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The American Health Care Plan



A Free-Market, Pro-Liberty
Alternative to Government-
Controlled Health Care

Haskins - Karnick

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Introduction

The United States is at an important crossroads for health care and the nation's economy. President Joe Biden and congressional Democrats, at the urging of the party's left-wing base, insist that America should adopt either a European-style single-payer health care system or a "public option," which would inevitably lead to a single-payer system by driving private health insurers out of business.

Republicans rightly argue a government-funded universal health care model, regardless of how it is structured, would create massive problems, including a loss of liberty, rationing of services, and long wait times for patients—an issue that would lead to premature deaths and unnecessary suffering. However, those on the right have continuously failed to present a clear and concise plan to the public for reforming America's broken health care system.

The purpose of this paper is to provide Americans with a pro-liberty, conservative proposal to fix the U.S. health insurance system, lower health care costs, and create universal or near-universal access to health care services—not by force or coercion, but through free-market reforms and improvement of existing social safety nets.

This *Policy Study* begins by briefly outlining the failures of the Affordable Care Act, commonly known as "Obamacare," and the shortcomings of our current

health care system. It then offers to lawmakers and the public a commonsense plan to create a pro-liberty health care system that would make health coverage available to all Americans without compromising quality or putting individual liberty at risk.

The plan is laid out in two distinct parts. The first (Section 2, beginning on page 8) describes a proposal to reduce health care costs and establish a new "Health Ownership Accounts" program, which would supplement and ultimately replace the United States' existing and irrevocably broken employer-sponsored model.

The second part of the proposal (Section 3, beginning on page 17) would provide substantial improvements and reforms to Medicaid, giving lower-income and poor families greater access to higher-quality health care services.

As this paper shows, those who make the assertion that the only way to provide all Americans with access to health coverage is to give the federal government total control over and management of the nation's health care system are completely wrong. There is no denying that the current health insurance model in the United States is severely flawed, but giving more power to the very same government that caused the creation of the current, failing model would not solve the present crisis and would make things much worse. There is a better way forward.

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1 The Obamacare Disaster

Prior to the passage of the Affordable Care Act (ACA), health care reform debates usually focused on the best way to provide health coverage for Americans with so-called “pre-existing conditions.” Pre-existing conditions fall into two categories: medical problems people develop prior to enrolling in a health insurance plan and health factors that are often associated with developing costly medical conditions, such as being overweight or consuming tobacco products.

Before the implementation of the ACA, which was passed into law in 2010 by a Democrat-led Congress and President Barack Obama, millions of Americans with serious pre-existing conditions struggled to purchase affordable health insurance because of their existing illnesses. Further, tens of millions of healthy Americans did not have health insurance—some of whom could have afforded to purchase a plan but chose not to—putting them at risk during a future health care crisis. In 2010, about 48.6 million people were uninsured in the United States, roughly 16 percent of the total population.¹

In some cases, the reason these individuals were uninsured is because they deliberately chose not to pur-

chase health insurance despite having the funds available to do so. But in other cases, people did not have health insurance because they could not afford it or because they lost their health insurance after becoming unemployed.

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The creators of the Affordable Care Act sought to resolve this problem through a far-reaching, radical set of reforms. One of the most important was the creation of government-run health insurance exchanges—markets where individuals without insurance would be required by law (or else face a monetary penalty) to purchase insurance plans. Under Obamacare, people apply for insurance every year during a designated open-enrollment period, and those who qualify (based on their

income and household size) receive government subsidies to offset the cost of health insurance premiums, but not deductibles, co-pays, and other related expenses.

A second significant reform imposed by the ACA is that health insurance companies operating within the Obamacare exchanges are not permitted to deny coverage to consumers with pre-existing conditions,

¹ Michael E. Martinez, Emily P. Zammitti, and Robin A. Cohen, “Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2018,” Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention, November 2018, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201811.pdf>

nor are they allowed to charge them more money than other, healthier consumers purchasing insurance through the exchanges, with only a few exceptions.

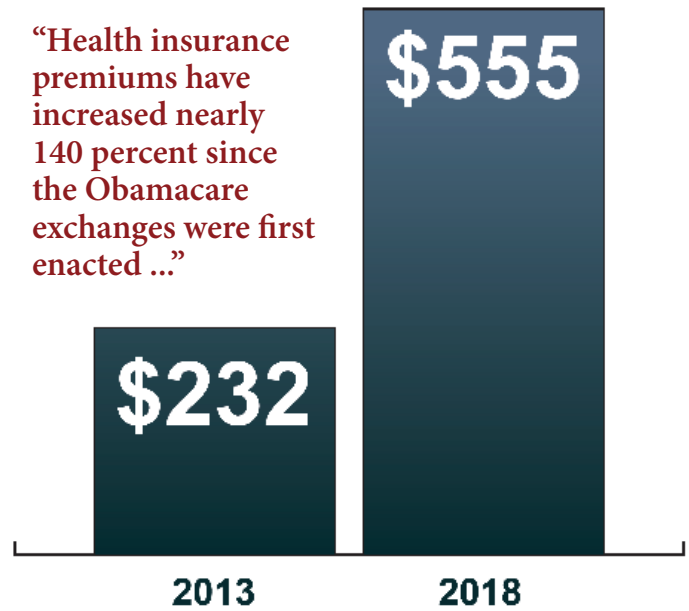
The theory advanced by Democrats at the time they passed the Affordable Care Act—a theory that had previously been supported by Mitt Romney while he served as governor of Massachusetts, as well as by analysts at The Heritage Foundation—was that by forcing all people to purchase health insurance, millions of healthy Americans who had previously chosen not to buy health insurance would purchase an insurance plan, helping to offset the extra costs imposed by this model on insurers, who are now required to cover the medical costs of millions of people with pre-existing conditions—even if those people could have afforded to purchase health insurance prior to getting sick but chose not to.

Democrats theorized that this scheme, coupled with numerous bailouts for insurance companies and a slew of new regulations—notably that insurance plans sold on the Obamacare exchanges must include “essential health benefits” coverage for services like substance abuse and maternity care—would give the nearly 50 million people without insurance access to high-quality plans at a reasonable price. This theory proved to be horribly wrong.

It has been more than a decade since the ACA became law, and it is now clear, beyond any doubt, that Obamacare is deeply flawed. In 2019, there were still more than 28 million Americans who were uninsured, and health care costs and insurance premiums and deductibles have skyrocketed since Congress approved the ACA.

As Justin Haskins and Charlie Katebi noted in an article for *RealClearHealth*, “Health insurance pre-

“Health insurance premiums have increased nearly 140 percent since the Obamacare exchanges were first enacted ...”



miums have increased nearly 140 percent since the Obamacare exchanges were first enacted, from \$232 in 2013 to \$555 in 2018. Even worse, deductibles have grown so high, most middle-class families can’t afford to use their Obamacare plan, even if they receive generous subsidies to help pay for the plan’s high premiums. An analysis by HealthPocket found the average deductible for an Obamacare Bronze family plan in 2018 is \$12,186.”^{2,3}

In the years since, premiums and deductibles have increased under the Trump administration, but not nearly as rapidly as they had under President Obama, thanks in large part to important free-market health care reforms created by President Trump through executive orders.

Some have argued that the Obamacare cost increases were worth the pain they imposed, because Obamacare exchanges provided tens of millions of people with access to health care that they previously

² Justin Haskins and Charlie Katebi, “Health Care Needs Free-Market Reform, Not Single-Payer,” *RealClearHealth*, November 15, 2018, https://www.realclearhealth.com/articles/2018/11/15/trump_makes_massive_improvements_to_obamacare_110841.html

³ “Average Market Premiums Spike Across Obamacare Plans in 2018,” *HealthPocket.com*, accessed November 16, 2018, <https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles#.W-78CVOJJZ>

did not have. This, however, is incredibly misleading. The truth is, the vast majority of people who have gained health care coverage since the ACA was passed have done so through the expansion of Medicaid under the ACA, not Obamacare exchanges.

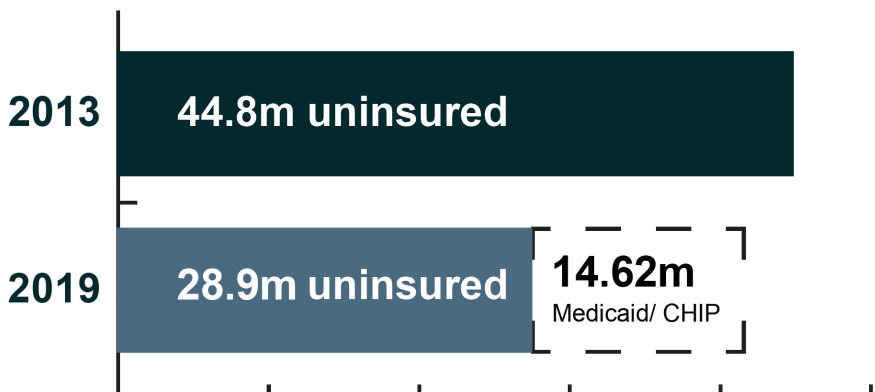
The Centers for Disease Control and Prevention report there were 44.8 million uninsured Americans in 2013, the year of the first Obamacare open-enrollment period. By 2019, the number of nonelderly uninsured had dropped to 28.9 million, a decline of 15.9 million compared to 2013.⁴ However, during the same period, 14.62 million additional individuals enrolled in either Medicaid or the Children’s Health Insurance Program (CHIP).⁵

With these figures in mind, it’s fair to argue that the overwhelming majority of the drop in the number of uninsured experienced since Obamacare went into effect is attributable to states choosing

to expand their Medicaid and CHIP programs—which provide inferior health coverage compared to private insurance plans—and not because of the creation of the Obamacare exchanges. This means that despite the billions of dollars spent on health insurance subsidies, large tax increases, and the gigantic health insurance premium and deductible increases imposed on consumers, the Obamacare exchanges have largely failed to accomplish the ACA’s primary mission: providing tens of millions of people with affordable, high-quality health insurance.

Although it is unlikely the ACA’s biggest supporters will admit it, the evidence 10 years after Obamacare became law is clear: The Affordable Care Act has worsened an already terrible health insurance system, harming millions of families in the process, when it could have attained similarly unimpressive results by simply expanding Medicaid.

“The truth is, the vast majority of people who have gained health care coverage since the ACA was passed have done so through the expansion of Medicaid under the ACA, not Obamacare exchanges.”



⁴ Jennifer Tolbert, Kendal Orgera, and Anthony Damico, “Key Facts about the Uninsured Population,” kff.org, Kaiser Family Foundation, November 6, 2020, <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population>

⁵ “Total Monthly Medicaid and CHIP Enrollment,” Kaiser Family Foundation, kff.org, updated Jan. 15, 2021, <https://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Pre-ACA%20Average%20Monthly%20Enrollment%22,%22sort%22:%22desc%22%7d>

2 A Free-Market, Pro-Liberty Health Care Plan

Although the current U.S. health care system is far from perfect, it remains the most advanced in the world, and it continues to draw huge numbers of medical professionals, researchers, and other experts from every continent, who come to the United States to work alongside providers offering the highest level of care available today and to earn a good salary. If you need heart surgery, brain surgery, or a wide range of other highly specialized health care services, there is still no better place in the world to have these procedures performed than in America.

But despite the many positive aspects of the U.S. system, both liberals and conservatives agree the health care industry suffers from a long list of significant flaws. The American model is highly inefficient, bureaucratic, full of burdensome regulatory hurdles, and unnecessarily expensive. The solution to these defects is not to give more power to many of the same government bureaucrats who have helped create the current health insurance crisis, but rather to enact significant and far-reaching free-market health care reforms that would increase access for lower-income Americans and encourage consumers to carefully shop around when purchasing health insurance as well as before selecting health care services.

The following reform package, which we call the American Health Care Plan (AHCP), would give nearly all Americans access to affordable and high-quality health care without substantially in-

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creasing government spending. In fact, over the long term, the plan would likely save billions of dollars compared to current health care spending projections. This is because under the AHCP, competition among health care providers and insurers would be more prevalent, which would significantly drive down costs. Moreover, consumers would be heavily incentivized to save money when using their Health Ownership Account—a kind of health savings account proposed later in this section—shifting the burden away from taxpayer-funded programs. Further, *most Americans would save large amounts of money* by cutting out health insurers from much of the primary care industry.

It is important to note the conclusions presented in this section are only based on the model provided here *in its entirety*. If any single part of the model below were to be removed from this plan, it is possible the system presented here would suffer from one or more significant problems.

It is also important to keep in mind that unless stated otherwise, the proposals below should be implemented simultaneously. The order of the following proposals is not meant to suggest some provisions are more important than others or that they should be passed into law sequentially.

Before presenting the plan in full, here is a brief outline of the proposal:

1. The Obamacare exchanges should be terminated, and many of the most burdensome Obamacare regulations should be repealed.
2. Association health plans and health savings accounts (HSAs) should be expanded dramatically. These reforms alone would greatly reduce costs and catalyze innovation.
3. Direct primary care agreements should be legalized everywhere, and consumers should be incentivized to enroll in these plans rather than use their health insurance for primary care services.
4. The current employer-sponsored health insurance model should be substantially reformed so that it empowers workers to make their own health insurance choices, encourages wise financial decision-making, and makes health insurance portable so that it is much less likely an employee would lose his or her health insurance when employment ends—a major contributor to America’s past pre-existing conditions problem. All of this can be achieved by transitioning to an employer-funded health savings account model, rather than continue with the current employer-provided health insurance system.
5. Medicaid should be transformed into a health savings account-based model, and policies should be enacted that require able-bodied, non-pregnant people enrolled in Medicaid to work, volunteer, or participate in an educational program. (See Section 3 on page 17.) Medicaid should be reformed so that it is easier for people to work their way out of Medicaid and other welfare programs, helping to end the cycle of poverty so many American families remain trapped in.
6. Every able-bodied American who cannot afford health insurance should be given access to a Health Ownership Account that would allow him or her to receive the aid needed to purchase an

insurance plan, but only if he or she fulfills work requirements and uses those funds to purchase a low-cost health insurance plan. (Those who suffer from a disability or are pregnant would not be subject to work requirements.)

7. Most, and perhaps all, of the long-term costs of this plan could be paid for using existing commitments for health care funding, as well as by cutting waste, fraud, and abuse.

The following sections and subsections describe the American Health Care Plan proposal in greater detail, and they offer other important reform ideas that could help improve access and lower costs—all while enhancing individual liberty.

A. Ending the Obamacare Exchanges

The Affordable Care Act dramatically increased the cost of health insurance premiums and deductibles, failed to accomplish its goal of providing health insurance to all Americans, and forced millions of people out of health insurance plans they liked. The Obamacare exchanges are, simply put, a disaster. They should be eliminated, and in their place, health insurance companies in every state should be permitted to offer a much wider variety of plans, including plans that do not include so-called “essential health benefits,” which mandate coverage of services not everyone uses, like maternity care and substance abuse treatment.

Under the American Health Care Plan, the federal ban on health insurance companies denying coverage to individuals based on a pre-existing condition would temporarily remain in place for those insurance companies operating in multiple states,⁶ but after a three-year transition period, this federal requirement would be phased out entirely. However, states would continue to be permitted to determine whether individuals

⁶ The U.S. Constitution permits Congress to create laws governing interstate commerce. It is my view that insurance companies that operate only in one state cannot be regulated under Congress’s interstate commerce powers.

with pre-existing conditions could be charged more money by health insurance companies or denied coverage because of a pre-existing condition.

Although it might appear to some that these provisions would cause substantial harm to people with pre-existing conditions, all those with pre-existing conditions would, as a result of other reforms presented later in this paper, be empowered with the ability to purchase affordable health insurance before the end of the three-year period, and safety nets would be created for those who fail to do so through no fault of their own.

The federal government's penalty for not being enrolled in a "qualifying" health insurance plan (the so-called "individual mandate")—which was reduced in 2017 to \$0 thanks to the Tax Cuts and Jobs Act—would be permanently eliminated. The penalty was an egregious violation of individual liberty that disproportionately harmed middle-income people who could not afford to use the health insurance they were required to purchase. Although the penalty is now \$0, it remains a threat to personal freedom because another Congress could easily raise the penalty in future legislation. It would be much more difficult to once again impose an individual mandate if it were to be eliminated today.

Under the AHCP, in line with the 10th Amendment, states would still have the power to choose to heavily regulate the health insurance companies operating within their borders, by, for example, creating and enforcing essential health benefits or mandating individuals purchase health insurance—although we do not recommend either of these policies.

“The federal government’s penalty for not being enrolled in a ‘qualifying’ health insurance plan (the so-called ‘individual mandate’)—which was reduced in 2017 to \$0 thanks to the Tax Cuts and Jobs Act—would be permanently eliminated.”

B. Association Health Plans

Another reform offered as part of the American Health Care Plan is to greatly expand association health plans (AHPs). AHPs are health insurance plans offered by associations of people or businesses. Under the current health care system, employers can negotiate with health insurers to purchase group health insurance plans. Because these employers purchase health insurance as a group with many members, they can buy high-quality plans at much lower rates than individuals can in the individual marketplace—a difference that existed even prior to the creation of Obamacare.

For years, Sen. Rand Paul (R-KY) and other advocates of free-market health care reform have called for legislation that would expand association health plans so that Americans in every state could join together to form associations for the purpose of purchasing health insurance, or so that they could use existing associations for the same purpose.

For instance, under proposals suggested by Paul, the National Rifle Association, which has millions of members, and automobile clubs like AAA, which has nearly 60 million members,⁷ would be able to offer an association health plan to their members and negotiate with health insurance companies to get the best rate possible. Large membership stores like Sam's Club and Costco would also be able to offer health care coverage products.

Similar to rules governing many employers, these associations would be able to purchase plans from insurers in any state in which they have members, and associations would not be permitted to deny coverage to a member because of a pre-existing condition.

⁷ “AAA Fact Sheet,” AAA Newsroom, accessed November 25, 2018, <https://newsroom.aaa.com/about-aaa/aaa-fact-sheet>

With this reform in place, any group of Americans could gather together to form an association for the purpose of buying health insurance, including churches, employees, people living in the same geographic area, etc. This arrangement would give significantly more power to consumers who are now forced to buy health insurance in the individual marketplace, because instead of negotiating with health insurance companies alone, the risk would be spread out among all the members of the group.

Expanding AHPs would also create unique opportunities for charitable groups to provide insurance at reduced rates for lower-income people. For example, a church could create an AHP and then choose to offer the plan to lower-income church members for much less than they would otherwise be required to pay. Other members of the church might end up paying more for their health insurance than they would in another association, but they would do so willingly as an act of charity, not because they are forced to do so as a result of government mandates.

“Expanding [association health plans] would also create unique opportunities for charitable groups to provide insurance at reduced rates for lower-income people.”

C. Direct Primary Care

Direct primary care agreements (DPCs) are contractual agreements between primary care physicians and patients. Under many DPC agreements (there are numerous variations), patients pay doctors a set monthly fee in exchange for a specified list of primary care services. Because DPC agreements remove health insurance middlemen from primary care transactions, DPCs reduce health care costs and the time that physicians and their employees must spend completing paperwork for insurance companies and regulators.

Matthew Glans, my former colleague at The Heartland Institute, explained how DPC arrangements work and described their benefits in a *Research & Commentary* published in May 2018:

Under a direct primary care agreement, patients pay a monthly membership fee, typically ranging from around \$50 to \$80. As part of the membership, patients receive a more generous allocation of appointments than they would under most traditional plans. Some agreements even include same-day appointments and house calls. The model removes the layers of regulation and bureaucracy created by the traditional insurance system and allows physicians to spend more time on each patient.

Routine tests and procedures are included in most DPC plans, and lower membership fees are typically charged for programs that do not provide these additional services. Under a DPC model, medical practice overhead can be reduced by as much as 40 percent, according to the Docs4Patient Care Foundation. DPC reduces costs across the board. A study in the *American Journal of Managed Care* found that individuals receiving direct primary care are 52 percent less likely to use expensive hospital services than those in a traditional private practice. The authors found “increased physician interaction is the reason for the lower hospital utilization and ultimately lower healthcare costs.”⁸

Although we do not believe the federal government has the constitutional authority to force states to allow direct primary care agreements, Congress can choose to create specific criteria states must meet to be eligible for federal funding for health care programs, and the legalization of DPC agreements should be one of them. Another should be that states

⁸ Matthew Glans, “Direct Primary Care, A Viable Solution to Pennsylvania’s Primary Care Shortage,” *Research & Commentary*, The Heartland Institute, May 30, 2018, <https://www.heartland.org/publications-resources/publications/research--commentary-direct-primary-care-a-viable-solution-to-pennsylvanias-primary-care-shortage>

refrain from classifying DPC providers as health insurers, a burdensome, inaccurate, and unnecessary problem that has greatly stunted the growth of the DPC industry.

Wherever direct primary care agreements have been permitted and encouraged, they have successfully reduced costs, improved the doctor-patient relationship, and allowed primary care physicians to spend more time with patients.

D. Revolutionizing Employer-Sponsored Health Insurance

To date, employers remain the primary providers of health insurance in the United States. In 2019, 158 million Americans were covered by an employer-sponsored health insurance plan, accounting for nearly half of all Americans.⁹

One of the biggest problems presented by this model is that when an employee with health insurance loses his or her job, the employee typically also loses access to his or her employer-provided health insurance plan, ultimately forcing people to buy health insurance in the individual marketplace, where insurance costs significantly more. This system also discourages employees with health insurance from an employer from pursuing entrepreneurial endeavors.

Prior to the passage of the Affordable Care Act, employees with serious medical conditions who were benefiting from an employer-provided plan but then lost their job would often be denied coverage by health insurers when they attempted to purchase a new plan. This problem also existed for those with children or a spouse with a serious illness. Because the ACA does not allow health insurers in the individual market to deny coverage based on a pre-existing condition, those who lose their employer-sponsored plan now are able to purchase health insurance, even

with a pre-existing condition. However, many are forced to pay so much for their Obamacare health insurance plan that they cannot afford to use it.

Proponents of free-market health care reform have suggested for decades that one of the biggest problems with the current health insurance model is that employers are providing health insurance directly, creating significant instability for half of all Americans. A much better approach would be to reform the health insurance system so that employees are able to purchase their own health insurance plans, rather than rely on their employers.

If people were to stop depending on employer-sponsored health insurance, the health insurance market would benefit in several important ways:

1. Employees would not lose their health insurance when they lose their jobs, making it far less likely for people to find themselves searching for a new health insurance plan with a pre-existing condition.
2. Many people who lose their health insurance are often forced to find a new health care provider, because some health care providers will not accept all forms of coverage. If there is continuity of insurance coverage, it is far more likely there will be continuity of care.
3. People would be able to shop for health insurance plans that suit their unique needs and circumstances, rather than pay for plans chosen by a company on behalf of their employees. Employees would have many more health insurance options.
4. Businesses would save time and money, because they would not need to shop around for health insurance plans or negotiate rates for their employees. They also would not need to worry about complying with various health-insurance-related government regulations.

⁹ "Health Insurance Coverage of the Total Population," KFF.org, Kaiser Family Foundation, accessed February 10, 2021, <https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

The primary reason employers continue to provide employees with health insurance is not because it is the most efficient way for their employees to receive insurance, but rather because they continue to receive a massive tax exemption in exchange for paying for health insurance. The Tax Policy Center reports the exclusion for employer-sponsored health insurance cost \$260 billion in 2017 alone.¹⁰

Numerous health care reform experts, including countless liberals, have called for the elimination of the exemption for employer-sponsored health insurance, but many employers oppose such a plan because they believe it helps them recruit new employees.¹¹

Empowering Workers by Reforming the Employer Exemption

Instead of abandoning the employer-sponsored health insurance exemption entirely, Congress should significantly reform it. Employers should receive the same exemption they do now, but instead of getting the exemption for providing people with health insurance, they should only benefit from the exemption for contributing the funds to an employee's Health Ownership Account (HOA), a health savings account proposed here for the first time.

Health Ownership Accounts could be used to pay for nearly all health-care-related expenses, including dental visits, mental health and substance abuse services, and, most importantly, health insurance premiums and deductibles."

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Employees would be able to contribute part of their salary to these HOA accounts tax-free, just as some employees can now with other HSA accounts. Left-over funds would automatically roll over into the following year, and they would never disappear. If an HOA member were to die, his or her account funds could be inherited, without any tax burden, by an immediate family member.

At the very least, immediate family members should be permitted to use the funds of a living parent, child, spouse, or sibling to help pay medical expenses. For example, a parent could use his or her HOA account to pay for a child's insurance deductible or surgery,

even if that child is no longer a dependent. Similarly, an adult could use HOA funds to pay the medical bills of a sick parent in the hospital. Permitting family members to use each other's HOA funds would allow families to take care of one another in a medical crisis, rather than rely on government.

However, policymakers should strongly consider expanding the ability to share funds beyond immediate family members, so that, for example, co-workers, friends, and even charitable strangers could donate HOA funds to those in need.

Health Ownership Accounts would have much greater annual contribution limits than those HSA now in existence, and they could be used for any health insurance plan on the market, not just high-deductible plans. (The HSA contribution limits for 2020 were \$3,550 for individuals and \$7,100 for

¹⁰ "How does the tax exclusion for employer-sponsored health insurance work?," Tax Policy Center, accessed November 25, 2018, <https://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work>

¹¹ For example, see Laura Joszt, "5 Facts About the Tax Exemption for Employer-Sponsored Insurance," AJMC, June 2, 2017, <https://www.ajmc.com/newsroom/5-facts-about-the-tax-exemption-for-employer-sponsored-insurance>

family coverage.¹²⁾

Under the HOA plan proposed here, employers—including small businesses—seeking to receive an exemption for providing health coverage would be required in the first year of the plan to contribute at least as much to their employees' HOA account as they spent on health insurance in the previous year.

In years two and three, employers would be required to contribute the same amount to their employees' HOA account as they did in the first year, but they could add as much as 5 percent more. After the third year, tax-free HOA exemption limits for employers would be free of any limitations. (In 2018, the average combined family health insurance contribution for employers and employees was more than \$19,000.¹³⁾

In their first year in the program, individual HOA enrollees receiving employer-provided HOA funds could contribute tax free to their HOA account the same amount of money as they do now for their employer-provided health insurance coverage, but they wouldn't be *required* to contribute anything. Self-employed individuals, small business owners, and other filers in a similar non-traditional employment situation could contribute tax-free as much money as they want into their HOA accounts, up to the total combined limits referenced above for employers and employees. These limits should also be designed by Congress to rise *slowly* over time, perhaps in line with the rate of inflation.

Additionally, Congress should draft provisions permitting all Americans to purchase health insurance plans across state lines and, over time, flattening disparities in regional HOA contribution limits so that all people throughout the United States eventually share the same limits. These provisions would dramatically lower health insurance prices across the country.

E. Incentivizing Efficient Spending Practices

“Congress should draft provisions permitting all Americans to purchase health insurance plans across state lines and, over time, flattening disparities in regional HOA contribution limits so that all people throughout the United States eventually share the same limits.”

To encourage consumers using HOAs to spend their money wisely, 10 percent of the money contained in an individual's HOA account could be withdrawn every 36 months (three years) and used for any purpose, including non-health-care-related uses. HOA accountholders would not need to pay taxes on the money withdrawn from the account under this provision of the plan. The maximum amount that could be withdrawn in a single year would start at several thousand dollars and auto-

matically increase at designated periods.

The ability to withdraw HOA funds every three years is a vital reform, because it would encourage consumers to shop around when purchasing a health insurance plan or paying for health care services. Whereas the current model offers no incentive for people to think about health care prices, this reform would financially reward those who are careful with their money.

¹² See “HSA Contribution Limits Rise in 2020,” Block Advisors, accessed April 18, 2020, <https://web.blockadvisors.com/2020-hsa-contribution-limits>

¹³ “Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance,” Kaiser Family Foundation, accessed April 18, 2020, <https://www.kff.org/other/state-indicator/family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

One of the stipulations for having an HOA account and withdrawing funds from it would be that all HOA accountholders must purchase a health insurance plan for themselves and their dependents once they enroll in an HOA account. Consumers would not necessarily need to spend a significant amount of money on a health insurance plan, however, because they would have a much wider variety of health care plans available to them than consumers do today. This is because, as it was previously mentioned, the plan proposed here would eliminate the Obamacare health insurance exchanges and many federal mandates.

A consumer could, for instance, choose only to purchase a low-premium “catastrophic” health insurance plan, which would likely cost under this model, based on the cost of these plans in the past, less than \$200 per month for an individual.

HOA enrollees would also be required to maintain health insurance coverage to continue having access to their HOA account and to withdraw cash from it, but employers and enrollees could continue contributing to the funds even if an enrollee is not eligible to use them.

A second stipulation for *fully* participating in the HOA plan would be that all accountholders must enroll in a direct primary care agreement with a doctor before the end of the third year of starting an HOA account. Those who do not fulfill this requirement would still be able to use their HOA accounts to pay for health-care-related expenses, but they would not be able to withdraw any funds from the account for non-health-care-related uses.

Those people residing in states that do not permit direct primary agreements would be able to use their HOA accounts exactly as those enrollees living in states with direct primary care agreements, but they would only be permitted to withdraw 5 percent of the funds every three years for non-health-care-related uses, rather than the 10 percent permitted for those enrolled in a direct primary care agreement.

A third stipulation of the HOA plan would be that all employers receiving the health care tax exemption

would be required in the first year of the plan to help their employees create and administer an association health plan composed of the employees of the business, as well as their spouses and children, to replace the existing employer-provided health insurance plan. After the first year of the Health Ownership Account plan proposed here, the association of employees would have full control to negotiate with their insurer for a new health insurance plan or to shop around to find a more comprehensive or affordable plan, and employers would no longer manage the employee health association.

The effect of the third stipulation would be to help transition the current employer-sponsored group market to a group market composed of consumer-controlled association health plans.

F. Big Reforms, Big Benefits

The benefits of the reforms listed above would be substantial. First, health insurance funding would continue to be offered to employees, but because employees would pay for the health insurance out of their own Health Ownership Accounts, their insurance would not be directly provided by their employer, which means if an employee were to lose his or her job, that employee wouldn’t automatically lose his or her health insurance. The individual who just lost his or her job could use money in an HOA account to continue paying insurance premiums while looking for another job. If that individual is short on HOA savings, a family member could donate HOA funds to his or her account, in line with the provisions discussed in subsection D above. That would help to ensure there is a continuity of health insurance coverage. It would also solve a large part of the pre-existing conditions problem mentioned earlier in this paper.

Second, the HOA model would empower employees to build a robust health savings account that could be rolled over indefinitely. Employees who opt to purchase more affordable health insurance options would have a large pot of money set aside for a future health care crisis, an opportunity that would

help curtail rising health care and health insurance prices.

For the purpose of illustrating the benefits of this model, in 2018 the average monthly premium for a family plan in the high-priced Obamacare exchanges was \$1,168.¹⁴ The average annual premium amount paid by employers for family health coverage was \$14,069.¹⁵ The average annual contribution paid by a worker for his or her family coverage was \$5,547.¹⁶ Even if we assume the unlikely scenario that under this new model, which includes the elimination of the Obamacare exchanges and essential health benefits requirements, the most affordable option for an employee would be to enroll in a direct primary care agreement and health insurance plan that together cost the same amount as the average Obamacare plan available in the ACA exchanges. Employees currently with family plans would still have, on average, \$5,600 remaining in their Health Ownership Account after paying their premiums for the year, assuming they choose to contribute the same amount they are now toward their health insurance plan.

In just three years of not having a significant health care expense requiring the employee to use a large portion of the HOA funds, the employee's account could contain as much as \$16,000 or more (depending on the price of the employee's family premium), allowing the employee to withdraw \$1,600 in tax-free funds at the end of the third year of enrollment.

The third benefit would be that the savings accrued in the Health Ownership Account could be used to cover health insurance costs when an employee loses

his or her job. The employee in the example above would have enough money saved in his or her HOA account to cover premiums for coverage costing the same amount as today's average Obamacare plan for one to two years, and there would still be thousands of dollars left over.

Fourth, unlike in the current system, people would have a strong financial incentive to shop around for the health care services that provide the best value. The more money consumers save, the better off they would be in the long run. That is a big change from today's system, which gives almost no reason for most people with insurance to be concerned with what providers are charging.

Imagine how expensive car insurance would be if people were to regularly use it for literally all car maintenance—including tire replacements and rotations, tune-ups, oil changes, and other routine services. Even worse, imagine what would happen if people were to use car insurance to purchase new vehicles, and if they were to do so without knowing the cost of any of the cars on a dealer's lot. That's what the current health care system is like, and it is pure madness.

Although the reforms presented above would go a long way toward fixing the numerous issues in the U.S. health insurance system, two of the biggest problems have yet to be addressed: (1) how to reform America's failing Medicaid program and (2) the best way to help the more than 20 million Americans currently without insurance get access to affordable, high-quality care. Both of these concerns are addressed in the next section.

¹⁴ "How Much Does Health Insurance Cost Without A Subsidy?," eHealth, updated September 2018, <https://www.ehealthinsurance.com/resources/affordable-care-act/much-health-insurance-cost-without-subsidy>

¹⁵ "2018 Employer Health Benefits Survey," Kaiser Family Foundation, October 3, 2018, <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey>

¹⁶ *Ibid.*



Medicaid was originally designed to provide health coverage to those who need it the most, especially those with significant disabilities, but following the passage of the Affordable Care Act, tens of millions of able-bodied Americans who previously were not eligible for Medicaid were permitted to enroll in this government program. All told, more than 14 million additional people have been added to states' Medicaid and CHIP rolls since 2013, not including those added in the wake of the 2020 coronavirus outbreak.¹⁷

Rising Medicaid enrollment presents numerous problems.

First, Medicaid provides inferior health insurance compared to the plans offered by employers and many of those available in the individual marketplace.¹⁸

Second, Medicaid reimbursement rates are often so low that it *costs* providers money to service Medic-

aid patients. As the Mercatus Center's Charles Blahous noted in an important *Working Paper* published in 2018, "in 2014, hospitals were reimbursed just 89 percent of their costs of treating Medicare patients and 90 percent of their costs of treating Medicaid patients—losses that were offset by hospitals collecting private insurance reimbursement rates equaling 144 percent of their costs."¹⁹ These lower reimbursement rates have caused many medical specialists to choose not to accept new Medicaid patients. It has also caused those with employer-based health insurance to pay higher prices for medical services, effectively subsidizing the losses incurred by treating Medicaid patients.

Third, Medicaid is highly inefficient and is eating away huge chunks of states' budgets. In 2017, states spent about 17 percent of all revenue on Medicaid, and in most states, Medicaid is the second costliest program, behind only K–12 schools.²⁰

¹⁷ Kaiser Family Foundation, *supra* note 5.

¹⁸ For evidence, see John O'Shea and Robert Moffit, "Medicaid: Obamacare Pushed More Americans into a Low-Quality Care System," The Heritage Foundation, July 11, 2017, <https://www.heritage.org/health-care-reform/report/medicaid-obamacare-pushed-more-americans-low-quality-care-system>; Kevin Dayaratna, "Studies Show: Medicaid Patients Have Worse Access and Outcomes than the Privately Insured," The Heritage Foundation, November 7, 2012, <https://www.heritage.org/health-care-reform/report/studies-show-medicare-patients-have-worse-access-and-outcomes-the>; Nina Owcharenko Schaefer, "Medicaid at 50: Reform Is Needed to Better Serve Low-Income Health Care Needs," The Heritage Foundation, July 30, 2015, <https://www.heritage.org/health-care-reform/report/medicaid-50-reform-needed-better-serve-low-income-health-care-needs>

¹⁹ Charles Blahous, "The Costs of a National Single-Payer Healthcare System," *Working Paper*, Mercatus Center, July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf

²⁰ Barb Rosewicz, Justin Theal, and Katy Ascanio, "States Collectively Spend 17 Percent of Their Revenue on Medicaid," Pew Charitable Trusts, [pewtrusts.org](https://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/09/states-collectively-spend-17-percent-of-their-revenue-on-medicare), Jan. 9, 2020, <https://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/09/states-collectively-spend-17-percent-of-their-revenue-on-medicare>

Fourth, like all government-run programs, Medicaid is subject to massive amounts of waste and abuse.²¹

Fifth, Medicaid's current design makes it incredibly difficult for people to break out of a cycle of poverty, because many lower-income people enrolled in Medicaid cannot find jobs that include insurance or pay so well that they can afford to purchase a private health insurance plan with reasonable premiums and deductibles, which means they cannot even afford to use it. Many Medicaid enrollees, especially those who are able-bodied, must choose between keeping their health insurance coverage or earning more money at a new job. For Medicaid recipients with children, this decision is exceptionally difficult and often heartbreaking.

“The best strategy for fixing Medicaid is to infuse the same free-market forces that have helped to reduce costs and spur innovation in other markets into this broken government program ...”

A. Reforming Medicaid

The best strategy for fixing Medicaid is to infuse the same free-market forces that have helped to reduce costs and spur innovation in other markets into this broken government program, while also creating a model that allows people to move from poverty to self-sufficiency. How can that be achieved? The first step would be to separate Medicaid into two distinct programs.

The current Medicaid system caters primarily to three groups: children; disabled Americans, such as those who are legally blind; and able-bodied adults who are eligible for Medicaid either because they have very low incomes and several children or because they

have low incomes and their states have chosen to expand Medicaid eligibility under the Affordable Care Act.

It never made sense to have people suffering from serious medical disabilities enrolled in the same government program as those who are able-bodied but cannot afford to purchase health insurance. Those with disabilities should remain enrolled in Medicaid, but the program should be renamed to something like the Medicaid Disability Program, while

those who are able-bodied—including kids in the Children's Health Insurance Program (CHIP), which is often included in analyses of Medicaid—should be moved into an entirely separate government program, which we propose calling the Temporary Health Care Assistance Program (THCAP).

It is important to separate Medicaid into two distinct programs so that policymakers can more easily and appropriately make adjustments, including changes to funding, without creating confusion or additional unintended consequences. The regulations governing the Medicaid Disability Program should not be the same as those applied to the Temporary Health Care Assistance Program, because these programs' enrollees would be too dissimilar.

B. Available Funding

Even worse than in the current private health insurance market, today's Medicaid recipients have absolutely no reason to consider costs when looking for

²¹ For example, according to a November 2018 report in *The News-Star* (Monroe, Louisiana), auditors in Louisiana released a report indicating the state's "Department of Health may have spent up to \$85.5 million on Medicaid recipients who are ineligible for the program." Source: Greg Hilburn, "BREAKING: La. may have spent \$85M on ineligible Medicaid recipients," *The News-Star*, November 13, 2018, <https://www.thenewsstar.com/story/news/2018/11/13/breaking-la-may-have-spent-85-m-ineligible-medicaid-recipients/1986059002/?fbclid=IwAR0K9GnvpvzsvBX8MBdrNLJuYvP11eE8Yo-Oyw9e9tKnstU1jOy22h8SdMc>

a health care provider, and the bureaucratic waste so common in other government programs is pervasive throughout Medicaid. To encourage health care savings, introduce market principles into Medicaid, and make it easier to transition to self-sufficiency, a plan similar to the Health Ownership Account model proposed in the previous section should be implemented in both the proposed Medicaid Disability Program and the Temporary Health Care Assistance Program.

At the end of 2018, total monthly Medicaid enrollment, including CHIP, was more than 71.8 million.²² Total Medicaid costs for the federal government and states—including administrative costs, Medicaid costs for U.S. territories, and accounting adjustments—equaled about \$632 billion for FY 2018. That means governments spent on average \$8,800 per person enrolled in Medicaid and CHIP.

If we were to provide each of these people, or their legal guardians, access to a Health Ownership Account that is funded with, say, \$6,000 per year, they would have more than enough money to purchase a direct primary agreement and pay for a lower-cost health insurance plan. Families of four would have access to \$28,000 per year under this plan.

However, we still haven't addressed what should be done to help the vast number of Americans who were enrolled in the Obamacare individual marketplaces prior to the coronavirus pandemic, about 12 million, and the additional 27.9 million other citizens of the

\$632B / **71.8 million**
Medicaid costs for FY 2018 / Medicaid enrollees, including CHIP

= \$8,800
per person enrolled in Medicaid and CHIP



United States who were believed to be uninsured at the end of 2019.²³ If we add together the Americans in these two groups, most of whom would likely end up enrolled in the Temporary Health Care Assistance Program, we're left with approximately 39.9 million people.

It's inaccurate to assume, though, that everyone in these two groups would qualify for government assistance. According to analysts at the Kaiser Family Foundation, only about half of the uninsured in the United States would qualify for an Obamacare subsidy, Medicaid, or another health care welfare program.²⁴ Another roughly two million people who purchase health insurance on an Obamacare exchange earn too much to qualify for a subsidy.²⁵ That means we only need to add 24 million to the 71.8 million enrolled in Medicaid and CHIP at the end of 2018 to get the final number of Americans (95.8 million) who

²² "Total Monthly Medicaid and CHIP Enrollment," Kaiser Family Foundation, accessed April 18, 2020, <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=11&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

²³ See Jennifer Tolbert *et al.*, "Key Facts about the Uninsured Population," Kaiser Family Foundation, December 13, 2019, <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population>; Kimberly Amadeo, "Health Insurance Exchange: What the Obamacare Health Exchanges Are, and What You Should Do Now," *TheBalance*, updated November 6, 2019, <https://www.thebalance.com/health-insurance-exchange-3306052>

²⁴ Rachel Garfield *et al.*, "Estimates of Eligibility for ACA Coverage among the Uninsured in 2016," Kaiser Family Foundation, June 19, 2018, <https://www.kff.org/uninsured/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016>

²⁵ Julie Rovner, "Overlooked By ACA: Many People Paying Full Price For Insurance 'Getting Slammed,'" Kaiser Health News, October 9, 2017, <https://khn.org/news/overlooked-by-aca-many-people-paying-full-price-for-insurance-getting-slammed>

would potentially need government assistance in either the proposed Medicaid Disability Program or the Temporary Health Care Assistance Program.

(Note: These numbers are approximate. Since the COVID-19 pandemic, many more people have lost access to their insurance. At present, it is unclear exactly how many people have lost access to their employer-provided health insurance, and it's even more difficult to determine how many Americans will regain coverage when the economy recovers.)

To calculate how much money would be available for distribution to Health Ownership Accounts for enrollees in the new Medicaid Disability Program and the Temporary Health Care Assistance Program (the 95.8 million Americans previously mentioned), we need to add the roughly \$55 billion per year typically paid by the federal government to cover Obamacare subsidies²⁶ to our \$632 billion

Medicaid fund, because the proposed plan assumes the Obamacare exchanges, including their subsidies, would no longer exist.

If we were to distribute this \$687 billion available to the 95.8 million people estimated to need coverage, there would be enough money for each enrollee to receive \$6,000 in his or her Health Ownership Account every year and still have \$112 billion left over.

The remaining \$112 billion would be reserved to pay for additional costs—especially insurance deductibles—for pregnant enrollees and mothers who have just given birth, those who already have expensive

illnesses in the Temporary Health Care Assistance Program, and those with the most serious disabilities, including mental illnesses, in the Medicaid Disability Program. (About 10 million adults enrolled in Medicaid are disabled, institutionalized, or have recently given birth to a child.²⁷)

An alternative approach would be to adjust the amount distributed in either (or both) the Temporary Health Care Assistance Program and Medicaid Disability Program to account for cost-of-living differences between the states. This model would carry with it

advantages and disadvantages. The most important advantage would be that those people living in states where health insurance is currently more expensive would have more money to help offset those costs—a problem that should go away over time under the plan, because Americans would be permitted to purchase insurance across state lines.

The biggest disadvantage would be that giving people more money in higher-cost states would help to reinforce those higher prices and do nothing to incentivize state lawmakers to pass reforms that would make their state health insurance markets more competitive with neighboring states. It also would disincentivize those living in states with higher medical costs from relocating to states with more affordable prices.

A second alternative would be to distribute less money to children's Health Ownership Accounts. Under this plan, about 35 million to 40 million children would be enrolled in the Temporary Health Care Assistance Program. If each one is given \$6,000 per year in an

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²⁶ Emma Ockerman, “Temporary Health Care Assistance Program,” Bloomberg, May 23, 2018, <https://www.bloomberg.com/news/articles/2018-05-23/it-costs-685-billion-a-year-to-subsidize-u-s-health-insurance>

²⁷ Amanda Lee and Beth Jarosz, “Majority of People Covered by Medicaid and Similar Programs Are Children, Older Adults, or Disabled,” Population Reference Bureau, June 29, 2017, <https://www.prb.org/majority-of-people-covered-by-medicaid-and-similar-programs>

HOA account, the total cost would be \$210 billion. There are good reasons to believe \$6,000 is more than what most children would need, however. Children generally do not cost nearly as much to cover as older adults, and under the plan proposed above, family members could use their HOA accounts to cover the health care costs of their children, spouses, parents, and siblings. That means many parents would have access to a lot more money to cover the health care expenses of their children than a single adult would.

If we were to reduce the amount given to children to \$3,000 or \$4,000 annually—and the program could be designed in such a way that this would only apply to children with siblings or two parents, to ensure these kids have access to enough health care dollars—policymakers could increase the annual amount provided to adults' HOA accounts by more than \$1,000 per year.

Lawmakers should strongly consider an approach that provides older adults with more HOA funds in the first several years of the plan, because older adults pay more for health insurance and out-of-pocket costs than younger adults and children. (In future decades, this would likely become unnecessary for many, because this plan encourages health care savings over time.)

Regardless of how the program is structured, it is possible more funding will be needed to ensure everyone who requires additional help in the proposed Temporary Health Care Assistance Program and most of those enrolled in the Medicaid Disability Program receive the funds they need to pay their health insurance deductibles. Many in these programs would be able to save up money over time, receive funds from family members, or find a charitable association health plan or other fund that could help them cover their costs, but for those who could not, there must be enough public funding available to ensure they can pay their health care deductibles and co-pays.

It's difficult to say how much, if any, additional funds would be needed to cover these costs, and the answer to that question could vary from year to year, depending on a variety of factors, such as a public health emergency or an economic downturn.

If more funding is required, then the first place policymakers should look is to slash existing wasteful government programs. Citizens Against Government Waste's 2019 *Prime Cuts* report "contains 620 recommendations that would save taxpayers \$433.8 billion in the first year and \$3.9 trillion over five years."²⁸ Even if just one-quarter of these recommendations were made, it would likely be enough to cover any additional costs required by the proposed plan.

C. Health Ownership Account Rules

The Health Ownership Accounts for enrollees in the proposed Medicaid Disability Program and the Temporary Health Care Assistance Program would operate in exactly the same way as all other HOA accounts (see Section 2 for details), with only two exceptions: (1) Children who have been enrolled in the Temporary Health Care Assistance Program would *not* be able to begin withdrawing health care funds for non-health-care-related uses until they are 18 years old (their parents would not be permitted to withdraw funds for non-health-care-related uses on their behalf, either), and (2) adults enrolled in THCAP would not be permitted to withdraw up to 10 percent of the funds in their HOA account for non-health-care-related uses while enrolled in THCAP.

After an enrollee leaves THCAP, he or she would be eligible to withdraw the maximum 10 percent of the funds in the account, subject to the previously mentioned limits, once the enrollee is employed for 12 consecutive months in a full-time job.

Preventing withdrawals for non-health-care-related

²⁸ Sean Kennedy, 2019 *Prime Cuts*, Citizens Against Government Waste, 2019, https://www.cagw.org/sites/default/files/pdf/Prime_Cuts_2019.pdf

uses for those who are enrolled in THCAP would incentivize people to work hard to leave the program and attain self-sufficiency, but additional provisions should be built into the Temporary Health Care Assistance Program to further help people escape government dependency.

D. Ending the Cycle of Poverty

There are numerous reforms that should be created to help able-bodied adults attain self-sufficiency but that shouldn't be applied to those with serious disabilities. Perhaps the most important is work requirements.

Work requirements for programs such as the Temporary Assistance for Needy Families (TANF) program and the Supplemental Nutrition Assistance Program (SNAP), commonly called “food stamps,” have repeatedly been shown to help people secure employment and learn important job skills. As Justin Haskins and Matthew Glans previously noted in an article published by *The Detroit News*:

For instance, before the Republican-led Congress and President Bill Clinton passed welfare reform for America's Temporary Assistance for Needy Families (TANF) program in 1996 — which included work requirements — there were 13.4 million Americans enrolled in the program. However, almost immediately after welfare reform was approved, rolls suddenly declined dramatically and millions of people found jobs. Since 1996, enrollment in TANF has declined by about 73 percent.

Similarly, after Maine policymakers instituted

work requirements to the state's Supplemental Assistance for Needy Families program, commonly called “food stamps,” the number of able-bodied adults without dependent children in the program dropped by 80 percent in fewer than six months.²⁹

Effective work requirement reforms do not simply mandate able-bodied people receiving government assistance find full-time jobs, they allow people to fulfill the requirements in a variety of ways. For instance, many work requirements permit welfare recipients to enroll in an education or job-training program. Numerous programs also allow able-bodied recipients to fulfill their requirements by volunteering for a nonprofit organization.

All able-bodied, non-pregnant adults without young children enrolled in the proposed Temporary Health Care Assistance Program would be required to work, enroll in an education or training program, or engage in community service activities as a condition of remaining in the THCAP program. This requirement would encourage people to develop new job skills and build up their resumes, helping them find full-time employment in the future.

Recipients should also be subject to asset testing, which mandates that those who have too much wealth be prevented from enrolling in a welfare program. So, for example, a millionaire with no income would not be able to qualify for the Temporary Health Care Assistance Program.

On their own, work requirements and asset testing might not be enough to help adults work their way out of the proposed Temporary Health Care Assistance Program. Something must also be done to ease

“There are numerous reforms that should be created to help able-bodied adults attain self-sufficiency but that shouldn't be applied to those with serious disabilities. Perhaps the most important is work requirements.”

²⁹ Justin Haskins and Matthew Glans, “Work requirements can save Medicaid,” *The Detroit News*, April 9, 2018, <https://www.detroitnews.com/story/opinion/2018/04/09/medicaid-work-requirements/33691283>

the large benefits “cliff” commonly found in many poorly designed welfare programs.

A benefits cliff refers to the criteria that limit, often abruptly, a welfare recipient’s ability to remain enrolled in a program. For example, a person receiving Medicaid might get a promotion or a job offer that would help him or her earn more money, but it could also simultaneously cause the recipient to stop qualifying for Medicaid coverage. Unless this recipient’s promotion or job offer is lucrative enough to help pay for the additional costs of purchasing health insurance in the private market, the recipient is typically incentivized to turn down these opportunities.

Policies need to be put into place to help working adults enrolled in the Temporary Health Care Assistance Program earn more money without being punished for doing so. The most effective strategy for achieving this goal would be to slowly phase out government-provided Health Ownership Account payments for those in the Temporary Health Care Assistance Program. Further, all able-bodied adult recipients should be required to contribute a small amount to his or her Health Ownership Account every month to continue accessing the HOA. The minimum amount should be very low, perhaps only \$5 per month. But as the person earns more money, the contribution mandate should steadily and very slowly increase, easing THCAP enrollees into health care self-sufficiency.

Additionally, as we mentioned previously, newly employed full-time workers leaving THCAP should be permitted to withdraw 10 percent of their funds out of their Health Ownership Account to help pay for other non-health-care-related expenses, such as food and housing, after a designated period elapses. This would further encourage people to find a full-time job.

These policies would make the transition from being enrolled in the Temporary Health Care Assistance Program to obtaining full-time employment outside of the THCAP program much less difficult and more appealing.

Of course, once an enrollee finds a full-time job that provides full Health Ownership Account funding, government contributions would no longer be needed at all.

E. High-Risk Pools

If you add the total projected enrollment of the proposed Temporary Health Care Assistance Program and Medicaid Disability Program to the number of people projected to receive employer-sponsored Health Ownership Accounts, total enrollment of Medicare, the population believed to be capable of buying their own health insurance, and the number of people remaining who receive health care from another source (like a pension), under this plan nearly everyone would have access to health coverage for the first time in American history—and

this impressive feat could be accomplished without spending significantly more than what taxpayers already spend on health care each year. In fact, over the long run, this plan would likely save money relative to projected future health care spending, because it heavily incentivizes price shopping and savings.

However, it is likely there would still be a very small number of people who would choose not to purchase health insurance and don’t fall into any of the categories mentioned above. A healthy young adult, for example, might choose not to purchase health insurance but then later develop cancer several years after the American Health Care Plan is in place, when insurers might be permitted by some states to charge

“These policies would make the transition from being enrolled in the Temporary Health Care Assistance Program to obtaining full-time employment outside of the THCAP program much less difficult and more appealing.”

people with pre-existing conditions more money for insurance. How do we make sure that people who find themselves in situations such as the one just described continue to have access to health coverage?

Prior to Obamacare, some states operated relatively successful high-risk pools to help cover people with pre-existing conditions.

High-risk pools offer people suffering from pre-existing conditions government-subsidized health insurance. The idea behind high-risk pools is that it's very difficult for free markets to provide health insurance to people with pre-existing conditions, because the entire concept of "insurance" is dependent on risk assessment and purchasing the policy prior to the illness developing. This is precisely why a person without car insurance cannot wreck his or her car and then go to an insurance company and force the insurer to sell the driver a policy that would pay for a new car. It's also why drivers with several speeding tickets and accidents on their record pay more for auto insurance. From an actuarial perspective, these drivers are considered high-risk.

High-risk pools would allow states to cover people with pre-existing conditions without significantly affecting prices in the health insurance marketplace, because the coverage provided would come directly from the government, not a health insurance company. The biggest downside to this policy is that it would encourage some people to wait until they get sick before

purchasing health insurance—although this number should be significantly lower compared to what is occurring now, because under the plan presented above, the overwhelming majority of Americans would have access to a Health Ownership Account funded by either an employer or the government.

“Ideally, state lawmakers would fund the high-risk pools by cutting waste, rolling back unnecessary social programs, and reducing lucrative pension agreements with public union workers—not by raising taxes.”

To combat this problem, state lawmakers should develop reasonable penalties or disincentives for those able-bodied people who end up both uninsured and with a pre-existing condition because they chose not to buy health insurance and now must rely on a government-funded high-risk pool. Exemptions should be made for those rare cases when a person develops a

health problem and does not have health insurance through no fault of his or her own. For instance, perhaps a parent neglects to provide health insurance for his or her teenage child, who then develops a serious medical condition just before becoming an adult. That person should not be punished for a parent's irresponsible behavior.

Funding for high-risk pools would come entirely from state governments, who would have total control over how the pools operate and who qualifies to enroll in these programs. Ideally, state lawmakers would fund the high-risk pools by cutting waste, rolling back unnecessary social programs, and reducing lucrative pension agreements with public union workers—not by raising taxes.

4 A Brief Summary and Concluding Remarks

We've covered a lot of ground in the previous sections, so let's briefly recap the key components of the proposed American Health Care Plan.

Ending Obamacare Exchanges

The Obamacare exchanges should be closed, and health insurance companies should be permitted to offer significantly more options for consumers. The federal essential health benefits mandates should be permanently eliminated, and states should have the power to allow insurers to charge people with pre-existing conditions higher rates, beginning three years after the full plan goes into effect.

Association Health Plans and Direct Primary Care

States choosing to accept federal health care funding should be required to permit expanded association health plans and direct primary care agreements, both of which would help to dramatically reduce the cost of health insurance.

Transforming Employer-Sponsored Health Insurance

Exemptions for employer-sponsored health insurance should not be eliminated, but they should be transformed so that instead of receiving an exemption for providing an employee with health insurance, employers would only be granted tax exemptions for making contributions to Health Ownership Accounts, which are being proposed here for the first time. Health Ownership Accounts are a kind of health savings account. They would only be used to pay for health-care-related expenses, such as co-pays and

health insurance premiums and deductibles. Amounts remaining at the end of each year would roll over to the following year. People could choose to make their own contributions to their HOAs, and all contributions, up to a specified limit, would be tax-exempt.

At the very least, immediate family members would be able to share HOA account funds to pay for health care expenses, helping families take care of each other when health care crises arise. When people with HOA accounts die, the money in their accounts would transfer, tax-free, to an immediate family member.

Every 36 months, those people with HOA accounts enrolled in a direct primary care agreement would be allowed to deduct 10 percent of the total funds available in their HOA account, up to a specified limit. (Those living in states without direct primary care agreements could only withdraw up to 5 percent.) This would incentivize people to carefully spend the money in their HOA accounts and would encourage consumers to seek innovative and more affordable health care services. It would also incentivize people to adopt healthy habits and behaviors while allowing people to keep more of their hard-earned money, and it would do so without adding large sums to the national debt.

Reforming Medicaid

Medicaid should be broken up into two programs: the Medicaid Disability Program, which would cover those with qualifying disabilities, and the Temporary Health Care Assistance Program, which would cover children now enrolled in Medicaid or CHIP and abled-bodied adults. Enrollees in these two programs would be given access to a Health Ownership Account. Each year, governments would distribute an average of \$6,000 to

each HOA account. (Amounts may vary based on age, differences in cost of living, etc., depending on what state and federal lawmakers decide.)

Like all other HOA accounts, the unused funds in these accounts would roll over at the end of each year, and immediate family members could share HOA funds to pay for health care expenses. Unlike the HOA accounts belonging to people not enrolled in the Temporary Health Care Assistance Program, adults in THCAP would not be permitted to withdraw the full 10 percent of the funds in their HOA account for non-health-care-related uses while enrolled in THCAP. (After an enrollee leaves THCAP, he or she would be eligible to withdraw up to 10 percent of the funds in the account when the enrollee reaches the end of his or her next 36-month period—just like all Americans with HOA accounts.)

Although THCAP enrollees would not be eligible to make 10 percent withdrawals from their HOA accounts, they would be given the option to accept a cash bonus every few years, paid out of their HOA account, if they meet certain goals, such as engaging in careful health care spending practices or completing job-training courses.

Children would not be permitted to make any withdrawals for non-health-care-related uses until they reach the age of 18, and their parents would not be allowed to make withdrawals from their children's accounts on their behalf, either.

In addition to providing enrollees in THCAP and the Medicaid Disability Program with, on average, \$6,000 annually, a \$112 billion fund would be created to cover additional expenses, such as insurance deductibles and copays, incurred by those with high-cost health care conditions. Policymakers are encouraged to structure Health Ownership Account payments based on age and other factors.

More money might be required to ensure everyone has the health care spending they need, and if it is, the funds should first come from cutting government waste, fraud, and abuse. (See Section 3 for more.)

High-Risk Pools

States should create their own high-risk pools to cover people with pre-existing conditions who cannot afford to purchase health insurance after the three-year phase-in period has expired. Although the reforms presented in the American Health Care Plan would make this group of people quite small, state lawmakers (not the federal government) should be encouraged to form these programs to ensure no one falls through the cracks.

Conclusion

Those arguing the only way to provide health insurance coverage to all Americans is to enact a massive, highly unaffordable single-payer health care program are either deliberately misleading people to increase the power of government or they haven't taken the time to carefully examine the numerous proposals offered by conservatives to expand health care access without spending trillions of additional taxpayer dollars—money the federal government simply doesn't have.

The American Health Care Plan presented in this paper includes many free-market policy reforms that health care experts have been discussing for decades. The AHCP, or something like it, would provide all Americans with the money they need to purchase health insurance, and it would introduce numerous free-market forces into the U.S. health care system, which would improve overall quality, lower costs for everyone, and encourage health care savings.

Taxpayers already provide more than enough money to ensure all people have access to high-quality health care coverage. The reason so many Americans remain uninsured is because the current health care system suffers from countless flaws, miles of bureaucratic red tape, and a lack of health care innovation. By giving people direct control over their health care spending and shifting away from a model that encourages using health insurance for virtually all services, including primary care visits, America can fix its health care problems without increasing the size and scope of government.

About the Authors

Justin Haskins is a widely published writer and political commentator and the editorial director and research fellow at The Heartland Institute, a national free-market think tank. Haskins is also the editor-in-chief of *StoppingSocialism.com*, one of the world's largest and most influential publications devoted to challenging socialism.

Haskins writes a column for *FoxNews.com*, serves as a contributor to *The Hill* and *Townhall*, and has appeared on television and radio more than 200 times, on shows like *Tucker Carlson Tonight*, *Fox & Friends*, and the *Glenn Beck Radio Program*.

Haskins is the author of the Amazon best-selling book *Socialism Is Evil: The Moral Case Against Marx's Radical Dream* (2018), and he served as the first contributor to Glenn Beck's *Arguing with Socialists* (2020), a *New York Times* best-selling book.

Haskins has been published more than 800 times in major digital and print publications, including *The Wall Street Journal*, *New York Post*, *Forbes*, *Newsweek*, and *National Review*, among many others. His writing has also been featured or discussed by *The Rush Limbaugh Show*, *Glenn Beck Radio Program*, *The New York Times*, *Drudge Report*, The Heritage Foundation, the White House, and *Newsmax*, which named Haskins one of "Top 30 Republicans Under 30" in 2017. In 2016, Haskins was named to MediaDC's "30 Under 30" list of young and influential leaders on the right.

Haskins is author or co-author of two Heartland *Policy Briefs*, both of which received significant media attention: "Estimating the Income Tax Hikes Required to Pay for Bernie Sanders' Medicare-for-All Plan" (2019) and "Debunking the Scandinavian Socialism Myth: An Evaluation of Denmark, Norway, and Sweden" (2019).

Haskins graduated from the University of Richmond (Richmond, VA) in 2010. In 2011, Justin earned his M.A. in government with specializations in international relations and American government from Regent University (Virginia Beach, VA), and he earned a second M.A., this time in journalism, from Regent in 2015. Haskins was inducted into the Philadelphia Society in 2018.

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Karnick has written several hundred articles for publications, websites, and academic journals, such as *USA Today*, the *New York Post*, *The American Spectator*, *American Thinker*, *National Review*, *Breitbart*, *The Daily Caller*, *Books and Culture*, and many others, as well as for radio, television, and podcasts. He also served as editor of *The American Culture*, which provided news and analysis about cultural, social, and political trends.

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- **There are many more achievements than those listed here.** Please contact us (see below) for a complete list.

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