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Revitalizing Healthcare in America

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Section One: The Need to Repeal the Affordable Care Act

Ending a Nightmare for Millennials

The Patient Protection and Affordable Care Act (PPACA, or ACA) was signed into law by President Barack Obama on March 23rd, 2010, remaining one of the few pieces of major legislation passed without at least one vote from both major parties in US history, using the reconciliation process. The ACA, also known as Obamacare, has affected healthcare for all up to the age of 65. However, its effects on Millennials are especially pronounced, with increasingly unaffordable premiums, astronomically high deductible rates, and less choice among insurers and doctors.

Healthcare reform was necessary prior to the passage of the ACA; however, this law was a rare instance where Congress voted to regulate a private industry on how much they could charge, how much they could profit, and how much they needed to spend on their products and services. The implications are particularly chilling as a precedent is now set. If Congress is capable and permitted to legislate an industry that controls one-sixth of the US economy, what limitations will be placed on them in legislating other economic sectors? Millennials should be concerned about the effect a growing government will have on all areas of their lives. The government takeover of our medical system is a telling example of how a one-size-fits-all program fails to provide high-quality and affordable care.

Goals, Stats and Missed Opportunities

Obamacare's stated goals are to "increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government."[1] Unfortunately for Americans of all generations, these objectives have simply not been achieved. Several statistics demonstrate how the tremendous promises that the ACA made were consistently broken.

The Congressional Budget Office (CBO) projected in 2009 that premiums would decrease by up to 3 percent in 2016.[2] In reality, the average premium for benchmark Obamacare plans increased 37.1 percent since 2014.[3] Similarly, Employer-Sponsored Insurance (ESI) premiums have increased every year, rising by up to 20 percent for ESI family plans.[4] Thirdly, the promise that Obamacare would bend the cost curve has also been left unfulfilled: annual healthcare spending growth was 4 percent in the year before it was passed, a percentage that rose to 5.8 percent in 2015.[5]

When the law first went into effect, 4.7 million people had their healthcare plans cancelled, despite promises to the contrary.[6] The coming years, however, were supposed to make up for this loss. Indeed, the Congressional Budget Office predicted 21 million people would enroll by 2016.[7] The actual number of enrollees, however, was 10.4 million by June of 2016—meaning that fewer than half of the original expectations have been met.[8]

In his address to Congress in February of 2009, President Obama stated, "My guiding principle is, and always has been, that consumers do better when there is choice and competition. That's how the market works. Unfortunately, in 34 states, 75 percent of the insurance market is controlled by five or fewer companies."[9] And yet we have less choice now than when the ACA was passed. For example, 20 percent of people on the exchange have only one choice of insurer in 2017 and the average number of insurers per county in 2017 is three – down from five in 2016.[10] Moreover, 23 health insurance co-ops entered the insurance market with the start of the individual market. Eighteen of these 23 co-ops have failed as of December of 2016, a staggering 78 percent.[11]

Finally, the now-infamous promise that "if you like your doctor, you can keep your doctor" has long been broken. There is now a narrow set of provider networks that are used to control costs. For example, 41 percent of silver plans have physician networks that were "small" or "extra small" in 2015.[12]

Subsidies: Helpful to Millennials?

Many supporters of the ACA argue that although premiums are prohibitively expensive, most individuals on the exchange are not responsible for the full cost of insurance. Nearly nine out of ten individuals on the health exchanges are eligible for government subsidies.[13] Those subsidies are financed by taxpayers who must also pay for their own insurance coverage. Many Millennials will not qualify for subsidies and be faced with astronomical care costs. Individuals making over $47,520 a year do not qualify for subsidized coverage.[14] The average monthly premium for a 27-year-old purchasing an unsubsidized benchmark insurance plan on the individual market in 2017 is $302 a month.[15] Most Millennials will find spending $3,624 in premiums a year in addition to co-pays, deductibles, and other out of pocket expenses unaffordable.[16] Subsidies just mask the true cost of care and do nothing to address the real problem: high healthcare costs.

Obamacare's Mandates on Insurers and Individuals

Despite Obamacare's promise to lower the cost of insurance, its health insurance regulations substantially increased premiums, particularly for Millennials. The healthcare law requires insurers to charge their younger subscribers no less than three-times as much as they charge their oldest subscribers.[17] However, young adults in their twenties only spend a fifth on healthcare as adults in their fifties.[18]

In addition, every health plan must cover a range of expensive *Essential Health Benefits* that most young and healthy adults don't benefit from. These mandatory benefits include pregnancy and maternity care, mental and substance abuse services, pediatric benefits, and more.[19]

These regulations make health insurance unaffordable for Millennials who shop on the individual market. A study by the Manhattan Institute found insurance premiums significantly increased in the first year that Obamacare's insurance regulations went into effect. On average, premiums for young men increased 97 to 99 percent in 2014. Premiums for young women also increased 55 to 62

percent.[20]

In an attempt to coerce young and healthy Millennials to buy Obamacare's unaffordable insurance, the law imposes a hefty tax penalty, called the Individual Mandate, on anyone that doesn't buy insurance. Starting in 2014, individuals had to pay the federal government $95 or 1 percent of their income; whichever is higher. But in 2016, uninsured individuals must pay $695 or 2.5 percent of their income for foregoing coverage.[21]

Obamacare also levees a steep tax on businesses with 50 or more employees that don't offer coverage to full-time employees (FTEs) working 30 hours or more. Under the employer mandate, businesses that don't provide health insurance as required are taxed $2,000 for every full-time worker they employ.[22]

However, neither of these penalties expanded healthcare coverage. In the fall of 2016, an estimated 27 million individuals still lacked insurance. A survey by the Kaiser Family Foundation found that the number one reason why individuals remain uninsured is because health insurance is too expensive.[23]

Indeed, a 2016 study by the Centers for Disease Control (CDC) shows that adults between the ages of 25 and 34 are among the highest rate of uninsured in the U.S.[24]

Most Millennials realize it makes more financial sense to pay the individual mandate rather than pay for insurance under Obamacare. The average Obamacare plan in 2017 costs $3,624 in annual premiums; roughly 520 percent more expensive than the tax penalty.[25] A report by the American Action Forum finds that 62 percent of Millennials in 2016 found it "financially advantageous to forego health coverage, and instead pay the mandate penalty and cover their own healthcare costs."[26]

Young people are also suffering from the unintended consequences of Obamacare's employer mandate. In order to avoid the mandate's penalties or the high costs of providing employer coverage, many small businesses decided to curtail new hiring and shift full time employees into part time work. Another study by the American Action Forum estimates that the employer mandate and other Obamacare regulations reduced employment among small businesses by 350,000.[27]

Section Two: Replacing the Affordable Care Act

Our Recommendations for Effective Reform

While there have been many accusations that the Republicans have no real replacement plan for the ACA, a number of replacement plans have been introduced repeatedly since the Affordable Care Act was passed on a party line vote in 2010. Numerous senators, congressmen, think tanks, and congressional committees have all put forth ideas for healthcare reform. The goals of all of these reforms are to reduce over burdensome regulations, even the playing field for all consumers, and promote more patient centered care.

The plans that received the most attention included the House GOP "Better Way Plan," Tom Price's Empowering Patients First Act and Senator Rand Paul's Obamacare Replacement Act.[28][29] The recently-released American Health Care Act encompasses previous proposals into a comprehensive bill that aims to improve care quality, increase consumer choice and lower costs. Some of the proposed ideas, such as high risk pools and permitting the sale of insurance across state

lines, are new concepts, while other provisions are modifications of current law.

When given the opportunity, no one is a better steward of a patient's healthcare than patients themselves. Today, individual stewardship is being strangled by burdensome regulation and excessive cost. The nation's healthcare system must be revitalized.

Key Principles for Reform

Millennials deserve a healthcare system that offers a diverse array of affordable options to fit their unique medical needs. Many young people are healthy and simply need an inexpensive insurance plan to cover catastrophic healthcare events. Others have greater healthcare needs that require more comprehensive benefits.

Unfortunately, government policies have imposed a one-size-fits model that doesn't work for everyone. As discussed above, the Affordable Care Act has increased premiums, reduced the quality of healthcare coverage, and diminished consumer choices. Patients in many parts of the country shopping in the individual market now have only one insurer to choose from. These factors have proven to be a dramatic disincentive for Millennials who might otherwise purchase a health insurance plan.

"As the rates rise, the healthier people pull out because the out-of-pocket costs aren't worth it," Aetna CEO Mark Bertolini said in October of 2016. "Young people can do the math. Gas for the car, beer on Fridays and Saturdays, health insurance."[30]

Any repeal of Obamacare must be replaced with an expansive array of market-based initiatives specifically tailored to remedy the genuine flaws within the system. In particular, any replacement effort must boost competition, both across state lines and for individuals in the private market; expand and retool health savings accounts as a method of increasing access to affordable care; deregulate the market in targeted ways; and address several other key concerns. In so doing, the cost of healthcare will decrease, quality will remain consistent or rise, deficits will be reduced, and access to care will be increased.

In this section, we will focus on some of the key elements that are essential to any comprehensive, patient-centered, and consumer-driven reform package. The below **Healthcare Revitalization Recommendations** will explore how to tackle these barriers to affordable, consumer-driven healthcare.

Health Savings Accounts

Health Savings Accounts are individual savings accounts used to pay for medical expenses. HSAs help with healthcare affordability, because contributions to these accounts are excluded from an individual's taxable income. Money from these accounts can be spent on routine medical expenses not covered by insurance. Individuals and an employer (or other third party payer) can contribute to these accounts. Currently, individual can't save more than $3,400 in HSAs and families can't save more than $6,750.[31] Individuals are also prohibited from using HSA funds on over-the-counter medication or premiums. They're also mandated to buy high-deductible health insurance, which limits their appeal to individuals with expensive healthcare needs.

HSAs are a mechanism to promote consumer-driven healthcare; they encourage patients to make informed choices based on quality and price. These accounts are owned by the individual and are

portable despite employment or insurance sponsor and grow tax free and roll over year to year. HSAs also help to decrease total healthcare spending. A study conducted prior to ACA implementation found that families who switched from traditional to consumer-directed health plans spent 21 percent less on healthcare the first year in a new plan.[32]

The study also forecast that the United States as a whole would spend $57 billion less on healthcare if 50 percent of the population shifted to HSA-linked plans. If 75 percent of the country shifts into HSAs, the projected savings increase to $85 billion. President Trump has expressed support for HSAs and they are included in all replacement proposals. These accounts discourage the over use of healthcare and put downward pressure on prices, because consumers shop around for the best prices on medication, medical equipment, and care.

There is wide agreement among many lawmakers that expanding the use of Health Saving Accounts is essential to health reform. The House GOP plan would expand eligible individuals and increase the maximum annual tax free contribution. Tom Price's legislation takes the provision one step further by providing a onetime refundable $1,000 tax credit in addition to the steps listed above.

The centerpiece of Senator Paul's plan is the use of HSAs. His plan would eliminate the requirement to be enrolled into a high deductible health plan to make tax free contributions to a HSA. Individuals enrolled in any type of coverage could make contributions to an account and the annual limit on tax deductible contributions would be eliminated. HSA contributions of up to $5,000 for individuals and $1,000 for a joint tax return would be eligible for a tax credit. The definition of qualified medical expenses is also widely expanded.

The AHCA greatly expands HSA use; it almost doubles contribution limits. It allows for individual contributions of $6,750 and family contributions of $13,100. It also allows for spousal catch up contributions over the age of 50 and expands the definition of a qualified medical expense.

High-Risk Pools

The ACA dealt with expensive consumers by putting everyone into the same risk pool, causing the young and healthy to subsidize the cost of care for sick individuals through higher premiums. The current ACA system is unsustainable, when premiums continue to rise, young healthy customers leave the market and the adverse selection causes a death spiral. The attempt to counter act this through the individual mandate, forcing everyone to purchase insurance, remains unpopular and conservatives believe that this is an improper use of government force. Reform legislation will instead include an alternative way to deal with the most expensive and unhealthy consumers.

Expensive consumers can be separated out from the traditional healthcare marketplace and insured through high-risk pools. High-risk pools provide health insurance to individuals whose healthcare costs are higher than premiums charged. These pools provide a way to insure individuals who have medical claims so high that it is impossible to provide affordable insurance under the current regulations and insurance system. One percent of insured individuals account for a nearly a quarter of total healthcare costs.[33] By separating these high-risk individuals, the premium costs are dramatically lowered for everyone else. The high-risk pools would be subsidized with a combination of taxpayer funded state and federal level grants to ensure affordability for enrollees. Prior to the ACA, 35 states had operating high risk pools, so many state insurance commissioners would be familiar with the implementation.[34]

Providing care to especially sick individuals will never be cheap and the pools will need to be heavily subsidized. The House GOP plan calls for a federal funding grant of $25 billion and Price's plan calls for $1 billion of funding per year for three years. High-risk pools ensure that care is available to those who need it most while allowing the market to work well for all consumers. High-risk pools combined with continuous coverage protections would provide insurance for all who want it, regardless of health status.

The ACHA replacement plan establishes a State Stability Fund. States could use these to lower patient costs and stabilize markets. This is the mechanism in which, states could choose to establish high-risk pools. The fund allows states to tailor insurance coverage the best way for their individual populations.

Continuous Coverage Protections

The Affordable Care Act currently requires insurers to accept patients regardless of their health status. But it also incentivizes people to wait until they get sick before they purchase coverage. The ACA's individual mandate is unpopular and not as effective as originally anticipated. Many young individuals chose to pay the penalty rather than purchase expensive insurance. IRS records show that in 2015, 6.5 million people paid the penalty and an additional 12.7 million people claimed an exemption from the mandate.[35]

Continuous coverage provisions will be a more effective mechanism to insure young and healthy individuals. Continuous coverage incentivizes young and healthy people to enroll into insurance, because if an individual buys insurance and stays continuously covered they cannot be medically underwritten, regardless of medical conditions they develop in the future. By purchasing insurance while healthy, individuals secure an affordable rate and bring much needed balance to the health insurance risk pool. This also provides a mechanism for protecting those with pre-existing conditions and provides guaranteed coverage despite future health status. Continuous coverage requirements also incentivize insurers to invest in wellness and preventive care services to promote health and keep consumer costs down as enrollees age.

The specifics on open enrollment and continuous coverage requirements vary by plan. The House GOP plan calls for a one-time open enrollment period that would allow customers to sign up and be protected from medical underwriting as long as coverage is maintained. Sec. Price's plan places more limitations on coverage protections. The plan allows for insurers to rate consumers based on a variety of factors including age, gender, and occupation, but for individuals with continuous coverage for the prior 18 months, rating based on health status would be prohibited.

For those continuously insured for the previous 18 months, pre-existing condition exclusion periods would also be prohibited. Insurers would be required to offer a 30-day open enrollment period every two years for all individuals and also offer 60-day special enrollment periods for individuals with qualifying events. Individuals with less than 18 months of continuous prior coverage, could be charged more for coverage or must wait to sign up for insurance. Senator Paul's plan repeals the requirement of guaranteed issue of insurance and would instead restore the pre-ACA requirements under HIPAA legislation.

The ACHA's continuous coverage provision and calls for a 12-month lookback period in which individuals who had a lapse in coverage for longer than 63 days would be charged a flat 30 percent surcharge in addition to the premium rate. This surcharge would be discontinued after 12 months.

Age Bands

The ACA only allows insurance companies to charge a 3:1 difference in premiums for the oldest and youngest customers. Pre-ACA the average age rating was 5:1. A 5:1 age band is more in line with actual health costs. The average 64-year-old costs 4.8 times more than a 26-year-old to insure.[36] The 3:1 age band is one of the primary reasons premiums have dramatically increased in the individual market since the implementation of the ACA. Young and healthy individuals are forced to overly subsidize their older and sicker counterparts. The inflated premiums serve as a disincentive for young and healthy individuals to buy insurance leaving an unbalanced risk pool. Premium prices should be aligned with healthcare costs, not arbitrarily mandated by the government.

The House GOP plan allows for rate variation of up to 5:1 based on age. It also gives states flexibility to adopt age bands they believe best fit the state population. Sec. Price and Senator Paul's plans repeal the ACA standard of 3:1 age rating, but do not offer a specific replacement proposal. The rating would likely fall to state insurance regulators to implement. The ACHA reverts to the 5:1 ratio, but gives states the flexibility to set their own ratio.

Association Health Plans

Leaders in Congress can further expand affordable health coverage by allowing small businesses to band their employees into Association Health Plans and use the bargaining power of their employees to offer less expensive health coverage. AHPs could also be formed between civic entities like churches, charities, alumni associations, and trade organizations to negotiate lower prices from healthcare providers on behalf of members.

State and federal regulations currently impose a number of restrictions on small employers and associations who wish to pool members into AHPs. Under the Employee Retirement Income Security Act (ERISA), association plans can only determine their benefits package if they are all part of a single employer.[37] If members of a risk pool do not work for a single employer, they must comply with costly state mandated health benefits regardless of whether members desire these benefits.

Congress can remove these barriers to AHPs by amending ERISA to allow any due-collecting entity to determine their benefits package independent of state regulations. This will free organizations to pool their members, expand their bargaining power, and reduce premiums. The Congressional Budget Office estimates that AHP's will decrease the cost of insurance in the small-group market by 25 percent and expand health coverage to up to 5.7 million individuals.[38]

Most Republican healthcare plans would make it easier for individuals and organizations to establish AHPs. Paul Ryan's Better Way plan, Tom Price's Empowering Patients First Act, and Rand Paul's Obamacare Replacement Act would encourage the formation of AHPs.[39] The AHCA, however, doesn't include this reform.

Employer-Sponsored Insurance Incentives

One of the greatest drivers of out-of-control healthcare spending is the federal tax exclusion for employer-sponsored health insurance. Since World War II, the federal government has exempted employer-provided health insurance from personal income and payroll taxes. This exemption incentivizes companies to offer extremely generous health insurance benefits that divorce employees

from the cost of their healthcare.

The estimated 177 million Americans that rely on employer-sponsored insurance pay only a small-share of their premiums and their employer pays the rest. On average, employers pay 70 percent of the cost of annual premiums for family insurance and 82 percent of the cost of premiums for individual plans.[40] Since workers pay such a small share of their premiums, they have an enormous incentive to pick plans with less deductibles, copayments, and other out-of-pocket expenses.

These types of insurance plans incentivize subscribers to over-use healthcare services that provide little value. According to the Institutes of Medicine, roughly 30 percent of all healthcare spending is wasted on overtreatment, administrative complexities, and pricing failures that permeate America's employer-sponsored healthcare system.[41]

The Obama Administration attempted to address the rising cost of employer-sponsored coverage by imposing a "Cadillac Tax" on expensive health insurance benefits through the ACA. Under current law, starting in 2020, the federal government will levy a 40-cent excise tax on individual employer plans that cost more than $10,400 and family employer plans that cost more than $27,500.[42] For instance, an individual plan that costs $16,200 will be taxed $6,480.

This is the wrong approach. For starters, the Cadillac Tax discourages workers from using health savings accounts which serve as an effective tool for controlling healthcare costs. The federal government counts employee contributions to Health Savings Accounts to the value of health plans. In addition, many employers may decide to curtail hiring or limit pay raises rather than reduce their health plan costs. Cities and state governments will likely raise fees and taxes to pay the Cadillac Tax.

Capping the Employer-Exclusion

Policymakers can reform the employer exclusion by capping the deduction. Employers would still have an incentive to offer health insurance as an employee benefit, but they'll also have an incentive to make their health benefits more cost-effective than today's employer-provided health plans.

The Urban Institute recently examined the impact of capping employer-exclusion at the 75th percentile of employers and applying payroll and income taxes to high cost "Cadillac" plans in the 25th percentile.[43] The study found that limiting the exclusion would preserve 93 percent of the tax benefits that employees currently enjoy. It would also generate $240 billion in additional tax revenue over the next ten years. Capping the exclusion is standard in most Republican health legislation. Policymakers would use this new tax revenue to subsidize coverage to low-income individuals who are currently uninsured. The bill should be amended to include such a cap. If not, at the very least, there will be an opportunity to cap the exclusion in future legislation—an opportunity which most certainly should be taken.

Several prominent Republican healthcare plans call for capping the tax exclusion for employer-sponsored coverage. The Secretary of Health and Human Services, Tom Price, proposed limiting the exclusion for employer plans that costs more than $8,000 for individuals and $20,000 for families. Speaker of the House, Paul Ryan, also included a cap on high cost health plans as part of his Better Way healthcare reform plan. The AHCA was initially going to limit the exclusion for employer-sponsored insurance for 10 percent of the most expensive health plans.[44] However, the final publicly available draft of the bill doesn't make any changes whatsoever to the tax exclusion.

Reforming Federal Support for Health Insurance

While capping the exclusion would undoubtedly lower the cost and improve the quality of American healthcare, Congress and the Trump Administration should ideally phase-out the employer exclusion entirely in favor of a personal tax credit. A personal credit will end the federal government's open-ended subsidy for employer plans and provide households a lump sum credit to purchase their health insurance directly.

Experts recognize these changes would expand access to healthcare services. Redirecting federal tax subsidies toward individual health coverage will spur patients to seek lower-cost healthcare providers and services in two ways. First, many workers will decide to leave their employer-sponsored plans and purchase insurance on the individual market that have higher coinsurance rates and other out-of-pocket costs that incentivize cost-conscious healthcare shopping. Second, companies will likely increase out-of-pocket costs in their employer plans as the federal government phases-out the employer tax exclusion. Research from the Journal of Public Economics and the American Economic Review estimate that eliminating the employer exclusion would lead to a 41 to 65 percent increase in coinsurance rates.[45]

Studies also show that greater cost-sharing helps individuals more effectively control healthcare spending. The Rand Corporation's ground-breaking Health Insurance Experiment found that individuals with higher out-of-pocket costs spend 20 to 30 percent less on healthcare services than those without any exposure to their healthcare expenses.[46]

Refundable Tax Credits Versus Standard Deductions

A crucial question is what kind of tax credit should replace the employer exclusion. A number of Republican healthcare plans propose offering standard deductions to purchase healthcare and health coverage. The Republican Study Committee recently released the American Healthcare Reform Act which offers a standard deduction of up to $7,600 to purchase health coverage.[47] Rand Paul's Obamacare Replacement Act offers a standard deduction of up to $5,000 in the form of an HSA contribution.

However, standard deductions won't help the majority of the uninsured population access health insurance. The US Census Bureau's Current Population Survey reveals large shares of the uninsured population earn too little to receive a large enough deduction to pay for health insurance. In 2015, 27 percent of the uninsured made between $11,700 and $23,283. And 26 percent made less than $11,700.[48] If an individual makes $23,283 every year, they would only receive a tax deduction of $1,530, while those that make just $11,700 would only receive $540 from a standard deduction.

Standard tax deductions would be particularly ineffective for older low-income people that wrestle with high healthcare costs. The average adult between the ages of 25 and 44 spends $4,450 on healthcare expenses. And adults aged 45 to 64 spend $9,513 per year on healthcare.[49]

Given that older individuals tend to have higher healthcare expenses; Congress should offer refundable tax credits to low-income households that increase with age. Individuals that are poorer and older would receive greater support while younger and higher income people would receive less.

Sec. Tom Price supports offering age-based refundable tax credits as part of his Empowering Patients First Act. His plan would offer $1,200 for young adults aged 18 to 35, $2,100 for those

between 36 and 50, and $3,000 for those between 50 and 64. Speaker Paul Ryan similarly called for a universal, age-based refundable credit under his Better Way plan.

The AHCA, provides refundable tax credits that are both age-based and means-tested for high income individuals. The bill offers a $2,000 credit for individuals under 30, $2,500 for individuals between 30 and 40, $3,000 for individuals between 40 and 50, $3,500 for individuals between 50 and 60, and $4,000 for those 60 and above.

Everyone who earns less than $75,000 will be able to access the full value of these tax credits. If an individual makes between $75,000 and $115,000, they will receive smaller tax credits. And those that make more than $115,00 won't receive any tax financial support.

Pairing Refundable Tax Credits with Health Savings Accounts
The Millennial Policy Center offers an innovative approach to distributing refundable tax credits. Policymakers can efficiently distribute these refundable credits through Health Savings Accounts. The credit *would not count* against the contribution limits, which would also be boosted to $9,750 for individuals and $20,100 for families. This would then help to provide lower-income and middle-class families with the funds they need to have savings available for out-of-pocket expenses when needed.

Because it would be injected into a Health Savings Account, the "HSA Refundable Tax Credit" would immediately be usable for *any* qualified HSA expense—including the purchase of a health insurance plan of the consumer's choice. In the alternative, if a tax credit recipient does not wish to purchase an insurance plan using HSA dollars, he or she may still receive the credit into his or her account and apply those funds toward other qualified medical expenditures, such as medications and doctor visits. It is entirely the consumer's choice.

Creating a market for healthcare centered more on the individual consumer would help to lower healthcare costs and maintain high quality by putting consumers in charge of their own healthcare spending. This would be done rather than permitting middlemen, such a large health insurance company or HMO, to make the decisions on care and cost.

One group that would particularly benefit from such a plan are the so-called "Young Invincibles," or those Millennials who are single, childless, and have few healthcare expenses. These young adults may not need or want a comprehensive or even a catastrophic insurance plan and would instead prefer to use their tax credits to build up a healthcare "nest egg" of sorts for when they need it, when an emergency hits, or when they start a family and want to purchase a comprehensive plan. These funds would accrue tax-free for the consumer's benefit.

An HSA coupled with an HSA Refundable Tax Credit could also be used as an alternative for the current Medicaid system. The government could provide support by using current funds to set up Health Savings Accounts for some families on the government system. This would still provide a safety net but also allow for individuals to easily leave the program as they make more money. The credits could be used to buy an insurance plan of their choice. This would address the "Medicaid cliff" that traps people and leaves many dependent on the government, because the gap between affordable insurance and Medicaid coverage is too large. A graduated tax credit based on income allows people to slowly transition off government support without losing benefits. This approach injects much-needed, consumer-based competition into the marketplace and allows people to be self-sufficient while still getting needed medical care.

Interstate Sale of Health Insurance

Federal tax policy isn't the only barrier to a flexible and dynamic individual health insurance market. State regulations also impede insurance carriers from tailoring health insurance products to individual needs of consumers.

The most egregious examples are state-mandated health insurance benefits that most individuals will never need nor desire. Such mandates include drug abuse treatment (34 states), alcohol abuse treatment (45 states), acupuncture (11 states), chiropractic care (44 states), hair pieces (10 states), naturopathy (4 states), and others.

States also mandate insurers cover worthwhile routine services that patients should pay for out-of-pocket. These services include treatments for ovarian cancer (3 states), prostate cancer (33 states), cervical cancer (29 states), mammograms (50 states), newborn hearing (17 states), and others.[50]

A study from the Council for Affordable Health Insurance found states impose 2,000 benefit mandates on insurance plans and increase the cost of insurance by 50 percent in some states.[51] For example, a non-smoking thirty-year old male could pay as little as $702 in annual premiums in Idaho, a state with only 13 benefit mandates in 2013. But that same young male would have to pay $2,232 in Rhode Island, a state with 47 requirements.[52]

While some of these provide important medical benefits to some people, young and healthy adults might prefer less comprehensive plans that cost less.

By ending state restrictions on out-of-state insurers, policymakers can free individuals and employers to choose from a greater array of health insurance options from around the country. Young adults could purchase low-cost, catastrophic coverage from lightly regulated states like Idaho and Alabama. At the same time, older and sicker adults would be free to purchase plans from heavily-regulated states like New York and California.

The Center for Health and the Economy estimates that creating a national market for health insurance will reduce health insurance premiums across-the-board. By 2026, the cost of health insurance would fall between 24 and 32 percent for individuals plans and between 24 and 37 percent for family plans.[53]

Allowing the interstate sale of health insurance will also offer more coverage choices for people currently enrolled in employer-sponsored coverage. In 2005, the CBO noted that at least one million will drop their employer-coverage in favor of cheaper out-of-state individual insurance under a national health insurance market.[54]

Sec. Price's Empowering Patients First Act, Paul Ryan's Better Way plan, and Rand Paul's Obamacare Replace Act would free consumers to shop for health insurance across state lines. However, the AHCA doesn't address state barriers to the interstate sale of insurance.

Other Considerations

Replacement legislation will also likely keep provisions that are popular under current law. This is a good tactical maneuver in winning over democrats to sign a bill and will also allay some of the concerns voiced by repeal opponents. Covering dependents until the age of 26 is a popular aspect of

the ACA will remain standard practice. Allowing young adults who are in the process of joining the workforce to maintain health insurance as a dependent decreases the uninsured rate and may increase the likelihood of those individuals purchasing insurance in the future.

A ban on pre-existing conditions exclusions will also be maintained. President Trump has also expressed support of this proposal. This should help to alleviate the fears of those who believe the end of the ACA means an inability to buy insurance for unhealthy individuals. Insurers would continue to be prohibited from denying coverage and would also prevent insurance companies from medically underwriting customers. This will most likely be paired with a provision prohibiting insurers from instituting caps on how much they will pay in health expenses on a yearly basis or throughout a lifetime. The ban will most likely apply to both monetary limits as well as health benefits offered.

Section Three: Let's Revitalize Healthcare in America

Concluding Thoughts

It is essential that any substantial healthcare reform measures repeal the Affordable Care Act and tackle the barriers to affordable, consumer-driven healthcare that remain. By unleashing individual choice, opportunity, and market incentives, a truly vibrant health insurance market will start to replace a stagnant system utterly lacking in innovation and bound up in red tape. Meaningful access to quality care, as well as real choice and competition, will trump top-down controls that stifle innovation, increase costs, and limit market options.

When it comes to just about every facet of our daily lives, the Millennial Generation thrives on seemingly-unlimited choices and opportunities for customization. Why should we be so limited in our mindset as to deny the same level of choice and customization when it comes to treating and caring for our own bodies? We argue it shouldn't be that way.

It's time to revitalize healthcare in America.

Endnotes

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