health coverage—a reduction that could exceed the additional cash compensation from the better-paying job. This is a tremendous disincentive to taking a higher-paying job, and thus also a hindrance to reducing welfare dependence.

The problem is further complicated by the lack of state flexibility regarding Medicaid. Today, the federal government enforces a series of rules that limit states' ability to use Medicaid resources more creatively to build a seamless statewide insurance system. The federal rules are a predictable byproduct of Medicaid's system of

federal-matching payments. On average, the federal government pays 57 percent of Medicaid costs, with the states paying for the balance. That inevitably leads the bureaucracy overseeing the program to implement rules intended to protect the federal government from unnecessary or wasteful expenditures.

Moreover, because the federal government pays more than half of each dollar spent in most states, states have much less incentive to pursue cost-cutting efforts because they lose federal funding with each dollar that is cut. So, for instance, in a state where the federal government is paying for 60 percent of Medicaid costs, the state legislature has to cut \$2.50 in combined federal and state Medicaid funding to reduce the state's costs by \$1.00. This is because the first \$1.50 in savings goes back to the federal government, not the state.

Fixing these problems requires fundamental reform at both the federal and state levels of government. For starters, the federal government should make all Medicaid participants eligible for the same refundable tax credit provided to small-business workers and other individuals who are not enrolled in large employer plans. This tax credit would form the foundation of their health care assistance, and would allow them to enroll in the same health insurance plans as other state residents. Importantly, the Medicaid participants would stay enrolled in these plans even if they go off Medicaid when they move into higher-paying jobs at small businesses.

Of course, the tax credit would be worth less than Medicaid coverage, and low-income families are not likely to have enough resources to pay large premiums for coverage themselves. Thus, the federal tax credit will need to be supplemented with a reformed Medicaid program that would be converted into a premium support payment for participants.

Implementing this reform would require changing the basis upon which the federal government makes payments to the states. Instead of matching payments, the federal government should make fixed, per capita payments to the states for coverage.<sup>9</sup> The per capita amounts would be tied to historical spending in the states, with the amount paid by the federal government in the form of tax credits deducted from the total. In the years after the first year, the per capita amounts would grow with an agreed-upon index, perhaps measuring medical inflation.

The per capita payments can be calibrated to be budget neutral for the federal government in year one (the tax credits paid to Medicaid-eligible participants must be

counted as part of the federal Medicaid spending commitment). In other words, aggregate federal payments to the states would be equal to expected federal spending if the matching system had been retained. After the first year, some savings would accrue to the federal government as the per capita payments would grow more slowly than Medicaid spending is expected to grow under current baseline projections.

Moving toward per capita payments would remove the distorting effects of today's matching system and provide budgetary predictability at the federal and state levels of government. It would also allow the federal government to give the states total discretion over the design of the program, because states could no longer increase the federal share of program spending with state-only actions.

States, for their part, should use this redesign of Medicaid at the federal level to put the program's participants into the same market-driven insurance system as everyone else. This would immediately improve access to care for the participants and also dramatically reduce the constant churning through insurance that causes so much of today's uninsured problem. The states would have wide discretion over how to accomplish this, including full authority to establish required benefits and other special rules that might apply to the Medicaid population. They would also establish the amounts of additional premium assistance provided through Medicaid, and how that assistance would be phased down as incomes rise.

States could also enroll Medicaid-eligible residents who fail to come forward to sign up for coverage in the same default insurance plans that apply to other tax-credit-eligible individuals. The premium for the Medicaid-eligible population would equal the combined value of the federal tax credit and the state-administered Medicaid payment. Enrolling the Medicaid-eligible population in default insurance would greatly reduce the ranks of the uninsured and broaden the population that would be protected against the costs of developing an expensive health condition.

## Spending Discipline to Offset Costs and Improve the Budget Outlook

A credible replacement program will cost *far* less than Obamacare, but it will not be free. In particular, the proposal to provide a refundable tax credit to individuals who are not attached to an employer plan or who work

for a small firm will result in some additional outlays as the amount of the credit will exceed the tax liability for many low-wage workers and thus will be assigned to the spending side of the government ledger. In addition, extending continuous coverage protection to persons who stay insured will necessarily mean providing some mechanism for subsidizing coverage for people who are high risks and get their insurance in the individual market at standard rates.

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It is quite plausible that a reform approach would generate \$5 to \$10 billion annually in savings after a few years of implementation.

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Today, the cost of providing insurance to high-risk enrollees is often shouldered by the enrollees themselves. When that option is negated, as it would be under this proposal, an alternative source of funding becomes necessary to cover the costs. One approach would be to increase funding for high-risk pools (at least during a temporary transition period) and allow states to use them to directly subsidize insurance premiums for people who are high risks but pay only standard rates because of the continuous coverage protection guarantee. After a period of time, as the number of individual-market insurance enrollees rises, the direct subsidies can be phased out as the high cost of a few enrollees can be spread over a larger number of healthy participants.

Estimating the expenditures of these two programs is difficult. However, based on prior proposals, it is likely that federal expenses would rise by approximately \$30 to \$40 billion per year—well below the \$200 billion (and rising) annual expense of Obamacare when fully implemented.

It is important to emphasize also that any proposed replacement health care system will need to differ markedly from Obamacare by providing a net tax and spending cut, rather than tax and spending increases. And the spending cuts must come from outside of the Medicare program, as the debate during the 2012 presidential campaign demonstrated. These are absolute requirements for securing the support of the political coalition needed to replace Obamacare with an alternative program. Moreover, the spending cuts will need to be larger than the tax cut to reduce projected federal deficits too.

How can this be done? For starters, there are offsets already built into the base policies of the replacement program described in this paper. Specifically, the upper limit on the tax preference for employer-paid premiums in large firms has the potential to generate substantial new revenue, depending on where the thresholds are established and the mechanism by which they rise each year after the first. The threshold and indexing mechanism can be adjusted as necessary to ensure that the tax take from this provision is close to, but does not exceed, the tax loss associated with extending tax credits to small-business workers and other individuals.<sup>10</sup>

This proposal would also reduce future federal Medicaid spending by increasing both the refundable tax credits and the new per capita Medicaid payments from the federal government to the states at rates that fall below projected baseline Medicaid spending growth. Additional cuts will be necessary, however. One option would be to cut Medicaid payments to the states for disproportionate hospital payments (DSH). Today, the Medicaid program spends about \$10 billion per year in payments to the states, notionally to provide subsidies to institutions caring for large numbers of uninsured citizens. Obamacare made cuts in this program, on the grounds that the law reduced the uninsured population and thus the need for the subsidies.

This same rationale could be used to retain the Obamacare cuts and to deepen them. Elimination of the Medicaid DSH payments in their entirety would generate about \$10 to \$11 billion per year initially, and lesser amounts in later years.<sup>11</sup>

Federal spending could also be substantially reduced by altering how the government establishes its contribution to health insurance for federal workers in the Federal Employees Health Benefits Program (FEHBP). Today, that contribution is tied to a percentage of the premium charged by a plan chosen by an individual worker, up to a limit. This approach is inconsistent with the defined contribution philosophy for reform because the government's contribution for federal workers goes up when a worker selects a more expensive plan, thus undermining the incentives for cost control.

Converting the government contribution to a fixed amount that is the same regardless of what plan is chosen by an individual worker would have much better incentive effects. The Congressional Budget Office (CBO) has estimated that converting the government contribution into an indexed voucher would generate \$15 billion in savings at the end of the decade.<sup>12</sup> These

savings would include some reduced payroll expenses for federal agencies that could only be captured by lowering the total caps on overall discretionary spending.

It is important to note that the proposal offered here for reforming the FEHBP differs from the CBO's estimate in that it would tie the federal government contribution more closely to the average premium charged by the competing plans, or perhaps some weighted average of the lowest two or three premiums. The cost savings are thus less certain, but it is quite plausible that a reform approach would generate \$5 to \$10 billion annually in savings after a few years of implementation.

Additional savings could be achieved by adjusting how the government subsidizes insurance for retired military personnel who are also eligible for Medicare. Under the TRICARE for Life program, the military provides additional insurance for retirees on Medicare, paying for the cost-sharing that Medicare does not cover. In an unmanaged insurance system like traditional Medicare, if there is no cost-sharing, then beneficiaries have no incentive not to use more services. That drives up costs for both the military and Medicare. Instituting modest cost-sharing amounts would reduce costs by about \$3 billion annually in the US Department of Defense. Additional savings would also occur in Medicare, but those savings would need to be dedicated entirely to deficit reduction, and not to the costs of an Obamacare replacement program.

## Conclusion

Despite the outcome of the presidential election, opposition to Obamacare remains intense. But it will not be possible to repeal Obamacare without also advancing a credible replacement program. This paper, along with the earlier paper providing the broad framework, is an attempt to help those who want to repeal Obamacare think through the practical details of building a market-based reform plan that is both politically viable and up to the task of solving the very real problems in the health care system.

There is no question that even this kind of a reform plan will entail significant controversy. Nothing as important as health care reform can be achieved without political risk. But the potential rewards are great as well. The public is dissatisfied with Obamacare's overreach, and remains open to credible alternative ideas. Obamacare's opponents should take advantage of this opening to present a fully developed alternative program. If they

do so, they may yet have the opportunity to move health policy away from Obamacare and toward a consumer-driven system.

## Notes

1. James C. Capretta and Robert E. Moffit, "How to Replace Obamacare," *National Affairs*, no. 11 (Spring 2012), [www.nationalaffairs.com/publications/detail/how-to-replace-obamacare](http://www.nationalaffairs.com/publications/detail/how-to-replace-obamacare).

2. US Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010*, September 2011, Table C-3, [www.census.gov/prod/2011pubs/p60-239.pdf](http://www.census.gov/prod/2011pubs/p60-239.pdf).

3. Pamela Farley Short et al., "New Estimates of Gaps and Transitions in Health Insurance," *Medical Care Research and Review*, August 3, 2012, [www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2012/Aug/1619\\_Short\\_new\\_estimates\\_gaps\\_hlt\\_ins\\_MCRR\\_07\\_24\\_2012\\_ITL\\_src.pdf](http://www.commonwealthfund.org/~media/Files/Publications/In%20the%20Literature/2012/Aug/1619_Short_new_estimates_gaps_hlt_ins_MCRR_07_24_2012_ITL_src.pdf).

4. This proposal differs from the "high-cost insurance tax" contained in Obamacare. That provision imposes an excise tax on insurance plans or employers that sponsor insurance coverage with premiums above a certain threshold. The proposal offered here would require that any employer-paid insurance premiums above the specified threshold be counted as taxable income to the worker. This would ensure that higher-wage workers pay more in taxes on their health insurance than low-wage workers because of their higher marginal tax rates.

5. The concept of continuous coverage protection is described in more detail in James C. Capretta and Tom Miller, "How to Cover Pre-Existing Conditions," *National Affairs*, no. 4 (Summer 2010), [www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions](http://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions).

6. Leigh Wachenheim and Hans Leida, *The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets* (Milliman, March 2012), [www.ahipcoverage.com/wp-content/uploads/2012/03/Updated-Milliman-Report.pdf](http://www.ahipcoverage.com/wp-content/uploads/2012/03/Updated-Milliman-Report.pdf).

7. Illegal immigrants would not be eligible for the refundable credit.

8. Medicaid has a large and diverse population of enrollees. Approximately one-third of enrollees are elderly and disabled, but they account for about two-thirds of Medicaid spending. The other two-thirds are working-age people and their families (very often, low-income women and children). The reforms discussed in this section are aimed at the enrollees who are not disabled or elderly and are enrolled in Medicaid for access to primary and acute medical care, not long-term care services.

9. Here, again, the reform applies to the nondisabled, nonelderly on Medicaid.

10. Though much of the cost of a refundable tax credit would show up on the outlay side of the federal budget, some would also reduce revenue.

11. Congressional Budget Office, *Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline*, March 2012, [www.cbo.gov/sites/default/files/cbofiles/attachments/43059\\_Medicaid.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/43059_Medicaid.pdf), and Congressional Budget Office, *Letter to House Speaker Nancy Pelosi from Douglas Elmendorf*, March 20, 2010, [www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf](http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf).

12. Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011, Mandatory Spending—Option 15, <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf>.