

BACKGROUND

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A Plan to Repeal and Replace Obamacare *Edmund Haislmaier, Robert E. Moffit, PhD, and Alyene Senger*

Abstract

Obamacare is a proven policy failure. Congress and the Trump Administration must completely repeal the law, beginning by seizing the opportunity to accomplish as much of repeal as possible through the reconciliation process. Congress must focus on the fundamentals: equalizing the tax treatment of health insurance; restoring commonsense regulation of health insurance; and addressing the serious need for reform in Medicare and Medicaid by adopting policies that give individuals control over their health care. High quality health care means all Americans should be free to choose a health care plan that meets their needs and reflects their values. Congress must act now to repeal Obamacare and replace it with a new set of options that empower Americans, not government.

High-quality health care means all Americans should be free to choose a health care plan that meets their needs and reflects their values. Congress must act now to empower Americans, not the government, when it comes to this personal and vital matter.

Obamacare's design flaws are well documented.¹ It is a sinking ship beyond repair. Congress must repeal Obamacare, freeing Americans from its damage. Congress should repeal as much of Obamacare through budget reconciliation as the process will allow. The 2015 reconciliation bill—which would have repealed much of Obamacare, but was vetoed—shows how to do this.

Congress must replace Obamacare through a careful process that establishes everyone on solid ground, offering greater fairness, choice, affordability, and sustainability than Obamacare—or the health care system before it—ever could. Moreover, the new health care provisions must not provide taxpayer funding of abortion.²

KEY POINTS

- Congress and the Trump Administration must repeal Obamacare, beginning immediately through the budget reconciliation process and executive action to roll back burdensome rules and regulations.
- Congress must replace Obamacare through a careful transition process that establishes everyone on more solid ground than that offered by either Obamacare or the prior system.
- Policymakers should empower consumers by equalizing the tax treatment of health care regardless of where individuals get their insurance, and they should increase Americans' health care choices through common-sense insurance market reforms.
- Congress can increase fairness, choice, and quality of care in Medicaid and Medicare by tailoring those programs to recipient needs, shifting toward a defined-contribution design that empowers participants to direct their health care.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3193>

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The new Administration and Congress have the opportunity not only to free America from the failure of Obamacare but also to improve on the prior system. Obamacare's design flaws render it unworkable, unfair, and unaffordable. Congress must repeal Obamacare, provide for a smooth transition,³ and focus on three elements necessary for creating an environment where all Americans have access to a variety of higher quality health care options:

- **Reforming** the tax treatment of health insurance so that individuals are treated the same by the government, regardless of where they buy health coverage;
- **Restoring** commonsense regulation of health insurance and devolving it back to the states; and
- **Modernizing** Medicare and Medicaid by adopting policies that harness the powerful free-market forces of choice and competition.⁴

Repeal Obamacare

The Trump Administration, Congress, and state officials must lead a smooth and methodical transition for the repeal of Obamacare. Congress should act immediately to initiate repeal while the Administration takes aggressive administrative actions to stabilize the private market for the upcoming 2018 plan cycle. States should take any steps necessary to reestablish control and oversight of their insurance markets. The Administration, Congress, and state leaders should then coordinate efforts to begin the process to have reforms in place for the 2019 plan cycle.⁵

Timing Is Critical. The provisions affecting private insurance markets should be changed as soon as possible. For 2017, insurance plans are already set, but insurers are preparing their 2018 plan offerings, which need to be finalized by May 2017.

Sequencing Is Also Crucial. Congress has adopted the two-budgets/two-reconciliation bills approach advocated by budget experts to enact repeal-and-replace legislation. Congress took the first step by passing a budget for fiscal year (FY) 2017 that created the opportunity to pass follow-on reconciliation legislation. But it still must pass a FY 2017 reconciliation package that repeals the major budgetary components of Obamacare. The next phase would be for Congress to pass a budget for FY 2018, again followed by a FY 2018 reconciliation package that includes a set of replacement provisions. To ensure a smooth transition between repeal and replacement, Congress (as it did in a previous version of reconciliation) could set the effective dates of provisions so that key elements of current law (such as subsidies) do not expire before the relevant replacement components are in place.

To accomplish the repeal of Obamacare, the new Congress and Administration should:

- **Maximize the reconciliation process for repeal.** The last Congress passed a 2015 reconciliation package that repealed the major budgetary provisions of Obamacare. Specifically, it repealed the various tax provisions, ended the individual and employer mandates, and sunset the subsidies for exchange and Medicaid coverage at the end of two years. President Obama vetoed this package, but the effort provides a clear road map for sending

1. Edmund Haislmaier and Alyene Senger, "The 2017 Health Insurance Exchanges: Major Decrease in Competition and Choice," Heritage Foundation *Issue Brief* No. 4651, January 30, 2017, <http://www.heritage.org/health-care-reform/report/the-2017-health-insurance-exchanges-major-decrease-competition-and-choice>; Edmund Haislmaier, "The Failures of Obamacare: Harmful Effects and Broken Promises," testimony before the Budget Committee, U.S. House of Representatives, January 24, 2017, <http://www.heritage.org/health-care-reform/impact/heritage-expert-testifies-congress-the-failures-obamacare>; and Alyene Senger, "8 Reasons Why Obamacare Should Be Repealed," Daily Signal, January 23, 2017, <http://dailysignal.com/2017/01/23/8-reasons-why-obamacare-should-be-repealed/>.

2. Sarah Torre, "Obamacare's Many Loopholes: Forcing Individuals and Taxpayers to Fund Elective Abortion Coverage," Heritage Foundation *Background* No. 2872, January 13, 2014, <http://www.heritage.org/health-care-reform/report/obamacares-many-loopholes-forcing-individuals-and-taxpayers-fund-elective>.

3. Nina Owcharenko and Edmund Haislmaier, "Preparing a Smooth Transition for the Repeal of Obamacare," Heritage Foundation *Issue Brief* No. 4631, November 21, 2016, <http://www.heritage.org/health-care-reform/report/preparing-smooth-transition-the-repeal-obamacare>.

4. Nina Owcharenko, Robert Moffit, Edmund Haislmaier, and Alyene Senger, "A Fresh Start for Health Care Reform," Heritage Foundation *Background* No. 2970, October 30, 2015, <http://www.heritage.org/health-care-reform/report/fresh-start-health-care-reform>.

5. For more on the process of repealing and replacing Obamacare, see Owcharenko and Haislmaier, "Preparing a Smooth Transition for the Repeal of Obamacare."

a repeal to the desk of a new President who has made the repeal of Obamacare a top priority. Congress should pass a reconciliation bill this year that repeals at least as much of Obamacare as the 2015 legislation did.

- **Execute an aggressive regulatory rollback.** While only Congress can make the necessary statutory changes, the new Administration can quickly implement initial reforms by aggressively rolling back many of the regulations implementing Obamacare.⁶ In many instances, the Obama Administration's regulations implementing the law further increased costs and exacerbated Obamacare's disruptive effects. The new Administration can immediately begin repealing or rewriting those regulations in ways that have the effects of reducing costs and minimizing disruptions. Rolling back or revising insurance market regulations would help to stabilize the non-subsidized insurance markets in 2017 and 2018 and offer consumers tangible evidence that relief is on the way. President Trump has issued an Executive Order instructing his appointees to take such actions, and in early February 2017, the Department of Health and Human Services took the first step by submitting to the Office of Management and Budget for review a proposed rule on "market stabilization." Those executive actions signal a new direction in health care reform to insurers, employers, and other stakeholders and will soon give health plans clearer guidance in developing their offerings for the 2018 plan year.

Timing and sequencing of these efforts are complex, and proper execution is critical. Congress, the Trump Administration, and the states should work together both to ensure a smooth transition for the repeal of Obamacare and to create a path toward a more patient-centered, market-based approach to reforming the health care system.

Regulatory Reform: What the Trump Administration Can Do

Obamacare granted the executive branch considerable discretionary authority to fill in the details

through regulation. Those details can now be changed by a new Administration.

In particular, the Trump Administration should focus, where it has authority under the statute to do so, on repealing or revising (as appropriate) the Obama Administration's numerous and detailed insurance market regulations, for two reasons. First, because that is the area where the new Administration can make substantive changes without having to wait for Congress to alter the underlying statute. Second, because anything that the Administration does to stabilize the non-subsidized insurance markets will address some of the current uncertainties entailed in transitioning to a better health reform approach, and thus support and encourage Congress enacting repeal-and-replace legislation to correct the law's underlying flaws.

For the Trump Administration, the starting point is to mitigate the damage of the law it inherited. The implementation approach taken by the Obama Administration was essentially to increase subsidized enrollment heedless of any resulting costs or disruptions to either the public or private sectors. The priority for the Trump Administration should instead be to minimize those costs and disruptions wherever possible. Insurers and others have already identified a number of areas where regulatory changes would help stabilize markets, such as:

- 1. Reduce the number of special enrollment periods.** The Trump Administration should eliminate many of the Obama Administration's criteria for individuals to obtain coverage through "special enrollment periods" outside the annual open season. The Obama Administration authorized numerous special enrollment periods under the mistaken belief that doing so would encourage more healthy individuals to purchase coverage. In reality, the effect was to open the door to more people gaming the system by dropping coverage once their medical expenses were paid and then re-enrolling the next time they needed care.
- 2. Establish stricter eligibility verification.** This would entail requiring that an applicant's eligibility be verified before allowing the appli-

6. The Heritage Foundation, *Blueprint for a New Administration: Priorities for the President* (Washington: The Heritage Foundation, 2016), pp. 19–22, <http://www.heritage.org/research/reports/2016/11/blueprint-for-a-new-administration>.

cant to enroll in coverage. The Obama Administration's lax approach to eligibility verification resulted in hundreds of thousands of applicants subsequently being disenrolled for failure to prove eligibility. In addition to being disruptive for those individuals, it imposed added costs on insurers—and consequently, on the broader market and taxpayers—in the form of payments for claims and subsidies, for ineligible persons.

3. Protect “grandfathered” plans. Having promised Americans that they could keep their existing health care coverage, the Obama Administration proceeded to adopt regulations that made it very difficult for insurers and employers to maintain those pre-Obamacare plans. The Trump Administration can rewrite those regulations to make it easier for those with such “grandfathered” coverage to keep their coverage.

4. Eliminate duplicative regulations. State governments have long experience in regulating insurance and protecting consumers. In a number of instances, the Obama Administration adopted regulations and review processes that duplicated those at the state level, adding time, cost, and complexity for insurers seeking approval to sell policies. By deferring to the standards and judgments of state insurance departments on those matters, the Trump Administration could reduce the regulatory burden on insurers seeking to enter new markets or to modify their policies and rates, thus increasing coverage options for consumers.

5. Stop coercing conscience. The Obama Administration adopted several controversial regulations that had the effect of requiring individuals to obtain, pay for, facilitate, or provide items and services that many consider to be unethi-

cal on religious or moral grounds.⁷ The Trump Administration can reverse such unwarranted and unconstitutional infringements on freedom of conscience and religious liberty by rescinding those Obama Administration regulations.⁸

Fairness: Empowering Consumers Through Reformed Tax Treatment of Health Care

Background. With over 160 million Americans covered by employer-based health insurance, the tax exclusion for employer-provided health insurance is one of the most significant, yet also one of the most misunderstood, features of America's health care system. The tax exclusion allows workers whose employers offer health benefits to exclude the value of those benefits from their incomes when calculating both income and payroll (Social Security and Medicare) taxes. In other words, the value of those benefits is not treated as taxable income to the employee. While this tax policy is very advantageous to workers, contrary to a common misperception, it actually offers little or no tax benefit to employers. Businesses pay income taxes only on their net profits—or what is left after deducting from gross revenues their costs of doing business. Thus, employee compensation, regardless of the form it takes, is a deductible business expense.

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. The aggregate value of this federal tax preference was about \$266 billion in 2016.⁹

This tax policy 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 large tax break for insurance and the second does not. This is profoundly unfair.

7. Edmund F. Haislmaier, “The Obama Administration's Design for Imposing More Health Care Mandates,” Heritage Foundation *Backgrounders* No. 3093, February 11, 2016, <http://www.heritage.org/health-care-reform/report/the-obama-administrations-design-imposing-more-health-care-mandates>, and Roger Severino and Ryan T. Anderson, “Proposed Obamacare Gender Identity Mandate Threatens Freedom of Conscience and the Independence of Physicians,” Heritage Foundation *Backgrounders* No. 3089, January 8, 2016, <http://www.heritage.org/health-care-reform/report/proposed-obamacare-gender-identity-mandate-threatens-freedom-conscience>.

8. Ryan T. Anderson, “Make Religious Freedom Great Again,” Daily Signal, November 9, 2016, <http://dailysignal.com/2016/11/09/make-religious-freedom-great-again/>.

9. Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026,” Table 2, p. 8, March 2016, <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf> (accessed February 7, 2017).

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.

Obamacare layered new complexity and distortions onto the prior tax treatment of health insurance. It provides 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 who purchase their coverage through government-run exchanges. Furthermore, it denies those 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 Obamacare makes is to limit the amount of employer-provided coverage that may be excluded from taxation. However, even this aspect of the law is convoluted and wrongly designed. Rather than simply setting a limit on the exclusion, Obamacare imposes a punitive 40-percent excise tax (commonly referred to as the “Cadillac Tax”) on any employer health plan whose value exceeds specified amounts.

Solution. 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—a health-maintenance organization (HMO), a preferred-provider organization (PPO), a high-deductible plan, or other 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-neutral and budget-neutral is

the first step in transforming the American health system into one that is more patient-centered, market-based, and value-focused.

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 current 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, 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 Obamacare’s problem of creating incentives for employers to discontinue coverage, but might actually result

in more lower-wage workers enrolling in employer-sponsored coverage. 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.

Choice: Expanding Options Through Commonsense Insurance-Market Reforms

Background. To create more patient-centered, market-based health system, reform of the regulation of health insurance to allow coverage to be more competitive and value-focused is essential. 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.

The relatively modest problems with insurance market regulation prior to Obamacare could easily have been remedied with a few thoughtful and limited reforms. Instead, Obamacare imposes 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 Obamacare—such as the new federal benefit mandates that standardize coverage¹⁰ and the rating rules that artificially increase premiums for younger adults¹¹—are counterproductive and depend on Obamacare's widely despised individual mandate to offset their destabilizing effects.

Solution. Congress should immediately devolve the regulation of health insurance back to the states. 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 Obamacare.

States should then 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. 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 act in a relatively simple fashion without resorting to the kind of sweeping and complex regulation enacted in Obamacare. 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.¹² 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.

10. 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>.

11. 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>.

12. Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

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 Obamacare.

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.

The 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.¹³

Medicare Reform: Fairness, Choice, and Quality Care

Background. The Medicare government health program for seniors over the age of 65, as well as for some disabled populations, faces monumental challenges. The program spent \$692 billion in 2016 and covers 58 million aged and disabled citizens. It is the most powerful force driving entitlement spending and will generate a long-term unfunded liability (an “off-budget” debt) of \$32 trillion to \$43 trillion.¹⁴

Medicare is also structurally complex.¹⁵ 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. The pro-

gram also fails to guarantee patient protection for the financial devastation of catastrophic illness. Not surprisingly, this and other shortcomings 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 depend on such supplemental coverage.

Medicare must also cope with an enormous demographic challenge.¹⁶ America’s aging population is steadily entering the program; enrollment is projected to increase from 58 million in 2017 to more than 81 million in 2030.¹⁷ But their Medicare coverage is being funded through taxation on a proportionally smaller working population.

Younger Americans face 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.

Rather than reforming Medicare to put it on more solid financial footing, Obamacare reduces Medicare spending by more than \$800 billion over 10 years. The largest chunk of Obamacare’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 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. Obamacare’s objective is to ratchet down Medicare Advantage payments to levels approaching the costs of traditional Medicare FFS.

In addition, for the first time, the law puts Medicare spending on a budget with the creation of the Independent Payment Advisory Board (IPAB). IPAB

13. 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>.

14. Suzanne Codespote, “Medicare Unfunded Obligation for 2016 Trustees Report,” memo to Senate Budget Committee Staff, June 22, 2016.

15. 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>.

16. 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>.

17. *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds*, June 22, 2016, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/> (accessed February 8, 2017).

is a board made up of 15 unelected bureaucrats charged with keeping Medicare spending below the global budget established by Obamacare. If spending exceeds the target, the board recommends spending cuts that go into effect unless Congress can come up with equivalent savings. Thus far, no one has been appointed to IPAB.

Solution. 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 significant savings.¹⁸

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.¹⁹

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” 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,²⁰ 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.²¹ This transition should take place over a period of no more than five years.²² 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.²³

Under premium support, the government would make a defined contribution to the health plan of the enrollee’s choice. The coverage options would include

18. Congressional Budget Office, “A Premium Support System for Medicare: Analysis of Illustrative Options,” September 18, 2013, <http://www.cbo.gov/publication/44581> (accessed February 8, 2017), 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>.

19. Robert E. Moffit, “The First Stage of Medicare Reform: Fixing the Current Program,” Heritage Foundation *Backgrounder* 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>.

20. 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>.

21. 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>.

22. Transition is a prudential matter, but delays, as the CBO and others have noted, reduce 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.

23. 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.

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.

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

Medicaid Reform: Fairness, Choice, and Quality Care

Background. Medicaid, established alongside Medicare in 1965, is the massive federal and state health care program for the poor. In 2015, an average of 70 million Americans were enrolled in Medicaid, and combined federal and state spending reached \$554 billion.²⁴ 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 Obamacare, sets the stage for future demographic, fiscal, and structural challenges in Medicaid.

A considerable increase in the number of adults enrolled in Medicaid is expected as a result of the expansion of the program included in Obamacare. It is projected that 30 million able-bodied adults will be enrolled in Medicaid in 2025, trailing only slightly behind the 31.1 million children expected to be enrolled in the program.²⁵ 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 2015, combined federal and state spending reached \$554 billion—\$349.8 billion in federal spending and \$204 billion in state spending. Spending is expected to hit \$957.5 billion by 2025.²⁶ At the state level, Medicaid is already consuming over 28 percent of states' budgets,²⁷ 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 2015, the aged and disabled made up just over 23 percent of enrollment, but accounted for 56 percent of Medicaid spending—principally payments for long-term care services.²⁸

Growth in enrollment and spending puts pressure on the program in other ways. Medicaid has a history of providing lower quality health care.²⁹ In addition to reasons such as bureaucratic red tape, many physicians decline to participate in Medicaid due to low payment rates in many states.³⁰ Historically, FFS Medicaid pays physicians two-thirds of

24. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, 2016 Actuarial Report on the Financial Outlook for Medicaid, 2016, p. i, <https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2016.pdf> (accessed February 7, 2017).

25. *Ibid.*, p. 61.

26. *Ibid.*, p. iv.

27. National Association of State Budget Officers, "State Expenditure Report: Examining Fiscal 2014–2016 State Spending," p. 6, [https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20\(Fiscal%202014-2016\)%20-%20S.pdf](https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/State%20Expenditure%20Report%20(Fiscal%202014-2016)%20-%20S.pdf) (accessed February 8, 2017).

28. U.S. Department of Health and Human Services, 2016 Actuarial Report on the Financial Outlook for Medicaid, p. 9.

29. 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/health-care-reform/report/studies-show-medicaid-patients-have-worse-access-and-outcomes-the>.

30. For a discussion on access and payment, see Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, June 2013, p. 50.

what Medicare pays for the same services,³¹ while Medicare typically pays less than the private market. Moreover, states continue to depend on various cost-containment measures to keep Medicaid within budget,³² some of which impact access and quality of care.

Obamacare simply fueled further expansion and spending.³³ The law expanded Medicaid 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, Obamacare fully funded this new expansion population for three years. The federal government assumed 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 gradually declines 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.³⁴ The CBO projects that Obamacare’s expansion adds \$998 billion in Medicaid spending over 2018–2027 and adds 17 million more beneficiaries to the Medicaid program.³⁵

Rather than simplifying and stabilizing Medicaid’s financing, the law’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.

Solution. To provide quality health care options to low-income individuals and families in need, the Medicaid program must be reformed. 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 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 eliminate the enhanced funding for the new expansion population provided to the states under Obamacare. Congress could phase out that extra funding over time so as to facilitate a smooth transition out of Obamacare’s Medicaid expansion for states that expanded their Medicaid programs while avoiding encouraging other states to expand.

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-Obamacare 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 tra-

31. Ibid.

32. 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 7, 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 February 8, 2017).

33. 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>.

34. 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>.

35. Congressional Budget Office, “Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO’s January 2017 Baseline,” Tables 1 and 2, <https://www.cbo.gov/sites/default/files/recurringdata/51298-2017-01-healthinsurance.pdf> (accessed February 8, 2017).

ditional 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.³⁶ 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 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 allow them to exercise greater control over the direction and management of their care.³⁷

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.³⁸

Time to Act

Obamacare is a proven policy failure. Congress and the Trump Administration must completely repeal it, beginning by seizing the opportunity to accomplish as much of the repeal as possible through the reconciliation process.

Their efforts should ensure that there is a smooth transition from repeal to the enactment of provisions that offer more fairness, choice, affordability, and sustainability.³⁹ Congress’ actions to establish this new direction in health care must focus on the fundamentals: equalizing the tax treatment of health insurance; restoring commonsense regulation of health insurance; and addressing the serious need for reform in Medicare and Medicaid by adopting policies that give individuals control over their health care.

High-quality health care means all Americans should be free to choose a health care plan that meets their needs and reflects their values. Congress must act now to repeal Obamacare and replace it with a new set of options that empower Americans, not government.

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36. Jonathan Crowe, “How Competitive Private Plans Can Improve Care for Dual-Eligible Beneficiaries of Medicare and Medicaid,” Heritage Foundation *Backgrounders* 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>.

37. For a description of these types of consumer-based reforms, see Lori De Milto, “Cash and Counseling,” Robert Wood Johnson Foundation, June 11, 2013, http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf406468 (accessed February 8, 2017), and Centers for Medicare and Medicaid Services, “Self Directed Services,” <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html> (accessed February 8, 2017).

38. 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-medicare-reform>.

39. Owcharenko and Haislmaier, “Preparing a Smooth Transition for the Repeal of Obamacare.”