

# BACKGROUNDER

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## The Health Care Choices Proposal: Charting a New Path to a Down Payment on Patient-Centered, Consumer-Driven Health Care Reform

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### Abstract

*After more than eight years of the Affordable Care Act, known as Obamacare, health insurance costs continue to spiral out of control, particularly for millions of Americans trapped in the individual and small-group markets. Choice and competition in most of the states' individual health insurance markets has virtually collapsed, leaving millions of Americans with either limited, or no, choice of health coverage. Patient access to physicians and medical specialists has declined, as health plan provider networks have progressively narrowed. The Health Care Choices Proposal offers Congress a path to reset the course of failed health care reform as a down payment on further needed reforms.*

Congress—working closely with the Trump Administration and the states—must quickly retake the initiative on health care reform and give millions of Americans lower costs, better access, and expanded personal choice. A new proposal, by the Health Policy Consensus Group, offers Congress a practical path forward to reset and correct the course of failed health care reform efforts.

After more than eight years of the Affordable Care Act, known as Obamacare, health insurance costs continue to spiral out of control, particularly for millions of Americans trapped in the individual and small-group markets. Choice and competition in most of the states' individual health insurance markets has virtually collapsed, leaving millions of people with either limited, or no, choice of health coverage. Patient access to physicians and medical specialists has declined, as health plan “provider” networks have progressively narrowed.

Across the political spectrum, there is a broad recognition that the Obamacare health law is unworkable and unsustainable. While

### KEY POINTS

- Across the political spectrum, there is a broad recognition that the Obamacare health law is unsustainable. While Congress and the Administration have already taken some meaningful actions to begin undoing Obamacare, Congress must do more in order to lower costs and improve choices.
- Meaningful change will require Congress to chart a new path that guarantees robust personal choice and private competition; improves access to affordable insurance while protecting the poor and the sick; and allows health plans and medical professionals to pursue greater innovation, higher quality, and economic efficiency.
- Health care reform is a process, not a singular legislative event. It is, therefore, essential that Congress take the initial steps to stop Obamacare's damage to insurance markets from getting worse. The Health Care Choices Proposal offers a framework to do just that, and its adoption would make a major down payment on future health care reform.

This paper, in its entirety, can be found at <http://report.heritage.org/bg3330>

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Congress and the Administration have already taken some significant actions, Congress must still make the structural changes that are necessary to improve access to care and to control health care costs.

Health care is at a crossroads. Some congressional leaders advocate keeping this flawed law afloat by forcing taxpayers to bail out (likely endlessly) health insurance companies to compensate for Obamacare's design flaws that are driving up health care costs and driving people and plans out of the market. Some others in Congress—including leading Democratic Senators and more than half of the Democratic membership of the House of Representatives—have endorsed proposals for a total federal government takeover of the health care system (a "government run health care" system or "single payer" system), including a prohibition of private ownership of health plans and abolition of employer-sponsored health insurance.

These proposals proceed exactly in the wrong direction. The urgent need, instead, is to change the direction of American health care toward a new patient-centered system, where the system responds to the needs and preferences of consumers, rather than to the interests of providers and insurers or the dictates of government central planners. What was needed before Obamacare, and is still needed in the wake of Obamacare's damage, are reforms that re-orient the system toward being patient-centered by giving individuals and families the ability to control the flow of health care dollars and crucial health care decisions, and by forcing providers and insurers to compete for customers by offering better care at lower costs.

**Charting a New Course.** Changing course will require Congress to chart a new path that will guarantee robust personal choice and market competition; legalize affordable health insurance while protecting the poor and the sick; and allow health plans and medical professionals to pursue greater innovation, higher quality, and economic efficiency in care delivery. Such a major legislative change, combined with administrative actions on the part of the executive branch and legislative actions in the states, will shift the policy direction away from Obamacare's centralized and inflexible regulatory regime toward a new path of reform based

on real patient choice and genuine market competition. The Health Care Choices proposal provides the architectural framework for that fundamental policy shift.<sup>1</sup>

The proposal is straightforward. It would repeal the Obamacare federal spending scheme and replace it with a more fiscally responsible block grant to the states. The proposal would address Obamacare's regulatory overreach by restoring state authority over some critical health insurance regulation. Thus, states would have the ability to adjust insurance rules to their own insurance market conditions, which differ sharply from state to state. It would also give individuals enrolled in government-run programs, such as Medicaid, the choice to opt out and enroll in private health coverage of their personal choice. Finally, it recommends changes to health savings accounts (HSAs), enabling consumers to use them with greater flexibility in meeting their health care wants and needs.

## **Eight Years of Failing Policy: The Obamacare Crisis**

Given the huge size and vast scope of the Obamacare law, its impact on American health care—a large and complex sector of the American economy—was bound to be dramatic and unprecedented.

It is important for Americans, particularly those struggling with explosive health insurance costs, to recall why they are in the situation in which they find themselves today. President Barack Obama and his allies in Congress repeatedly made a series of bold and high-profile promises, ranging from the right of persons to keep their health plans and their physicians to annual reductions in typical family insurance costs and a full exclusion of middle-class citizens from additional federal taxation in support of the law. None of these promises proved true.

Consider the facts:

- **Skyrocketing Costs.** Next year, Americans enrolled in the individual and small-group health insurance markets—those markets directly governed by the law—can expect another big jump in health insurance costs, ranging from 15 percent to 30 percent.<sup>2</sup> This year, enrollees in the stan-

1. Health Policy Consensus Group, "The Health Care Choices Proposal: Policy Recommendations to Congress," Medium, July 19, 2018, <https://medium.com/@consensusgroup2018/the-health-care-choices-proposal-policy-recommendations-to-congress-a4660182d830> (accessed June 26, 2018).

2. Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028," May 2018, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53826-healthinsurancecoverage.pdf> (accessed June 26, 2018).

dard (“silver”) health plans in the exchanges face average deductibles of over \$4,000 for self-only coverage and \$8,000 for family coverage.<sup>3</sup>

While liberals in Congress and other Obamacare defenders are attempting to blame President Donald Trump for these cost hikes,<sup>4</sup> the truth is that the recent premium and deductible increases are the result of the failing Obamacare policies. Between 2013 and 2017, premiums increased by 105 percent.<sup>5</sup> Today, for many middle-class persons, such high-cost coverage is practically inaccessible. Not surprisingly, there is emerging evidence that more Americans are foregoing medical appointments simply because they cannot afford them.<sup>6</sup>

The law’s comprehensive regulatory regime has directly contributed to the increased health insurance costs over the past four years.<sup>7</sup> It is therefore not surprising that millions of younger and healthier Americans have avoided enrollment in the exchanges and the non-exchange markets, or that only a tiny number of persons with incomes above 400 percent of the federal poverty level (FPL), and therefore ineligible for Obamacare subsidies, have enrolled in the exchanges. For 2018, only 11.8 million persons enrolled in the Obamacare exchanges, thus continuing a pattern of decline.<sup>8</sup>

■ **Declining Choice.** Likewise, millions of Americans have experienced a decline in their plan choices instead of the benefits of robust market competition among health plans. Between 2013 and 2018, the number of insurers in the individual health insurance markets declined from 395 to 181.<sup>9</sup> At the county level, the decline in patient choice and insurance competition has been devastating. In 2018, there are just two insurers offering exchange coverage in 35 percent of U.S. counties, and there is just one insurer in 52 percent of the nation’s counties.<sup>10</sup> In other words, in over half of U.S. counties, Obamacare exchange customers already face a government-sponsored monopoly in the form of a single, federally regulated and standardized health plan; a “government-run health care” system on the installment plan.

More insurers are leaving the Obamacare exchange market than are entering. Heritage Foundation analysts found that in 2015, 64 insurers entered the market, and nine exited.<sup>11</sup> In 2017, only 10 insurers entered the market, and 80 exited. Negative trends continue: Thus far in 2018, only seven insurers have entered, and 44 have exited.<sup>12</sup>

In 2016, Heritage analysts found that unsubsidized enrollment in the individual market declined by 8.2 percent, after declining by 7.5 percent in 2015.<sup>13</sup>

3. HealthPocket, “Average Market Premiums Spike Across Obamacare Plans in 2018,” *HealthPocket Infostat*, October 27, 2017, <https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles> (accessed June 26, 2018).
4. Center for American Progress Action Fund, “Tracking Trump’s Sabotage of the ACA,” April 10, 2018, <https://www.americanprogressaction.org/issues/healthcare/reports/2018/04/10/167820/tracking-trumps-sabotage-aca/> (accessed June 26, 2018).
5. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Individual Market Premium Changes: 2013–2017,” *ASPE Data Point*, May 23, 2017, <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf> (accessed June 26, 2018).
6. Abby Goodnough, “As Some Got Free Health Care, Gwen Got Squeezed: An Obamacare Dilemma,” *The New York Times*, February 19, 2018, <https://www.nytimes.com/2018/02/19/health/obamacare-premiums-medicaid.html> (accessed June 26, 2018).
7. Edmund F. Haislmaier and Doug Badger, “How Obamacare Raised Premiums,” *Heritage Foundation Backgrounder* No. 3291, March 5, 2018, <https://www.heritage.org/sites/default/files/2018-03/BG3291.pdf>.
8. Abby Goodnough, “The Final Obamacare Tally Is In, About 400,000 Fewer People Signed Up This year,” *The New York Times*, April 3, 2018, <https://www.nytimes.com/2018/04/03/health/obamacare-enrollment-insurance-trump.html> (accessed June 26, 2018).
9. Edmund F. Haislmaier, “2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink,” *Heritage Foundation Issue Brief* No. 4813, January 25, 2018, <https://www.heritage.org/sites/default/files/2018-06/IB4862.pdf>.
10. Ibid.
11. Ibid.
12. Ibid.
13. Edmund F. Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Decline, Medicaid Growth Slowed,” *Heritage Foundation Issue Brief* No. 4743, July 26, 2017, [https://www.heritage.org/sites/default/files/2017-07/IB4743\\_0.pdf](https://www.heritage.org/sites/default/files/2017-07/IB4743_0.pdf).

Even the growth in subsidized Obamacare enrollment is flattening. Heritage experts found that subsidized enrollment grew by only 3.7 percent in 2016 compared to 35.8 percent in 2015.<sup>14</sup> Furthermore, over the three-year period, of the 15.7 million individuals who gained coverage, 89 percent of that increase was through Medicaid.<sup>15</sup>

- **Less Access.** This year, Americans enrolled in the individual and small-group markets are experiencing, as they have year after year since the law's enactment, progressively narrowing provider networks. Avalere, a national health care consulting firm, found that health maintenance organizations (HMOs) and exclusive provider organizations (EPOs) with narrow provider networks make up 73 percent of plans offered in 2018, up from 68 percent in 2017 and 54 percent in 2015.<sup>16</sup> The result: Some highly prized specialized medical practitioners are no longer in the Obamacare networks. For example, in Texas, the physicians at the MD Anderson Cancer Center are not included in any individual plan on or off the exchange.<sup>17</sup>

## Some Relief from Obamacare, But Not Enough

Both Congress and the Administration have already taken some modest steps to provide millions of Americans with welcome relief from the financial burdens imposed by Obamacare. These changes, while important, beg for additional federal action.

**Congressional Action.** The 2017 Tax Cuts and Jobs Act and the end-of-year omnibus spending bill

included two significant but limited congressional changes to Obamacare's regulation of the health insurance markets. Specifically, Congress:

- **Eliminated the individual mandate penalty.** Congress zeroed out the individual-mandate penalty. While the mandate still remains in the law, the penalty for not complying was changed to zero, effective starting in 2019.<sup>18</sup>
- **Delayed some Obamacare taxes.** Congress also delayed the effective date of some major Obamacare taxes. The "Cadillac tax" was delayed until 2022, the medical device tax was delayed until 2020, and the health insurance tax was delayed until 2019.<sup>19</sup>

**Administration Action.** The Administration has also taken steps to offer relief from Obamacare. Specifically, the Administration has announced:

- **State waivers.** In February 2017, the Secretary of Health and Human Services and the Centers for Medicare and Medicaid Services, which has broad authority over the implementation of Obamacare, sent a letter to governors signaling an openness to new state flexibility.<sup>20</sup> States have taken advantage of this opportunity specifically with initiatives focused on developing risk-mitigation mechanisms and reformatting their Medicaid expansion programs.<sup>21</sup>
- **Executive order.** On October 2017, President Trump issued an executive order to federal agencies to review and reinterpret regulations, rooted in existing federal law, to promote choice and

14. Ibid.

15. Ibid.

16. Caroline F. Pearson and Elizabeth Carpenter, "Plans with More Restrictive Networks Comprise 73% of Exchange Market," Avalere news release, November 30, 2017, <http://avalere.com/expertise/managed-care/insights/plans-with-more-restrictive-networks-comprise-73-of-exchange-market> (accessed June 26, 2018).

17. Merrill Matthews, "At MD Anderson You Can Have Cancer Care or Obamacare, But Not Both," Institute for Policy Innovation *PolicyBytes*, September 5, 2017, [https://www.ipi.org/ipi\\_issues/detail/at-md-anderson-you-can-have-cancer-care-or-obamacare-but-not-both](https://www.ipi.org/ipi_issues/detail/at-md-anderson-you-can-have-cancer-care-or-obamacare-but-not-both) (accessed June 26, 2018).

18. Peter Sullivan, "Final GOP Tax Bill Repeals Obamacare Mandate," *The Hill*, December 15, 2017, <http://thehill.com/policy/healthcare/365185-final-gop-tax-bill-repeals-obamacare-mandate> (accessed June 26, 2018).

19. Naomi Jagoda, "Congressional Scorekeeper of Obamacare Taxes in Spending Bill Will Cost About \$31B," *The Hill*, January 23, 2018, <http://thehill.com/policy/finance/370251-jct-delay-of-obamacare-taxes-in-spending-bill-costs-about-31b> (accessed June 26, 2018).

20. News release, "Secretary Price and CMS Administrator Verma Take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program," U.S Department of Health and Human Services, March 14, 2017, <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf> (accessed June 26, 2018).

21. States have used Section 1332 of the ACA and Section 1115 waivers under Medicaid.

competition in the health care system.<sup>22</sup> The executive order highlighted three key initiatives:

- **Association health plans (AHPs).** AHPs allow businesses, especially small businesses, to band together as a group for the purpose of purchasing health insurance for themselves and their employees. By banding together, small businesses and the self-employed will be able to avoid costly federal insurance mandates that Obamacare imposed on the individual and small-group markets. In June 2018, the Administration issued major regulatory changes to ease the formation of such associations for these purposes.<sup>23</sup>
- **Short-term, limited-duration insurance (STLDI).** STLDI offers individuals a coverage option that is not subject to the costly insurance regulations of Obamacare. In February 2018, the Administration proposed restoring long-standing rules of operation for such short-term plans, undone by the previous Administration, and proposed consideration for extending the terms of such arrangements as well.<sup>24</sup>
- **Health reimbursement arrangements (HRAs).** HRAs are an employer-based health care financing arrangement that provide employees with greater access and flexibility

for financing their health care. The Administration is expected to release a proposed rule to expand the flexibility of these arrangements, including consideration of using them with non-group coverage.

## **Charting a New Direction for Health Care Reform**

These efforts by Congress and the Administration are a good start, yet they do not go nearly far enough. Congress must change the fundamental direction of health care reform away from Obamacare's failed government-based regime toward patient-centered, market-based health reform. The Health Policy Consensus Group plan offers a meaningful proposal for Congress to get health care reform back on track.

**The Key Elements.** The design of the Health Policy Consensus Group's Health Care Choices Proposal is straightforward.<sup>25</sup> Congress should:

- **Eliminate Obamacare spending schemes.** Under the current formulation, Obamacare is expected to cost taxpayers roughly \$1.6 trillion from 2019 to 2028.<sup>26</sup> The proposal would repeal and replace the federal financing for the exchange premium subsidies, the exchange cost-sharing subsidies, and the funding of the law's Medicaid expansion.<sup>27</sup>

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22. The White House, "Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States," October 12, 2017, <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/> (accessed June 26, 2018).
  23. News release, "President Donald J. Trump Helps Millions of Americans Employed by Small Businesses Gain Access to Quality, Affordable Health Coverage," U.S. Department of Labor, June 19, 2018, <https://www.dol.gov/newsroom/releases/osec/osec20180619> (accessed June 28, 2018).
  24. News release, "Trump Administration Works to Give Relief to Americans Facing High Premiums, Fewer Choices," U.S. Department of Health and Human Services, February 20, 2018, <https://www.hhs.gov/about/news/2018/02/20/trump-administration-works-give-relief-americans-facing-high-premiums-fewer-choices.html> (accessed June 26, 2018). See also, Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternatives to Obamacare Policies," Heritage Foundation Backgrounder No. 3310 April 26, 2018, <https://www.heritage.org/sites/default/files/2018-04/BG3310.pdf>.
  25. Health Policy Consensus Group, "Health Care Choices Proposal: Policy Recommendations to Congress."
  26. Congressional Budget Office, "Federal Subsidies for Health Insurance for People Under Age 65: 2018 to 2028," pp. 16 and 17.
  27. The proposal is focused primarily on block grant terms and conditions, with some details left to elected congressional Members to work out, such as allocation formulas to states and how to ensure that federal spending is sustainable. With regard to the latter, a 2016 Heritage Foundation report by Paul Winfree found that 2 percent of the nearly 1,800 spending accounts funding all government activities are unsustainable. While the funding is contained, it is large, as spending from those accounts is equivalent to 60 percent of gross spending, with public health care programs contributing the largest component to fiscal unsustainability. In order to reduce the exposure to the federal budget, any proposal to reform federal health care programs must reduce the rate of growth in spending so that they are growing no faster than the economy over the business cycle. For more details, see Paul Winfree, "Causes of the Federal Government's Unsustainable Spending," Heritage Foundation Backgrounder No. 3133, July 7, 2016, <https://www.heritage.org/budget-and-spending/report/causes-the-federal-governments-unsustainable-spending>.

- **Provide block grants to the states.** In lieu of the Obamacare spending scheme, the proposal would provide states with a fixed allotment of federal funding. The funding would be based on current state ACA funding and would be gradually rebalanced based on each state's number of low-income residents, bringing greater equity between the states. The states would adhere to the following guidelines in using their allotments:
  - **Low income.** At least half of a state's grant funding would be used to provide coverage for low-income populations.
  - **Private coverage.** At least half of a state's grant funding would be used to support the people's purchase of private coverage.
  - **Risk mitigation.** State grant funds could be used to offset the costs of individuals with expensive medical conditions through reinsurance programs or other, similar mechanisms.
  - **Premium support.** Individuals who are subsidized by a state grant program, and individuals currently on Medicaid and Children's Health Insurance Program (CHIP), would be able to direct their share of funding to the private coverage of their choosing.
  - **Pro-life protections.** By making the grant program an amendment to the existing federal CHIP statute, the current pro-life protections that prohibit taxpayer funding of abortion in CHIP would also apply to the new grant program.
  - **Optional use.** States could also incentivize insurers to offer discounts to individuals who maintain continuous coverage, or to young adults in general, who have been fleeing the market altogether.
- **Extend new regulatory flexibility for states.** The Health Care Choices Proposal would repeal certain costly and constrictive federal regulation, returning state regulatory authority over such matters bringing about more affordable options. The proposal:
  - **Repeals federal single-risk-pool requirement.** The ACA requires that in the individual and small-group markets, insurers must set their rates based on the cost of all of their customers in each of those market segments—as opposed to basing rates on the claims cost of the different groups of customers purchasing different plan designs. This federal restriction prevents variation on product price.<sup>28</sup> Repealing this requirement would enable states to target more assistance directly to those with expensive medical conditions while reducing the cost of coverage for other enrollees, so that fewer of them would need subsidies to afford a plan.
  - **Repeals federal essential health-benefit requirements.** The ACA requires insurance plans in the individual and small-group market to cover the 10 categories of federal benefits. This federal requirement pre-empted previous state benefit requirements and in most states increased the cost of coverage. Analysis found that this federal requirement has increased premiums between 5 percent and 11 percent, depending on the state.<sup>29</sup>
  - **Repeals federal medical-loss-ratio requirement.** The ACA sets the minimum share of premium income that an insurer must spend on claims costs. This federal requirement perversely discourages insurers from spending money to limit claim payments. It also creates a barrier to new insurers entering the market and to existing insurers expanding into new markets, because it does not account for the higher administrative costs associated with the initial years of such expansions.<sup>30</sup>

28. Some states have used Section 1332 of the ACA to waive this requirement in their states. See Centers for Medicare and Medicaid Services, "Alaska: State Innovation Waivers Under Section 1332 of the PPACA," July 11, 2017, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf> (accessed June 26, 2018).

29. Haislmaier and Badger, "How Obamacare Raised Premiums."

30. Edmund F. Haislmaier, "Effects of the PPACA's Minimum Loss Ration Regulation," testimony before Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, September 15, 2011, <https://www.heritage.org/testimony/effects-the-ppacas-minimum-loss-ratio-regulations>.

- **Repeals federal age-rating limitation.** The ACA limits age variation of premiums for adults to a maximum ratio of three-to-one. Meaning, for the same plan, an insurer is not permitted to charge a 64-year-old a rate that is more than three times the rate for a 19-year-old. Analysis has found that this federal requirement lowered premiums by 10 percent to 15 percent for those between 50 and 64 years of age, but *increased* premiums for younger adults by about one-third.<sup>31</sup>

**Guarantee Individual Choice.** The Health Care Choices Proposal would ensure that individuals and families have the final say in the type of coverage they receive. Under the ACA, individuals and families are constrained by law and regulation in their choices of the kinds of health plans, benefits, benefit designs, or coverage levels. Under this proposal, individuals currently subsidized by Medicaid and CHIP would gain new freedom to direct the subsidy to the private coverage of their own choice. While states would be free to use the block grant to design their own state programs, if an individual was unhappy with the coverage option or options offered by the state using its grant funding, she would have the ability to take the value of her state subsidy and apply it toward any private coverage for which she was otherwise eligible, such as a plan offered by an insurer, an employer, or an association, including health plans sponsored by professional or faith-based organizations, or health plans that included a direct primary care component. Finally, the Health Policy Consensus Group's Health Care Choices Proposal recommends making HSAs more flexible, available, and useful to consumers.

### **Goals: Lower Costs, More Choices, Better Access**

The combination of these provisions will begin to mitigate the damages of Obamacare and chart a new course for health care reform—one that is patient-centered and market-based. By replacing the Obamacare spending with a block grant to the states and restoring state authority over some critical regulatory matters, states will have new tools to amelio-

rate much of the market dislocation that has plagued Obamacare and to lower costs, increase choices, and improve access.

There are several likely actions the states will take in response. First, states will likely reassess the essential-benefit, medical-loss-ratio, risk-rating, and the single-risk-pool requirements. Careful not to recreate Obamacare's overreach, the states will likely take a fresh approach to these rules to strike the right balance. If done correctly, states could reduce premiums while still ensuring access. Second, free from Obamacare's flawed subsidy scheme, states would be able to implement their own assistance programs. States can structure their programs in ways that avoid the mistakes of Obamacare, including the problem of individuals with costly conditions migrating from other coverage into the individual market, which has been a major driver of Obamacare's premium increases.<sup>32</sup> Third, states will likely take a more aggressive approach to risk mitigation. Unlike the waiver process, which is unpredictable and ad hoc, this proposal would provide states with certainty and authority to design risk-mitigation programs that best fit their citizens' needs. For example, a state may decide to re-open its high-risk pool or develop a more comprehensive reinsurance mechanism. These efforts would help to bring greater stability to premiums in the market.

Fourth, states can redesign existing programs. States will likely reassess how best to provide care and coverage to those currently locked out of the health care market and allow insurers to develop more innovative approaches to reaching those populations to make coverage more attractive and affordable. Finally, the block grant will end the all-or-nothing proposition on Medicaid expansion. Today, states must expand their Medicaid programs up to 138 percent of the FPL in order to receive additional federal Medicaid funding. The block grant would allow states to receive federal dollars and design state-specific programs outside the Medicaid straightjacket of federal rules to assist those in need while preserving the Medicaid program for those traditionally eligible for the program: poor women and children, the disabled, and the elderly who depend on long-term-care services.

31. Haislmaier and Badger, "How Obamacare Raised Premiums."

32. Ibid.

## The Empty Promises of False Alternatives

Across the political spectrum, there is general recognition that Obamacare is not working. Yet, the solutions either call for even greater centralization of power in Washington, higher federal spending, and heavier federal regulation, or do little to make the necessary changes to advance a patient-centered, market-based system:

**Government-Run Health Care/Single Payer.** Most liberals in Congress are, either tacitly or explicitly, abandoning Obamacare in favor of a comprehensive “single payer” system, a complete federal government takeover of the health care financing and delivery.<sup>33</sup> Of course, this proposal merely expands the federal government’s already massive presence in America’s health care economy. In substance it consists of the standard recipe of the same old, unappetizing ingredients: more federal rules, regulations, and mandates, plus the huge infusion of ever-larger taxpayer subsidies. This proposal outlaws all private health insurance, including employment-based coverage, and thus closes the door on any American seeking alternative or better care than he can get from the government program. Rather than control health care costs, it likely will shift costs to the taxpayer in the form of reduced access to medical benefits and services (due to price controls) or higher taxes, larger deficits, and bigger and even more dangerous levels of debt.

**Bailouts.** Previous attempts to bail out Obamacare with more infusion of taxpayer cash are, at best, a temporary palliative. In isolation, these taxpayer bailouts do nothing to address the underlying regulatory and design flaws that fuel the need for more bailouts in the first place, nor do they offer any meaningful course change. Thus, bailouts are just another exercise in cost-shifting, transferring the losses of a few big insurance companies that are concentrating their control over the nation’s individual markets on to beleaguered federal taxpayers.<sup>34</sup>

**Pre-Obamacare Status Quo.** The individual and small-group markets have been crippled by Obamacare’s inflexible regulatory and subsidy structure. Any effort to repeal or otherwise unravel

Obamacare must involve charting a new path forward, not only because the pre-Obamacare health care system no longer exists, but because health care had problems even before Obamacare. That world was characterized by incessant frustration of patient choice in a restricted system that favored the interests of providers and insurers over those of patients, government-engineered market distortions, and an absence of portability in health insurance coverage. The pre-Obamacare world was also plagued by high and rising costs and uneven quality, particularly for those enrolled in the Medicaid program. Any successful legislative attempts to increase choice and decrease costs must recognize institutional, procedural, and political constraints. Those constraints must not serve as an excuse for inaction or the perpetuation of big-government policies, but rather a recognition that legislative success in this case requires a practical approach that can secure congressional enactment and fundamentally shift the framework for additional reforms.

## The Consensus Plan: A Solid Down Payment on Patient-Centered, Market-Based Reform

American health care reform is, of necessity, a process; it is not a singular legislative event. It is, therefore, essential that Congress take the initial steps to stop Obamacare’s damage to the health insurance markets from getting worse. The Health Care Choices Proposal offers a framework to do just that and would constitute a major down payment on future health care reform. Restructuring the financing of Obamacare, and returning key decision-making authority to the elected representatives of the people of the states, is a critical first step.

The Health Care Choices Proposal breaks the gridlock in Washington and begins to restore state authority over the regulation and delivery of health care. With states in the lead, progress can be made to reduce costs, expand opportunities for new forms of coverage, and unleash robust experimentation and innovation at the state level. Moreover, this exercise will help states identify other obstacles that need

33. Robert E. Moffit, “Government Monopoly: Senator Sanders’ ‘Single Payer’ Health Care Prescription,” Heritage Foundation Backgrounder No. 3261, October 31, 2017, <https://www.heritage.org/sites/default/files/2017-10/BG3261.pdf>.

34. Nina Owcharenko Schaefer, “Bailouts Will Not Bring Lasting Stability to the Health Insurance Market,” Heritage Foundation Issue Brief No. 4825, March 7, 2018, <https://www.heritage.org/sites/default/files/2018-03/IB4825.pdf>.

remedy at the state and federal level, including policy obstacles that pre-date Obamacare,<sup>35</sup> and create additional pressure on Congress to finish the job.

The Health Care Choices Proposal is just the start. Congress will need to revisit any remaining Obamacare regulations that adversely affect the market as well as other federal policies that contribute to rising costs or impede choice and stifle market competition, including those that pre-date Obamacare. Achieving the goal of patient-centered, consumer-driven, market-based health care will take time. It will also take a firm commitment to pursue many other reforms that extend far beyond this proposal and well beyond the repeal of Obamacare.

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35. Robert E. Moffit, "Health Care Reform: Why State Officials Should Take the Lead," Heritage Foundation Backgrounder No. 1285, January 24, 2018, <https://www.heritage.org/sites/default/files/2018-01/HL1285.pdf>.