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# Power to the People: Repealing and Replacing Obamacare with Patient Power

by Peter Ferrara\*

Obamacare can be and must be repealed and replaced by free-market, patient-centered health care reforms that

- expand patient power,<sup>1</sup> giving individuals more control over health care decisions and more choice of providers and treatments,
- ensure health care for all, with no employer mandate and no individual mandate, and
- reduce taxes, federal spending, and regulation.

Unlike Obamacare, such reforms would slow and ultimately reverse the growth of health care costs through proven free-market incentives and competition. Also unlike Obamacare, such reforms would promote job creation, rising wages, economic growth, and general prosperity for working people across America.

Obamacare can be and must be repealed and replaced by free-market, patient-centered health care reforms.

Obamacare was sold to the political Left on the prospect of providing universal health coverage. But the Congressional Budget Office (CBO) projects Obamacare will leave 30 million Americans uninsured, even 10 years after its full implementation.<sup>2</sup> Millions of Americans lost

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\* Peter Ferrara is a senior fellow of The Heartland Institute. For a more complete bio, see page 14.

<sup>1</sup> John C. Goodman and Gerald L. Musgrave, *Patient Power: The Free-Enterprise Alternative to Clinton's Health Plan* (Washington, DC: Cato Institute, October 1992). See also John C. Goodman, *Priceless: Curing the Healthcare Crisis* (Oakland, CA: The Independent Institute, June 2012).

<sup>2</sup> Douglas Elmendorf, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010.

their insurance when the individual mandate went into effect, and many millions more likely will lose coverage upon implementation of the employer mandate, which the Obama administration delayed fearing negative political effects before the 2014 elections.

## Obamacare Will Raise Health Care Costs, Not Lower Them

President Barack Obama tried to sell the political Right on Obamacare with the claim it would reduce rapidly rising health care costs. But there was never any foundation for that rhetoric. Expanding third-party coverage of health care spending leaves both patients and doctors with no incentive to control costs, and that can mean only higher, not lower, costs. The legislation includes various bureaucratic, manipulative schemes touted as controlling costs, but even the CBO was not fooled by that. It concluded those bureaucratic measures have no hope of meaningfully reducing health care costs.<sup>3</sup>

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Obama repeatedly has tried to take credit for a national trend of slowing health care costs, shown in Figure 1. But that downward cost trend started in 2003, when Obama was a state senator in Illinois and Obamacare, which went into effect at the start of 2014, was just a gleam in his eye.

What happened in 2003? The Republican-majority Congress enacted, and President George W. Bush signed, a measure creating health savings accounts (HSAs). How HSAs created revolutionary market incentives to control health care costs is discussed further below.

The number of HSA accounts and the amount of money held in them have grown by double digits every year since 2003. In 2012, the number of HSA accounts grew by 22 percent, with total HSA assets growing by 27 percent to nearly \$15.5 billion. HSA assets were projected to grow another 22 percent in 2013, reaching nearly \$27 billion.<sup>4</sup>

More than 17 million Americans were estimated to be covered by HSAs at the start of 2014. Nearly 30 million are covered by consumer-directed health plans (CDHPs) of some sort, including HSAs and the health reimbursement accounts (HRAs) more commonly offered by large employers. More Americans today are covered by CDHPs than by patient-unfriendly health

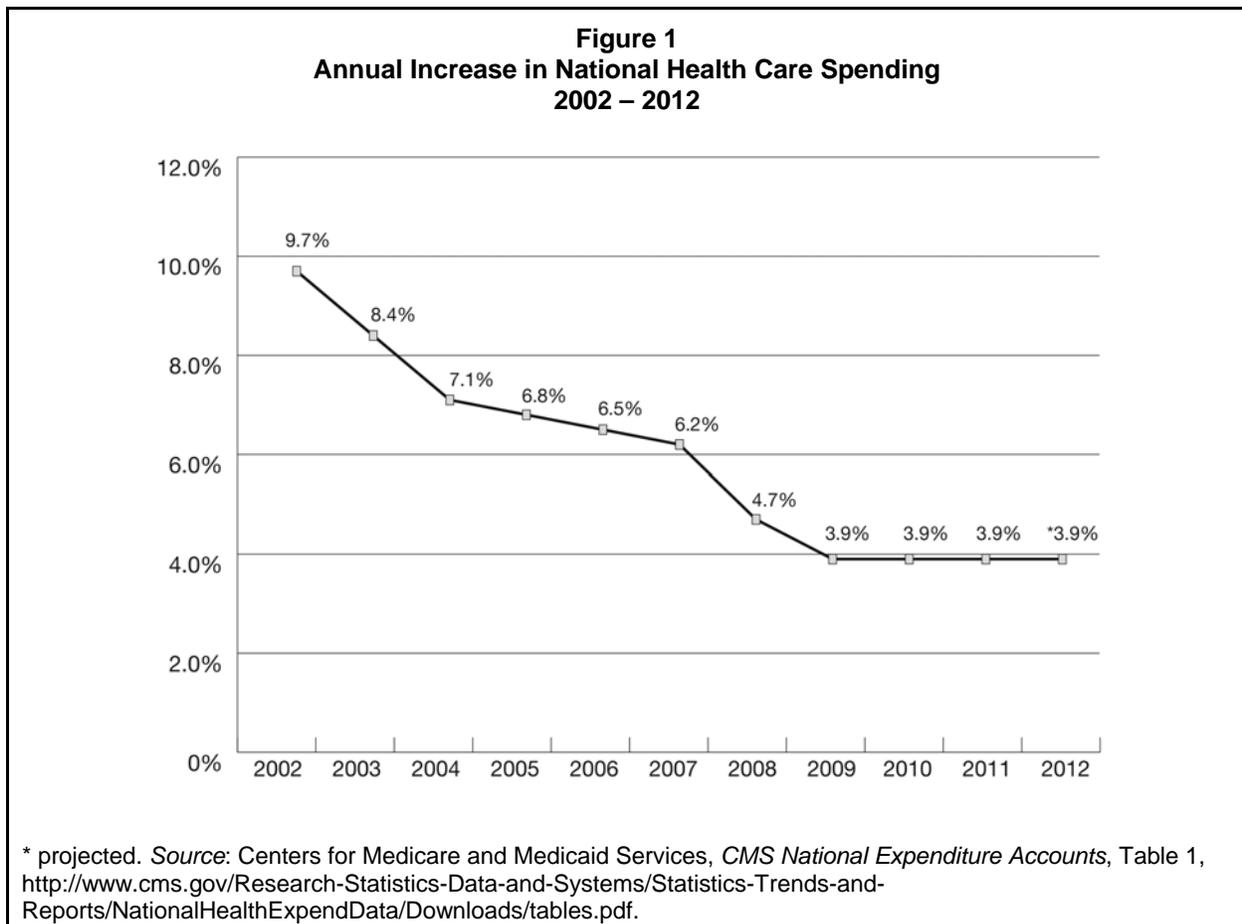
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<sup>3</sup> Letter from CBO Director John Elmendorf to the Honorable Senator Harry Reid, *Cost Estimate, H.R. 3950, Patient Protection and Affordable Care Act*, March 11, 2010; Congressional Budget Office, *The Long Term Budget Outlook*, July 2014; Office of the Actuary, Centers for Medicare and Medicaid Services, *National Health Expenditures, 2013 to 2023*, September 17, 2014.

<sup>4</sup> America's Health Insurance Plans (AHIP), "January 2014 Census Shows 17.4 Million Enrollees in Health Savings Account-Eligible High Deductible Plans (HSA/HDHPs)," May 2014; John C. Goodman and Peter Ferrara, "The Real Reason Health Spending Has Slowed," *NCPA Brief Analysis* No. 793, February 13, 2014; Peter Ferrara, "Obamacare Is the Problem, Health Savings Accounts Are the Solution," *NCPA Issue Brief* No. 124, July 2013.

maintenance organizations (HMOs).<sup>5</sup>

As Americans embraced CDHPs, national health care spending growth declined, slowing to 3.9 percent each year from 2009 to 2011, and 3.6 percent for 2012, almost two-thirds slower than a decade before. That is the slowest rate of increase since the 1960s, when the federal government's role in health care expanded dramatically.



Obamacare was passed in 2010, as the spending growth decline was underway. With one exception, Obamacare contributed to *increasing*, not declining, health care costs.

The one exception is \$716 billion in Medicare cuts called for by Obamacare. In a *Wall Street Journal* op-ed,<sup>6</sup> Obama spokesman Jason Furman emphasized the reduction in Medicare spending, saying it involves reducing “overpayments” to health care “providers” (doctors and hospitals). Medicare actuaries say the cuts ultimately will decrease payment rates to doctors and

<sup>5</sup> America's Health Insurance Plans, *ibid.*; John C. Goodman and Peter Ferrara, *ibid.*; Peter Ferrara, *ibid.*; Greg Scandlen, "Ten Ways Consumer Driven Health Care Is a Proven Success," *Policy Study* No. 125, The Heartland Institute, January 2010.

<sup>6</sup> Jason Furman, "Obamacare Is Slowing Health Inflation," *The Wall Street Journal*, January 6, 2014.

hospitals to one-third of what is paid by private insurance and only half of what is paid by Medicaid, through which the poor already cannot get timely and adequate health care because doctors and hospitals have no incentive to treat them. As the Medicare actuaries further explain, “The large reductions in Medicare payment rates to physicians would likely have serious implications for beneficiary access to care; utilization, intensity and quality of services; and other factors.”<sup>7</sup>

Medicare actuaries say the cuts ultimately will decrease payment rates to doctors and hospitals to one-third of what is paid by private insurance and only half of what is paid by Medicaid.

The Medicare actuaries further observe the Obamacare Medicare cuts would result in “negative total facility margins” for approximately 40 percent of the nation’s hospitals, skilled nursing facilities, and home health agencies by 2050. The actuaries explain, “In practice, providers could not sustain continuing negative margins [total

losses] and, absent legislative changes, would have to withdraw from providing services to Medicare beneficiaries.” Timothy Jost, a law professor at Washington and Lee University, writes in the *New England Journal of Medicine*, “If the gap between private and Medicare rates continues to grow, health care providers may well abandon Medicare.”<sup>8</sup>

Is this what Obama and the Democrats mean when they say Obamacare is reducing health care cost inflation? In 2012, the Obama campaign denied Obamacare included any such cuts to Medicare.<sup>9</sup>

The Medicare actuaries conclude these cuts will have such severely negative impacts on health care for seniors that Congress will be forced to reverse them, sharply increasing the federal budget deficit. They write, “It is reasonable to expect that Congress will legislatively override or otherwise modify the reductions in the future to ensure that Medicare beneficiaries continue to have access to health care services.”<sup>10</sup>

Except for these Medicare cuts, which do not involve any actual health care reform, Obamacare is likely to increase health care costs in the future. In their September 3, 2014 report on national

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<sup>7</sup> John D. Shatto and Kent Clemens, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Office of the Actuary, Centers for Medicare and Medicaid Services, August 5, 2010.

<sup>8</sup> Timothy Jost, "Subsidies and the Survival of the ACA - Divided Decisions on Premium Tax Credits," *New England Journal of Medicine*, July 30, 2014.

<sup>9</sup> "Wow!! Stephanie Cutter Slices Up Romney's White Board BS!!," Daily Kos, August 17, 2012; Stephanie Cutter, Deputy Campaign Manager, Obama for America, Medicare Whiteboard video, Obama Presidential Reelection Campaign, 2012.

<sup>10</sup> John D. Shatto and Kent Clemens, *Projected Medicare Expenditures under Illustrative Scenarios with Alternative Payment Updates to Medicare Providers*, Office of the Actuary, Centers for Medicare and Medicaid Services, May 18, 2012.

health care expenditures,<sup>11</sup> Department of Health and Human Services actuaries projected the rate of annual health care spending increases would grow from 3.6 percent in 2013 to 5.6 percent in 2014 (when Obamacare went into effect), and then continue at 6 percent a year on average through the rest of the decade. That means health care spending as a percent of GDP grew from 16.2 percent in 2007 to 17.2 percent in 2013 and is projected to reach 19.3 percent in 2023. As *The Wall Street Journal* noted in an unsigned editorial, “In other words, health care will soak up nearly one of every five U.S. dollars, instead of one in six.”<sup>12</sup>

The actuaries attributed the accelerating growth in health care spending at least in part to “spending growth associated with the coverage expansions in the Affordable Care Act (ACA) in 2014 and beyond,” such as the 23 percent expansion in Medicaid enrollment resulting from Obamacare. Notably, they attributed the pre-Obamacare slowdown in health care spending growth in part to “increases in cost-sharing for people with private health insurance” and “additional increases in cost-sharing requirements, including continuing increases in the adoption of high deductible plans,”<sup>13</sup> meaning CDHPs. They noted even rapid cost increases under Obamacare “would be dampened somewhat by ... the ongoing trend toward higher cost-sharing requirements for the privately insured.”<sup>14</sup>

## **Obamacare Will Reduce Jobs, Incomes, and Economic Growth**

One of the biggest drags on economic growth under President Barack Obama will be Obamacare. That drag will come primarily from the sweeping overregulation it involves.

The biggest culprit is likely to be the employer mandate, which requires all employers of 50 or more full-time employees to buy their employees health insurance with terms and benefits specified by the federal government. That is effectively a tax on employment, more than \$10,000 a year per employee with family coverage.

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Even for employers that already provide health insurance, the mandate is likely to represent a big tax increase, because the mandated health insurance will likely cost more than what the employer is already providing. As they are wont to do, politicians and bureaucrats responded to

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<sup>11</sup> Andrea M. Sisko, *et al.*, “National Health Expenditure Projections, 2013–2023: Faster Growth Expected with Expanded Coverage and Improving Economy,” *Health Affairs*, Vol. 33, No. 10 (2014), <http://content.healthaffairs.org/content/33/10/1841>.

<sup>12</sup> “The ObamaCare Escalator,” *The Wall Street Journal*, September 6–7, 2014, p. A14, <http://online.wsj.com/articles/the-obamacare-escalator-1409957215>.

<sup>13</sup> Andrea M. Sisko, *et al.*, *supra* note 10, p. 1.

<sup>14</sup> *Ibid.*

political pressure to include in the mandated health insurance generous benefits most people will think the employer is paying for. That will drive up the cost of the insurance.

Moreover, the mandated health insurance is subject to costly guaranteed issue and community rating requirements. Guaranteed issue requires insurers to sell health insurance to everyone who applies, regardless of how sick they are when they first apply. That is like requiring homeowners insurance companies to sell fire insurance to buyers who apply after their house has caught fire.

Community rating requires health insurers to sell health insurance to everyone at the same standard premium rates, without regard to how sick (and therefore costly) an applicant may be when he or she first applies. That is like requiring homeowners insurance companies to sell fire insurance to an applicant whose house has already caught fire for the same premium charged to those whose houses have not burned down.

Of course, if homeowners insurance companies were subjected to guaranteed issue and community rating requirements, the standard premiums would be very high. The same will be true for health insurance. There are better, less costly ways of ensuring health insurance is available to everyone, including those with costly preconditions.

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To avoid the costly tax on employment resulting from the employer mandate, millions of employees across the country have been reduced to a part-time work schedule of 29 hours a week or less, because the Obamacare definition of a full-time employee is 30 hours a week or more. That is driving down the net wages of middle-income and working-poor Americans, and increasing

economic inequality as a result. Small companies currently near the employer mandate's 50-employee threshold are reconsidering any plans they might have had to add employees.

Clearly, the employer mandate has been slowing economic growth, stunting the recovery, and extending the misery of the recession well beyond the record of previous recessions. Similarly, the individual mandate – which requires most Americans obtain health insurance by year-end 2014 or pay a tax penalty – is increasing the costs of health insurance in the individual market and having a similar negative impact on the economy.

The employer mandate and the individual mandate are effectively tax increases, which are a drag on economic growth. Obamacare is financed directly by another half-trillion dollars in tax increases, which are also anti-growth.

### **Three Reforms, Health Care for All ...**

Outlined below is a plan for repealing and replacing Obamacare with free-market, patient-centered health care reforms: patient power. Just three reforms will achieve health care for all –

and, as shown in the next section, lower health care costs as well.

**Universal Health Insurance Tax Credit.** The centerpiece of patient power is extending to everyone the tax preference enjoyed today only by those who receive employer-provided health insurance. This should take the form of a refundable, universal health insurance tax credit of roughly \$2,500 per person per year (\$8,000 for a family of four) for the purchase of private health insurance, as proposed by longtime patient power advocate John C. Goodman.<sup>15</sup> That \$2,500 would not be meant to pay for the entire cost of such insurance, only to help pay for it, just as the tax preference for employer-provided insurance does not pay the entire cost of such insurance.

The credit would provide an incentive to purchase health insurance. By *capping* the credit, the plan ensures there is no incentive to buy unnecessarily expensive health insurance, as would be true of an open-ended deduction for health insurance. Moreover, the capped credit would provide everyone with an equal tax benefit for purchasing health insurance, rather than the widely varying and arbitrary tax benefits under Obamacare.

The insurance purchased by an individual with the tax credit would belong to the individual, not to his or her employer, and so it would be fully portable, following the employee to any job he or she may choose. Employees would be free to use the tax credit to purchase a health insurance plan other than the one provided by their employers, including health savings accounts (HSAs).

The insurance purchased by an individual with the tax credit would belong to the individual, not to his or her employer, and so it would be fully portable, following the employee to any job he or she may choose.

Once a health insurance plan is purchased, renewability would be guaranteed as long as the premiums continued to be paid. No one's premium could be increased higher than the premium for others in the same initial risk class. Such guaranteed renewability is required by current law – indeed going back to the common law – because guaranteed renewability protecting against the costs of getting sick is what health insurance contracts promise. That requirement became federal law in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

A person who chooses not to purchase health insurance would not receive the credit. But there would be no affirmative penalty for failing to comply with any mandate, because there is no mandate of any sort in the patient power alternative to Obamacare. For every person in every household that files a tax return without claiming the credit, the \$2,500 would fund care for the poor and uninsured in the taxpayer's community – an automatic funding mechanism for a health care safety net.

No government mandate would require the credit be used to buy any particular insurance with any particular terms or benefits. Each individual, including employees who have employer-provided coverage but would prefer to choose insurance of their own, would be free to use the

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<sup>15</sup> John C. Goodman and Gerald L. Musgrave, *supra* note 1.

credit to buy the health insurance of his or her choice. That provides working people with an important check on the insurance the employer may choose for the company's employees, which may be designed more to suit the employer's interests rather than the employees'.

Employees would even be free to use the credit to buy into coverage through Medicaid. The credit amount is roughly equal to the CBO-estimated average cost of adding one person to Medicaid coverage. This feature would ensure coverage for anyone with a preexisting condition, because Medicaid is required to cover everyone regardless of preexisting conditions. Few people, of course, would choose Medicaid, for reasons discussed below. More likely, current Medicaid beneficiaries would use the credit to *leave* that program and purchase the private health insurance of their choice.

Some observers worry the universal health insurance tax credit would cause employers to drop their current coverage, a problem that currently afflicts Obamacare. But there's no reason for that to happen under patient power replacement. Employers who provide health insurance for their employees will continue to deduct that expense from their taxes as a cost of doing business, just as they do their employees' wages. For employees, there would be no net tax increase, as the tax credit would simply replace the current tax exclusion they receive for the value of employer-provided insurance.

**Block-Granting Medicaid to the States.** The second component of patient power reforms would be to transfer control over Medicaid to the states. Federal financing would be provided through fixed, finite, block grants to each state, as under the successful 1996 reforms of the Aid to Families with Dependent Children (AFDC) welfare program. Currently, federal financing for Medicaid is provided under a matching formula that pays more to each state the more it spends on Medicaid.

Under the patient power alternative – a fixed, finite, block grant – state officials know if they redesign their Medicaid program to cost more, their taxpayers will pay 100 percent of the difference. If their redesigned program costs less, 100 percent of the savings remains with the state. These are ideal incentives for each state to weigh the costs against the benefits for Medicaid spending.

Medicaid currently pays so little to doctors and hospitals that the poor often face grave difficulties in finding timely, essential health care.

Preferably, each state would use its power under the Medicaid block grants to provide assistance to the poor through health insurance vouchers the beneficiaries could use to supplement the universal health insurance tax credit to help them obtain the private health insurance of their choice. Each

state would determine how much assistance at what income levels would be necessary to ensure the state's poor could buy essential health insurance. Those levels would be very different for Louisiana and Mississippi than for California and New York, given their widely varying health care cost structures and income levels.

Such Medicaid reform would be enormously beneficial for the poor. Medicaid currently pays so little to doctors and hospitals that the poor often face grave difficulties in finding timely,

essential health care under the program. Scott Gottlieb of the New York University School of Medicine noted in a March 10, 2011 commentary, “In some states, they’ve cut reimbursements to providers so low that beneficiaries can’t find doctors willing to accept Medicaid.”<sup>16</sup>

Gottlieb added, “Dozens of recent medical studies show that Medicaid patients suffer for it. In some cases, they’d do just as well without health insurance.” Gottlieb reported a 2010 study of throat cancer “found that Medicaid patients and people lacking any health insurance were both 50 percent more likely to die when compared with privately insured patients.” A 2011 study of heart patients “found that people with Medicaid who underwent coronary angioplasty were 59 percent more likely to have ... strokes and heart attacks, compared with privately insured patients. Medicaid patients were also more than twice as likely to have a major, subsequent heart attack after angioplasty as were patients who didn’t have any health insurance at all.” A 2010 study of major surgical procedures, Gottlieb noted, “found that being on Medicaid was associated with the longest length of stay, the most total hospital costs, and the highest risk of death.”

If you’re a reader less moved by statistics than by true stories, consider the case of 12-year-old Deamonte Driver, from a poor Maryland family on Medicaid.<sup>17</sup> When Deamonte complained of a toothache, his mother tried to find a dentist who would take Medicaid. Only 900 of 5,500 dentists in Maryland do. By the time she found one and got the boy to the appointment, his tooth had abscessed, and the infection had spread to his brain. Now she needed to find a brain specialist who took Medicaid. Before she could locate one, the boy was rushed to Children’s Hospital for emergency surgery. He called his mother from his hospital room one night to say, “Make sure you pray before you go to sleep.” The next morning, he was dead.

The patient power reforms described here would represent an enormous benefit for the poor as compared to the current Medicaid program.

With private health insurance made affordable by the universal health insurance tax credit, supplemented for the poor with Medicaid health insurance vouchers, families like the Drivers would enjoy the same health care as their middle-income neighbors, because they would have the same health insurance as their middle-income neighbors. Competitive market pressures force those insurance companies to pay enough to doctors and hospitals to ensure those covered by the insurance can get timely, essential health care. The patient power reforms described here would represent an enormous benefit for the poor as compared to the current Medicaid program.

House Budget Committee Chairman Paul Ryan included Medicaid block grants in the GOP budget that has been adopted by the House. CBO has scored the block grant proposal as saving nearly \$1 trillion over the first 10 years alone.

**Risk Pools for the Uninsurable.** States would be free to use part of the Medicaid block grants to

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<sup>16</sup> Scott Gottlieb, "Medicaid Is Worse Than No Coverage at All," *The Wall Street Journal*, March 10, 2011.

<sup>17</sup> Mary Otto, "For Want of a Dentist," *The Washington Post*, February 28, 2007, <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html>.

set up risk pools to provide coverage to those uninsured who are too sick, and therefore costly, to obtain insurance in the market. Those insured by the pools would pay premiums based on their ability to pay, so the pools would serve a safety net function.

Risk pools are less expensive and less distorting than guaranteed issue and community rating regulations.

Thirty states had established such risk pools before Obamacare. They proved to be a low-cost means of providing for the treatment of preexisting conditions for those who were uninsured when they contracted a very costly illness, such as cancer or heart disease. Such

pools are low-cost because only relatively small numbers of people become truly uninsurable in the private market. Risk pools are less expensive and less distorting of the insurance market than guaranteed issue and community rating regulations, which raise health insurance costs sharply for everyone, creating more uninsured as a result.

**Health Care for All.** Unlike Obamacare, the three reforms outlined above – tax credits, Medicaid block grants, and risk pools – would ensure universal health care for all. Everyone would receive the universal health insurance tax credit, which they could use to help pay for the health insurance of their choice. Once insured, current law guarantees renewability of that coverage as long as they continue to pay the premiums, and those premiums could not be raised higher for someone who became ill than for others in the same initial risk class. The poor would get additional assistance through the Medicaid vouchers, empowering them to get essential health coverage. The uninsured who had become uninsurable could turn to the risk pool for their coverage or use their tax credit to buy into Medicaid.

### **... and Lower Health Care Costs, as Well**

The patient power reforms described above make health insurance coverage available to all ... and they reduce the growth in health care costs at the same time.

**Health Savings Accounts.** Health savings accounts (HSAs) would be included among the insurance options available to all through patient power reforms. They pair savings accounts for small or routine expenses with high-deductible health insurance for catastrophic or unexpected expenses.

The insurance component, with a deductible in the range of \$2,000 to \$6,000 a year, pays for health expenses over the deductible. Such high-deductible insurance costs substantially less than more traditional, first-dollar-coverage insurance. The premium savings would be deposited in the savings account and used to pay for health care expenses below the deductible. Any funds that remain in the savings account at year-end roll over to the next year, accumulating to pay for future health care expenses, or to spend on anything in retirement.

HSAs reduce the growth in health care costs by giving patients an incentive to become cost-conscious consumers of health care: The more careful they are with their spending, the more funds will accumulate in their savings accounts. HSAs also give doctors and hospitals incentives

to lower their prices in order to attract those newly cost-conscious consumers. The cost-cutting incentives flow all the way through to the developers of health care technology, who would have market incentives to develop technology that reduces health care costs in addition to improving health care quality and effectiveness.

After one healthy year, the typical consumer with an HSA will have more than enough in the savings account to pay for all expenses below the insurance component's deductible. Moreover, patients with HSAs enjoy complete control over how to spend their savings account funds. They don't need the approval of their insurance company to spend their funds on whatever health care they want.

After one healthy year, the typical consumer with an HSA will have more than enough in the savings account to pay for all expenses below the insurance component's deductible.

HSAs can be especially beneficial for vulnerable populations, particularly the sick and the poor. Because they have complete control over their savings account funds, the sick become empowered consumers in the medical marketplace. Because they can pay for care themselves out of their savings accounts, the poor have ready access to a wide range of providers, unlike under Medicaid today, and they can use the funds to pay for effective *preventive* care, a missing component of care for many of the poor.<sup>18</sup>

HSAs and the incentives they provide have proven very effective in controlling costs in the real world. A 2012 Rand Corporation study found persons covered by HSAs on average spend 21 percent less on health care in the first year after switching from more traditional coverage. Rand estimated national health care costs would fall by nearly \$60 billion if half of all employees were covered by HSAs.<sup>19</sup> The high-deductible insurance component of HSAs has experienced premium increases about half as high as conventional health care coverage, and in some cases those premiums have not increased at all.<sup>20</sup>

**Controlling Health Care Costs.** The market-based HSA incentives become more effective at controlling health care costs the more people are covered by HSAs. Through the patient power reforms, HSAs would become available to everyone in the health care marketplace. Medicaid beneficiaries would enjoy the freedom to choose HSAs for their Medicaid coverage. Employees would enjoy the freedom to choose HSAs through the universal insurance tax credit if their employer-provided coverage didn't include HSAs. Senior citizens on Medicare would enjoy the freedom to choose HSAs through Medicare Part C.

Choice, market incentives, and competition among insurers to attract consumers newly

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<sup>18</sup> Center for Poverty Research, University of California Davis, "How Is Poverty Related to Access to Care and Preventive Healthcare," <http://poverty.ucdavis.edu/faq/how-poverty-related-access-care-and-preventive-healthcare>.

<sup>19</sup> John C. Goodman and Peter Ferrara, *supra* note 4.

<sup>20</sup> *Ibid.*

empowered with the universal health care tax credit would further reduce health care costs. Allowing the sale of insurance across state lines and implementing medical malpractice reform would complete a highly effective reform package to control health care costs.

The patient power approach is the polar opposite of Obamacare, which largely works to *increase* health care costs through the distorted incentives and expense of extended, overregulated, third-party payment health insurance coverage.

## Restoring Economic Growth, Jobs, and Prosperity

Repealing Obamacare and replacing it with patient power would junk the federal overregulation of health care and insurance imposed by Obama's ill-conceived program. Gone would be the employer mandate and the individual mandate, two onerous taxes on employment. They would be replaced by freedom of choice and competition, whereby each consumer chooses the health insurance he or she wants in a competitive marketplace.

Patient power would mean the end of the Obama-era 29-hour work week. The Bureau of Labor Statistics (BLS) reports more than seven million Americans are currently stuck in *involuntary* part-time employment. "These individuals were working part-time because their hours had been cut back or because they were unable to find a full-time job," the BLS reports.<sup>21</sup> Repealing the employer mandate's effective tax on employment would increase employment and jobs. The return of the 40-hour work week would lead to the return of rising wages and incomes for middle-income and working people. That increased labor input to the economy, in turn, would increase economic growth and prosperity.

Lower health care costs brought about by the patient power reforms will effectively constitute a major tax cut for the economy, increasing economic growth and prosperity.

Patient power also would remove regulations imposing guaranteed issue and community rating, resulting in a sharp reduction in health insurance costs. Further reductions in health care costs would result from the broad availability of health savings accounts throughout the nation's health care marketplace. Competition and market

incentives created by the capped universal health insurance tax credit would further reduce costs, as would the liberation of national competition as insurance is allowed to be bought and sold across state borders. Medical malpractice reform would further reduce costs.

All told, the lower health care costs achieved by patient power reforms would effectively constitute a major tax cut for the economy, increasing economic growth and prosperity.

This reversal of the health care cost increases of Obamacare would reverse the drag on the economy created by that effective tax increase. The repeal of Obamacare also would reverse trillions of dollars in *direct* tax increases under the act. That would mean a 16 percent reduction

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<sup>21</sup> Bureau of Labor Statistics, Employment Situation Summary, September 5, 2014.

in the capital gains tax and the tax on corporate dividends, and nearly a 25 percent reduction in the Medicare payroll tax.

Reversing tax increases on capital gains and corporate dividends promotes capital investment, the economic foundation for increased jobs and higher wages. Other tax increases under Obamacare, such as the medical device tax and the tax on health insurance, directly raise the cost of health care and insurance. Repealing them would be another tax cut.

This all adds up to a tax cut of trillions of dollars for employees and health care consumers over the years. Repealing Obamacare also would reduce future government spending by trillions of dollars, further promoting economic growth by reducing the government's drain on the productive private economy.

## Conclusion

Repealing and replacing Obamacare with patient power would ensure health care for all, which Obamacare dismally fails to do. Patient power also would deliver on the promise of reducing health care costs; Obamacare does the opposite. Patient power would reverse the Obamacare drag on the economy, restoring economic growth, jobs, and prosperity.

Patient power would accomplish all of this while repealing the employer mandate, the individual mandate, and other costly regulations, replacing them with freedom of choice and control over health care, market incentives, and market competition. It would constitute a pro-growth tax cut of trillions of dollars over the years and reduce federal spending by trillions of dollars as well.

Patient power would constitute a pro-growth tax cut of trillions of dollars over the years and reduce federal spending by trillions of dollars.

Too many self-appointed wise men in Washington are saying we can no longer repeal Obamacare because doing so would cause millions of people to lose their Obamacare insurance and benefits. That fearmongering rings hollow in the light of this Heartland *Policy Brief* series outlining positive, populist, win-win entitlement reform that can fundamentally transform not only health care but also Social Security, Medicare, Medicaid, and welfare. The reforms outlined in this series can bring better benefits and higher incomes for senior citizens and the poor, and better health care for the sick. Through these reforms, average-income families would be able to retire as millionaires, and poverty could be effectively eliminated.

Obamacare is based on central planning, coercive mandates prescribing from the top down exactly what health insurance everyone must buy. Such central planning naturally involves banning many existing health insurance policies people previously had, liked, and were promised they could keep. The patient power replacement for Obamacare is based on unrestricted individual consumer choice in a competitive marketplace.

Voters will wildly and widely applaud replacing Obamacare with patient power.

## About the Author

Peter Ferrara is senior fellow for entitlement and budget policy at The Heartland Institute, a senior fellow at the National Center for Policy Analysis, senior policy advisor on entitlements and budget policy for the National Tax Limitation Foundation, and general counsel of the American Civil Rights Union.

He served in the White House Office of Policy Development under President Ronald Reagan and as associate deputy attorney general of the United States under President George H.W. Bush. He is a graduate of Harvard College and Harvard Law School. He is author of *The Obamacare Disaster* (Chicago, IL: The Heartland Institute, October 2010) and *President Obama's Tax Piracy* (Jackson, TN: Encounter Books, October 2010).

Ferrara's latest book is *America's Ticking Bankruptcy Bomb: How the Looming Debt Crisis Threatens the American Dream – and How We Can Turn the Tide Before It's Too Late* (New York, NY: Broadside Books, June 2011).

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