HEALTH-CARE REFORM

TO LOWER COSTS AND IMPROVE ACCESS AND QUALITY

JAMES C. CAPRETTA

Public opinion polls have consistently shown that more voters oppose Obamacare than support it, and that opposition to the law is more intense than support for it.[1] This resistance seems to perplex many of the law's defenders. How could voters oppose what the authors of the law plainly view as a well-intentioned effort to promote more widespread enrollment in health insurance?

The answer, of course, is that the public does not oppose sensible steps toward more secure and widespread health-insurance coverage. What voters oppose is the heavy governmental and technocratic approach that Obamacare embodies, and its consequences for affordability, quality, and choice. Though many left-leaning politicians assume it is self-evident that this kind of technocratic approach is necessary to fix the problems with American health care, voters are not so sure. They have first-hand experience with many public programs, and are wary of handing over something as complex and important as health care to the federal government. Their fear is that Obamacare will ultimately harm the quality of their care, inflate their costs, diminish their job prospects, and vastly increase the expense of the federal government and thus ultimately their taxes. The launch of Obamacare confirmed that all of these fears are well-founded.

The Obama administration got one thing right in its health care push: The system was badly in need of reform when the president took office. Unfortunately, administration officials misdiagnosed the cause, and then prescribed the wrong solution.

The core problem in American health care has been, and continues to be, that there is not a functional marketplace in health insurance or health services to discipline costs and promote quality and value for consumers. The Obama administration pays lip service to market-driven reform, but the real thrust of Obamacare is to expand governmental authority over the system, not to empower consumers or to encourage innovation.

Enthusiasts for government intervention, including the authors of Obamacare, often argue that a free-market approach to health care was tried in America and failed. But that is false. American health care has been dominated for decades by the federal government, through

vast subsidies for insurance and through payment regulations shaping the provision of medical services by hospitals and doctors. The result was a system dominated by third-party insurance arrangements, not consumer choice, and by federal regulations setting the terms for reimbursing hospitals and physicians.

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Providers were often restricted from trying new approaches to organizing and financing coverage and care, most consumers did not have the power to choose among real options, and failed price-control systems in massive federal programs persisted despite a proven inability to control costs. In sum, American health care before Obamacare was very far from a genuine marketplace.

Looking at that landscape in 2009, the Obama administration came into office and somehow concluded that the problem with American health care was insufficient governmental involvement. And so the law that was passed by a heavily Democratic Congress in 2010 doubled down on many of the worst features of the existing system: heavy public subsidies for third-party insurance enrollment and new and more restrictive federal regulations governing payments for medical services. It also handed vast new regulatory authority over the insurance sector to the Department of Health and Human Services and empowered new federal agencies and bureaucracies to step up the government's influence and control over the manner in which doctors and hospitals organize themselves to care for patients. All this tends to make it even more difficult for providers and insurers to try new approaches, for consumers to make real choices among real options, and for bad ideas to be abandoned.

In short, Obamacare was a step in exactly the wrong direction. More than anything else, the law set in motion a massive shift of decision-making authority from states, employers, insurers, and consumers to the federal government. In a way, that was the point. The authors of the law believe that muscular federal control is essential to expanding coverage in an equitable manner.

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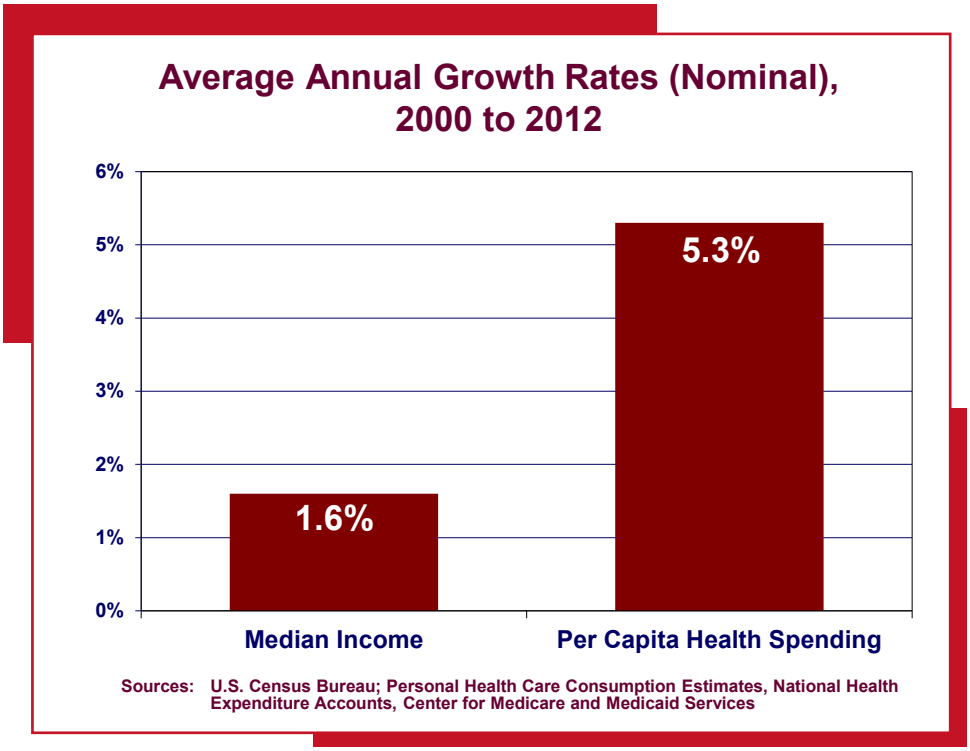
But average middle-class families do not expect this shift of power to do anything to help them, especially with respect to rising health costs, which are their chief concern. From 2000 to 2012, median household income rose at an average annual rate of just 1.6 percent, according to the Census Bureau. During that same period, per-capita health spending rose at an average annual rate of 5.3 percent. Rising health costs have contributed directly to the stagnation of cash compensation as employers have kept pay raises low in response to the rising costs of employee health benefit plans. Obamacare's substantial new subsidies for third-party insurance look likely to increase cost pressures, not decrease them.



The centralization of power within the federal government, and specifically within HHS, will also have serious negative consequences for the quality of the health system. Government rulemaking and demonstration projects have already begun to displace private initiative. Instead of taking the lead to solve problems and improve care, the major players in the health system—employers, states, providers, and insurers—are now waiting for the latest pronouncements from HHS about what is and is not acceptable under Obamacare. Over time, it will become more difficult to find investment capital for initiatives that have to be given regulatory approval by the government. The spreading passivity among private actors will undermine innovation and adaptation, and thus also hinder improvements in the quality of care for patients.

The economic costs of the law are also coming into sharper focus. The Congressional Budget Office (CBO) recently issued new estimates for the law's impact on the labor market, and

found that it will reduce employment in the United States by the equivalent of some 2.5 million workers by 2024.[2] CBO's new projections also show that, even after a ten-year gross expenditure of $2 trillion, the number of uninsured Americans will still total 31 million in 2021 and beyond.[3]

For all of these reasons, public unease with the 2010 reform plan has grown, not receded, since the law was enacted. And therein lies an historic opportunity.

The Opening for an Appealing Conservative Alternative

Conservatives are united in their belief that Obamacare needs to be repealed. There is also near unanimity that the law needs to be replaced with an effective, market-based alternative. But there is still a great deal of disagreement among conservatives about the content of that alternative plan.

There shouldn't be.

If a plan is to appeal to middle-class Americans—as it must to gain traction—then it will need to address middle-class concerns, and particularly the need to provide coverage for persons with pre-existing health conditions, to ensure all Americans have access to stable insurance, and to slow the pace of rising costs. These objectives need to be met without increasing the deficit and without handing over too much power to the federal government, as Obamacare would do.

It will also be necessary to have independent verification—in practice that means by the Congressional Budget Office—that a replacement plan could address these issues in a credible way. For instance, if a plan to replace Obamacare is found by CBO to do little or nothing to reduce the number of uninsured Americans, it is unlikely to get the political momentum necessary to fully displace Obamacare.

These objectives will narrow the policy options available to policymakers. Lower-income households will need public subsidies, for example, to be able to secure at least catastrophic insurance coverage and participate in a thriving consumer market, and those subsidies will have a budgetary cost. The new plan will also have to be designed so as not to unduly disrupt the insurance arrangements of the millions of middle-class families who now have coverage they are happy with.

Some conservatives get nervous at the prospect of engaging in this kind of policy discussion. They would prefer to repeal Obamacare and then proceed with a series of very small, incremental changes to the pre-Obamacare health system. But that approach is unlikely to succeed because it will be criticized as undoing protections for pre-existing conditions and doing nothing to help low-income households without health insurance. It also falls short of the significant step toward a market-oriented system that we should take.

Conservatives must see the present opportunity, provided by Obamcare, clearly. We have an opportunity to move our health-care system to the right not only of Obamacare but also of the pre-Obamacare status quo. The middle class is ready to hear from conservatives about their practical and realistic proposals to improve their lives. If conservatives seize the political moment, they

could displace the largest expansion of governmental power in a generation with a program that would unleash, for the first time, the real potential of consumer choice in health care. It would be the most significant conservative policy victory in many years.

Four Keys to Reform

The ideas that would inform a practical conservative alternative have been around for many years now, developed and advanced by a cadre of health-policy analysts and economists. All that is needed at this point is a persistent effort to pull those ideas together in a reform plan that can appeal to America's middle class and around which a stable center-right political coalition can form.

In early 2014, two plans were introduced that conservatives should look to as politically viable and credible blueprints for replacing Obamacare. The first was released by Republican Senators Richard Burr, Tom Coburn, and Orrin Hatch.[4] The second was put together by the 2017 Project, a non-profit organization dedicated to building and promoting a conservative reform agenda.[5] Though some of the details of these two plans differ, and future proposals from various conservatives could well differ in some key particulars too, they share a common structure and vision that will likely define any plausible conservative replacement for Obamacare. This structure consists of four key parts: a decentralized, market-oriented approach to the health-care system; tax credits for people outside the employer system achieved with minimal disruption of employer coverage; continuous coverage protection for all Americans; and significant state flexibility.

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First, the basic market orientation of this approach is in a sense its overarching characteristic. Addressing the complex problems bedeviling American health care will require the dynamism and discipline of a functioning marketplace. Rather than assume that bureaucrats in Washington have all the answers, such a market would allow providers on the ground to try new ways to deliver quality care at a low cost, would allow consumers on the ground to choose among these options to enable incremental progress toward a better system, and would allow those approaches that do not succeed to fall away and create both the incentives and the space for further improvement.

The Obama administration claims that Obamacare is a marketplace, but the reality is that it is a top-down, bureaucratic solution, with all of the critical decisions made in Washington. HHS strictly defines the insurance product and then compels insurers to sell it while the IRS compels consumers to buy it. That is not a market. The conservative alternative must employ a decentralized approach, with consumers driving the system

by the decisions they make about insurance coverage and the use of medical services. It must therefore feature far less prescriptive insurance regulation and much more room to experiment with options for consumers to consider. A model for these reforms can be found in the Medicare Part D program, a real marketplace that has restrained cost growth while also yielding high levels of choice and satisfaction for seniors.

Second, economists of all political stripes have long agreed that the open-ended tax subsidization of employer-paid health insurance is one of the main distortions of the existing system. It encourages excessively costly employer plans and discriminates against households that do not have access to employer coverage and thus must rely on the individual market for insurance. But conservatives must resist the temptation to simply undo current tax policy in an Obamacare replacement plan. Approximately 160 million people in the United States are enrolled in employer-sponsored insurance. Any widespread disruption of that coverage, as a complete rewrite of the federal tax treatment would surely involve, would be strongly resisted by the families benefitting from that coverage and would likely doom the entire reform effort.
A better approach, pursued in both the Republican Senators' plan and in the blueprint offered by the 2017 Project, among others, would leave in place the tax preference for employer coverage, but place an upper limit on the amount of employer-paid premiums that would enjoy tax-preferred status. This approach would allow these plans to continue operating as they do today, just with a greater incentive for cost discipline. The upper limit could be set to affect only the most expensive plans (such as plans with premiums in the top tenth or twentieth percentile, by cost).

At the same time, households that do not have access to employer coverage should be given a tax credit that is roughly equivalent to the value of the tax subsidy afforded to employer-sponsored plans. The credits could be adjusted by age categories (such as 18 to 34, 35 to 50, and 51 to 65), so that older citizens would get credits more reflective of their health risks, as would younger workers. The reform plans offered by the Republican Senators and the 2017 Project both provide age-adjusted credits.[6] The credits would also be entirely under the control of the households to which they are provided, and could be used only to secure insurance (or, if the credit exceeded the premium for coverage, to deposit into a health savings account).

A tax credit of this kind would help generate intense price competition in the marketplace. Consumers receiving the credit would have every incentive to find good value in health insurance because any premium charged by an insurance plan above the credit would be paid by the consumer, not the government. The upper limit on the tax preference for employer coverage would also encourage both firms and workers to shop around for good value in insurance plans.

Third, continuous-coverage protection would help address the challenge of covering Americans with pre-existing medical conditions. Americans must often switch insurance when they switch jobs, and a law passed in 1996 has largely worked to smooth out transition problems between job-based plans. Specifically, workers (or their family

members) with a pre-existing condition can't 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, that law did not adequately extend the same protection for people who transition from job-based coverage to individually purchased insurance.

This gap needs to be filled in the context of a broad commitment to the American people. Under the emerging conservative alternative to Obamacare, people who remain continuously insured, with at least catastrophic insurance, will never be forced to pay high premiums solely on the basis of developing a costly health condition. This new assurance would provide a powerful incentive for Americans to stay continuously enrolled in insurance. In combination with the new federal tax credits for coverage (provided to anyone without access to an employer plan), this reform would provide a direct and ready mechanism for all Americans to afford insurance and to have coverage that does not penalize them for their health conditions. Of course, for this new system to work, insurers must be allowed to assess the risks of those who opt out of insurance and then seek to enroll later in a plan.

This approach to solving the pre-existing condition problem is more or less the exact opposite of the approach taken in Obamacare. Under Obamacare, insurers are never allowed to take health risks into account, even if someone has dropped out of insurance and is signing up only because of a recently diagnosed condition. The law tries to counteract the strong incentive to wait until the last minute to enroll by taxing anyone who fails to buy qualified insurance. This "mandate and tax" scheme, which is a central feature of Obamacare, is one of the main reasons the current law is highly unpopular. By instead putting coverage within everyone's reach and rewarding the decision to obtain it, a conservative reform could cover more people while avoiding heavy handed and constitutionally dubious policies.

Finally, any solution to the problems in American health care will necessarily entail some uniform national policies. But the plans offered by the Republican Senators and the 2017 Project, like any plausible conservative approach, also leave plenty of room for states to adopt policies suited to their needs within a federal framework.

States are given the lead role in insurance regulation and ensuring consumers have the information they need to make informed choices. They also have the lead role in Medicaid reform. In both of the recent conservative replacement plans for Obamacare, like others before them, Medicaid recipients would be allowed to take the base part of their entitlement in the form of the new federal tax credit. States would then be allowed to establish mechanisms by which Medicaid enrollees use their credits, plus any additional Medicaid support provided by the state, to purchase from the same coverage options as other working-age people in the state. This is a crucially important reform, as it would allow Medicaid participants to stay enrolled in the same insurance plan even as they move into higher-paying jobs.

To give states the authority they need to make this kind of reform work, states

need to receive their Medicaid funds in predictable and flexible per-capita payments from the federal government. This would replace today's cumbersome and counterproductive matching program. The per-capita amounts would be tied to historical spending in the states. 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 to the federal government in the first year (and the tax credits paid to Medicaid-eligible participants must be counted as part of the federal Medicaid spending commitment). In other words, federal payments to the states would be equal, in the aggregate, to expected federal spending if today's 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 in Medicaid 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 state decisions could no longer increase federal spending commitments.

States would have wide discretion over how to design the new Medicaid program, 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.

Obamacare included many changes to Medicare too, many of which also deserve repeal and replacement. Among other things, the law includes large cuts in the Medicare Advantage program—a counterproductive move that will push more seniors back into the inefficient Medicare fee-for-service program. There are also deep cuts in the payment systems for hospitals and other providers of care that could cause access problems for seniors. Most conservatives rightly oppose this micromanagement and recognize that what Medicare needs are reforms that point the program in a more market-oriented direction (like those proposed in the House Republican budgets of the last few years).

But reversing the damaging Medicare changes in current law, and replacing them with sensible reforms, need not come in the same legislation replacing Obamacare.[7] Improving health care for the working age population and their families is likely to prove politically challenging enough without also adding to the mix significant Medicare reforms. Those can and should be considered in a separate piece of legislation.

Covering Millions at a Fraction of Obamacare's Expense

The Obama administration has frequently cited the estimates of the Congressional Budget Office to argue that Obamacare will deliver more enrollment in health insurance than the previous system, while still providing for a small reduction in the federal budget deficit over the program's first decade of implementation. The administration tends

to omit that these estimates rely on massive cuts in the Medicare program ($700 billion over a decade) and a $1 trillion tax increase. By contrast, the emerging conservative alternative can deliver just as much insurance enrollment without the massive taxes and spending of Obamacare.

A model for conservative reforms can be found in the Medicare Part D program, a real marketplace that has restrained cost growth while also yielding high levels of choice and satisfaction for seniors.

Recently, a new, independent analytical organization—the Center for Health and Economy—produced a cost estimate for the Burr-Coburn-Hatch blueprint.[8] Those estimates clearly indicate that the proposal from the Republican Senators would reduce the number of uninsured in the U.S. to essentially the same levels as Obamacare—about 30 million people. And it would do so with spending levels that are far lower than Obamacare. Consequently, there would be no need for the large taxes imposed by Obamacare either.

There is, in short, a real alternative to Obamacare. It will make secure insurance available to the uninsured and people with pre-existing conditions. It won't increase the nation's budget deficit, and, in fact, will lay the foundation for genuine cost discipline to lower health costs. And it will retain the rights of individuals, employers, and states to make decisions that are in their best interest without having to first ask permission from the federal government.

The difference between this approach and Obamacare is not a difference of degree but of kind. It is rooted in a different diagnosis of the problems with American health care and a different approach to solving complex economic and social problems more generally. Rather than empowering consolidated bureaucracies to impose strict rules, it empowers a decentralized system of continuous learning and incremental improvement to find solutions, try them out, build on those that work, and reject those found wanting. It offers a far superior approach to addressing our health-care dilemma, and a model of conservative problem-solving.

As Obamacare's implementation continues, voters are seeing up close the major flaws of handing over so much control over the health system to the federal government. It's an inflexible approach, with heavy benefit mandates, high expense, cumbersome bureaucracy, and high implicit taxes on work. As voter disenchantment with the current law intensifies, an historic, and possibly time-limited, opportunity is opening up for the law's opponents. The public is ready as it never has been before to hear about a credible, practical, and realistic market-based alternative to Obamacare's heavy-handed govern-

ment approach. It is imperative that conservatives seize this opportunity and begin to coalesce around just such a replacement plan.

There are some political risks associated with doing so. Health-care policy is complex, and moving toward a real marketplace requires placing more responsibility on the shoulders of consumers. Supporters of Obamacare will no doubt try to exploit this fact by scaring consumers about the supposed risks this shift would entail.

Proponents of the Obamacare alternative should not be deterred. They should be politically prudent of course, to minimize the risks. But if they follow the policy roadmaps outlined by Senators Burr, Coburn, and Hatch, by the 2017 Project, and by many other conservative reformers, they will have a plan that is far more appealing than Obamacare: a plan that addresses the pre-existing-condition problem, ensures widespread enrollment in affordable health insurance, and brings real cost discipline to the marketplace, all without the mandates, the taxes, or the massive power grab of Obamacare. There is great potential here not just for a policy victory, but for a massive political victory as well.

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The Problem: The anxieties and worries of Middle America PETER WEHNER

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5. Eduardo Porter, "America's Sinking Middle Class." *New York Times,* September 18, 2013, B1.
6. Carville and Greenberg, 49.
7. Jim Tankersley, "Economic mobility hasn't changed in a half-century in America, economists declare." *Washington Post,* January 22, 2014, A1.
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The Solution: A conservative governing vision to restore America's promise YUVAL LEVIN

1. So, for instance, Paul Krugman can write: "Start with the proposition that there is a legitimate left-right divide in U.S. politics, built around a real issue: how extensive should we make our social safety net, and (hence) how much do we need to raise in taxes? This is ultimately a values issue, with no right answer." Like many on the Left, he takes the essential question of our politics to be exactly how much of the Left's agenda should be adopted. ("The Closing of the Conservative Mind," *New York Times*, May 25, 2013, http://krugman.blogs.nytimes.com/2013/05/25/the-closing-of-the-conservative-mind/.)
2. As former representative Barney Frank put it at the Democratic National Convention in 2012, "There are things that a civilized society needs that we can only do when we do them together, and when we do them together that's called government." Similarly, in his second inaugural address, in 2013, President Obama sought to depict individual action as the only alternative to government action, saying: "No single person can train all the math and science teachers we'll need to equip our children for the future, or build the roads and networks and research labs that will bring new jobs and businesses to our shores. Now, more than ever, we must do these things together, as one nation and one people."
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Health-care reform to lower costs and improve access and quality JAMES C. CAPRETTA

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7. The Burr-Coburn-Hatch plan leaves the PPACA's Medicare changes in place, but that should not be construed as an endorsement of those provisions. Senator Coburn, for instance, has backed significant, market-based Medicare reforms in the past that would displace the need for the PPACA provisions. The 2017 Project plan would repeal the PPACA's Medicare cuts.
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Tax reform to strengthen the economy and lighten the burdens families bear ROBERT STEIN

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K–12 Education reform to give the next generation a chance to thrive FREDERICK M. HESS

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Higher-education reform to make college and career training more effective and affordable ANDREW P. KELLY

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