SYSTEMIC WELFARE REFORM IN GEORGIA

Part 3: How the New System Will Work

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About Georgia Center for Opportunity

Georgia Center for Opportunity (GCO) is independent, non- partisan, and solutions-focused. Our team is dedicated to creating opportunities for a quality education, fulfilling work, and a healthy family life for all Georgians. To achieve our mission, we research ways to help remove barriers to opportunity in each of these pathways, promote our solutions to policymakers and the public, and help effective and innovative social enterprises deliver results in their communities. Our ultimate goal is to see every Georgian who is willing to seize the opportunities presented to them living a life that can be characterized as truly flourishing.

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Acronyms

ABAWD: Able-Bodied Adults Without Dependents, as pursuant to SNAP policies

ABD: Aged, Blind and Disabled

ACA: Patient Protection and Affordable Care Act of 2009, also known as ObamaCare.

ACF: Administration for Children and Families, HHS

ACS: American Community Survey of the U.S. Census Bureau

ACTC: Additional Child Tax Credit

AFDC: Aid to Families with Dependent Children program, the predecessor to TANF

APTC: Advance Premium Tax Credits pursuant to purchased HIX policies per the ACA

ARM: AFDC-Related Medicaid, where AFCD is Aid to Families with Dependent Children, the predecessor program to TANF.

CAPS: Child Care and Parent Services

CCDBG: Child Care and Development Block Grant

CCDF: Child Care and Development Fund

CCR&R: Child Care Resource and Referral System

CFR of C.F.R.: Code of Federal Regulations

CHIP: Children's Health Insurance Program

CMO: Care Management Organization

CMS: Center for Medicare and Medicaid Services, HHS

COMPASS: Common Point of Access to Social Services

COSTAR: County Statistical Reporting System of DFCS

DCA: Georgia Department of Community Affairs

DCH: Georgia Department of Community Health

DECAL: Georgia Department of Early Care and Learning

DFCS: Division of Family and Children Services, DHS

DHS: Georgia Department of Human Services

DOE: Georgia Department of Education

DPH: Georgia Department of Public Health

EBT: Electronic Benefits Transfer

EITC: Earned Income Tax Credit

FFY: Federal Fiscal Year

FMAP: Federal Medical Assistance Percentage (matching funds for Medicaid and SCHIP)

FNS: Food and Nutrition Service, U.S. Department of Agriculture

FPL: Federal Poverty Level

GAO: U.S. Government Accountability Office

Ga. R & R: Rules and Regulations of the State of Georgia

GCAA: Georgia Community Action Association

GCO: Georgia Center for Opportunity

HCV: Section 8 Housing Choice Vouchers

HHS: U.S. Department of Health and Human Services

HIX: Health Insurance Exchange pursuant to the Affordable Care Act

HUD: United States Department of Housing and Urban Development

IFIP: Individual financial independency plan; a plan drawn up by the coordinating agency that establishes goals to move from dependency on means-tested welfare programs to financial independence.

IRS: Internal Revenue Service

IT: Information Technology

LIHEAP: Low Income Home Energy Assistance Program

LIM: Low-Income Medicaid

LII: Legal Information Institute of the Cornell University Law School

MTW: Moving-to-Work (special designation of public housing authorities by HUD)

MFP: Money Follows the Person project

NSLP: National School Lunch Program

OCC: Office of Child Care, ACF

OCGA.: Official Code of Georgia Annotated

OFA: Office of Family Assistance, ACF

OFI: Office of Family Independence, DFCS

PICS: PIH Information Center (PIC) System.

PIH: Office of Public and Indian Housing, HUD

PHA: Public housing authority

PRWORA: Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

PTC: Premium Tax Credit pursuant to purchased HIX policies per the ACA

RSM: Right from the Start Medicaid

RTC: Refundable tax credits

SBP: School Breakfast Program

SCHIP: Separate (or State) Children's Health Insurance Program

SFY: State Fiscal Year, which is July 1 through June 30th for most states, including Georgia

SOI: also known as SOI Tax Stats; Statistics of Income Division, IRS

SSA: Social Security Administration

SSI: Supplemental Security Income

SLCSP: Second Lowest Cost Silver Plan, pursuant to HIX

SNAP: Supplemental Nutrition Assistance Program, also known as food stamps.

TANF: Temporary Assistance for Needy Families

TTP: total tenant payment, as related to housing assistance

USDA: U.S. Department of Agriculture

USC or U.S.C.: United States Code

WIC: Women, Infants and Children program

WIPA: Work Incentives Planning and Assistance of SSI

Preface

This monograph presents a grand vision for modular systemic welfare assistance reform for the state of Georgia. It is a grand vision because it incorporates the entire welfare system that impacts families. It is systemic because it proposes a reconfiguration of the entire system to become one that provides an effective and cost-efficient safety net with no disincentives for work and no penalties for marriage. It relies on those things we know that bring success and wealth for individuals.

The reform is modular because it proposes to streamline more than fifteen major welfare programs administrated by a host of federal, state and local agencies into five coordinated programs controlled by a single, lead agency. Each of these consolidated programs can be pursued as a separate reform, and if all are pursued and accomplished, they will fit together to create the grand vision.

A functional welfare system relates directly to the mission of the Georgia Center of Opportunity (GCO). It promotes the GCO goals of creating opportunities for fulfilling work and a health family life for those who are struggling in poverty or marginally above poverty. Additionally, there is considerable interplay between a functional welfare system and GCO's other goal of promoting a quality education for all Georgians.

This monograph consists of several parts. This first part reviews the case for reform. The second part explains the new system, gives guiding principles, provides a general framework for how the reformed system will function, and establishes preliminary steps to implement the vision. The third part discusses each of the program modules, giving detail on their structure, design, estimated effectiveness, and a framework on how to proceed to accomplish them. The fourth part provides outlines for federal legislation.

Food Assistance Module

Purpose

All food assistance program—SNAP, WIC supplemental nutritional packages and school meals—will be combined into a single program. Food benefits will not be combined with other assistance but kept separate as a safety valve against hunger and to ensure individuals receive their nutritional needs.

The purpose of food assistance is to provide the essential nutrition needed to live a healthy life. When there is no other income, the assistance will be sufficient to guarantee the proper nutrition, and the benefit will taper off in conjunction with increased earnings subject to the eligibility engine to prevent disincentives.

Program Consolidation

Food assistance programs will be consolidated into a single program. This approach will simplify assistance from different perspectives. From the point of view of recipients, they will only need to know about one program. Administratively, there is only one program to manage, eliminating duplication of effort by various governmental agencies.

The major federal programs are as follows:

- Supplemental Nutrition Assistance Program
- National School Lunch Program
- Special Supplemental Nutrition Program for Women, Infants and Children
- School Breakfast Program

In addition, there are smaller programs as follows:

- Child and Adult Care Food Program
- Nutrition Service for the Elderly
- Summer Food Service Program
- The Emergency Food Assistance Program
- Commodity Supplemental Food Program
- Fresh Fruits and Vegetables Program

Most food assistance programs provide funds for the purchase of foods. All these will be funneled into the single program. Exceptions may be the Fresh Fruits and Vegetables Program that helps schools purchase fruits and vegetables. These programs may continue without consolidation into the single program.

A few programs provide food commodities, and the lead agency will need to devise a plan to distribute these foods. For now, however, the focus will be on the money-funded programs

Administrative Streamlining

The consolidated program will be administered by the lead agency. OFI already administers SNAP that is the largest food-assistance program. Now, however, other funds will be blended into the pool of money available for distribution. OFI will be the only agency that works directly with recipients.

The Department of Education will continue its work with schools on regulating how they prepare nutritious meals for children. However, funding for school meal programs will no longer be routed through the Department.

Schools will allow parents and caretakers to purchase meal plans using EBT cards of the new consolidated program, and OFI will design an easy way to facilitate the purchase.

The Department of Health may provide advice on nutritious meals, but it will cease running the special supplemental nutrition program of WIC.

New Program Description

SNAP EBT cards will be the method for dispensing benefits for the combined program, and recipients will continue using those cards when purchasing food.
The EBT card system was developed to allow easy purchase of food while giving administrators some control so only allowable items are purchased. It is a technological advancement over the original food *stamps*.

The current EBT system requires program integrity measures to ensure that the cards are used only for the purchase of food items as defined by the program. This means working with vendors and checking users to ensure they both comply with the rules. For example, one known abuse is that some users sell EBT cards for cash, and then use the cash to purchase non-allowable items, such as cigarettes. For this reason, the state of Maine has embedded photo IDs on EBT cards to prevent the abuse. Program integrity methods such as these will still need to be continuously reviewed, improved, and expanded upon because of those few abusers who are always scheming to circumvent the system.

Like the WIC program, the consolidated food assistance module will adopt nutritional standards on what may be purchased with EBT cards. This standard will go beyond current efforts to ban sugary drinks. Only those items deemed to be essential for nutrition will be allowed. Pastries, cakes, desserts, candy bars, ice cream are examples of food that will be not allowed. This standard will not mean that poor persons are banned from having sweets. They will be able to use cash—from either cash assistance or earnings—to purchase sweets, or they may be able to obtain sweets from food banks or charitable donations. What the standard will mean is that the taxpayer-funded food assistance module will be reserved for nutritional needs.

The lead agency will establish a food assistance working group that will include representatives from other agencies, such as the Department of Public Health. This team may include outside experts. The job of the working group will be to provide strict guidelines on what foods meet the

nutritional standards of the program. No food purchases that fail the nutritional standards will be allowed.

In addition, the team will limit purchases to more cost-effective foods. Exclude high cost items will help individuals better manage their benefits so they last the entire month. The ultimate task of the team is to create a master list of allowable items.

To create the master list, the lead agency will need to work with vendors and programs that identify the nutritional values of food. The U.S. Department of Agriculture and the Food and Drug Administration have publicly available databases, and there are commercially available products. The creation of the master list will be hard work at first, but the task can be lightened by using the WIC program as a starting point. However, the team will need to make value judgements on food items meeting nutritional standards but fail to meet affordability tests. Once the master list is completed, the panel will need to review and update it periodically as nutritional science develops and new food items are introduced. The panel will need to establish a procedure where vendors can submit new items to be included.

The master list will be detailed down to the level of the Universal Product Code (UPC), and the list will be made available to all vendors and users alike. Vendors will be able to incorporate the list into their point-of-purchase scanning systems that most vendors already rely on. In this manner, recipients will be able to easily purchase food, which are scanned by the cashier, and the system will immediately know whether and which items qualify.

The panel will also develop simplified guidelines for consumers so they can easily know what products qualify for EBT purchases. Additionally, the lead agency will create an app using the master list database that can be downloaded for free onto smart devices where consumers and smaller vendors without point-of-purchasing scanning systems can scan items in a store and know immediately which products qualify.

The lead agency will encourage vendors to allow consumers to easily identify which items qualify because not all recipients will have smart devices. Whether an insignia located on shelving labels or on consumer accessible scanning devices, the decision should be left to the vendor on how best to mark qualifying items.

Vendors currently benefit from food assistance programs by increasing sales. They will benefit even more from the reform because they no longer will be working with two programs—WIC and SNAP—but a single program.

When someone qualifies for food assistance, they will be provided guidelines on what foods qualify. In addition, they will be given information on how to access the UPC databases, which will be publicly available, so they can see specifically which items qualify. This information will become part of the IIP, which will also explain the reasoning behind the nutritional standards and the advantage of having earnings.

Recipients will be encouraged to use food banks to supplement their food budgets and stretch their EBT account balances. The IIP will provide information on how the recipient can find food

banks and other charitable organizations that provide food to help recipients find additional food items they may desire.

Finally, recipients will receive information on how to manage their EBT cards to efficiently meet their nutritional needs. This information will help recipients understand how to stretch dollars so they do not find themselves without food or an EBT account balance before they receive their next allotment.

School Meal Integration

The Department of Education will continue working with schools to provide nutritional meals. However, lead agency will have responsibility in determining eligibility. EBT cards may be used to purchase meal plans from schools and other qualifying institutions, such as day care centers, providing choice for parents on how best to provide for their children's nutritional needs. A parent might choose to pack lunches, which they may be able to do more efficiently and nutritiously, giving the parent more control over what the child eats rather than relying on institutionally-provided meals.

Additionally, the lead agency may create a system where benefit amounts can be transferred directly from a food assistance account to schools and other qualifying institutions.
For the purchase of school meals, the nutritional standards will not be applied. Rather, the food assistance program will rely on the school's adherence to nutritional guidelines promulgated by the Food and Nutritional Service of the U.S. Department of Agriculture as well as assistance from the School Nutrition Program of the Georgia Department of Education.

A key advantage to including school meals in the reform is that school meals will now be subject to the eligibility engine. Currently, school meals have two tiers—free and reduced cost—that create welfare cliffs because benefits do not taper off. The eligibility engine will differentiate benefit amounts based on income levels to eliminate those cliffs, and only OFI will have that capability.

Benefit Level Determination

A final task of the food assistance working group, which it may delegate to a special research team, will be to determine the maximum level of food assistance benefits based on family size. The team will use a prudent and frugal person standard to determine the amount of money required to satisfy nutritional needs for one month, which is equal to the benefit cycle.

It will be important for all team members to understand that the standard must remain at an affordable level for the program to be fiscally sound. It may make a reasonable assumption that some items will be acquired from food banks, provided there is evidence that recipients will have ready access. The team may decide to make other assumptions, such as adjustments for geographic regions or farming when it can be demonstrated that there are good reasons for doing so.

The core task for the research team will be to determine the amount of money that is necessary by household type and size. These amounts will become the maximum levels of food assistance

when a household has no earnings and no other non-assistance income. The working group will be able to compare its results to the SNAP maximum monthly allotments as a reference, but they will differ considering the consolidated program includes school meals, the variance in food prices across the nation, and how well the panel applies the prudent and frugal person standard. The tapering of benefits when there are earnings will be left to the eligibility engine working group. It is this group's duty—not the food assistance team's duty—to ensure that the tapering is done in a manner that eliminates all welfare cliffs. Unlike the SNAP program, there will be no income disallowances for food assistance. Because the welfare system will be unified, these adjustments become not only unnecessary but also undesirable. As demonstrated in prior reports, the various SNAP disallowances, such as for shelter and child care, create distortions that can make welfare cliffs worse.[1]

However, the food assistance working group will play a crucial role in eliminating the marriage penalty. When devising the matrix of maximum food benefits, the working group must treat each spouse of a married couple equally in the calculation of the benefits. In other words, the amount of the benefit cannot have a different value for second spouse as opposed to the first spouse. Otherwise there will be a marriage penalty.

For example, consider the following maximum allotments for the SNAP program: [2]

People in household	Maximum monthly allotment	Marginal benefit (Calculated)
1	$194	$194
2	$357	$163
3	$511	$154
4	$649	$138

The first two columns give the maximum monthly allotment by size of household for FFY 2017 per the U.S. Department of Agriculture. The third column calculates the marginal benefit per person, which is simply the difference between the maximum monthly allotment for the household size and the allotment for the immediately preceding household size. In other words, it is the additional benefit received by adding another person to the household. When the household has just one person, the marginal benefit is $194. When a second person is added to the household, the total allotment becomes $357, which is $163 more than for a household of just one person ($194).

These marginal benefits prove the current system creates a marriage penalty with the SNAP program. Suppose you have a couple with two children. If they are not married and report themselves as separate households, their maximum monthly allotment is $705, which is derived

[1] Erik Randolph, *Disincentives for Work and Marriage in Georgia's Welfare System,* Georgia Center for Opportunity, September 2016; revised March 2017.

[2] U.S. Department of Agriculture, Supplemental Nutrition Assistance Program: FY 2017 Allotments and Deduction Information [for the 48 states and the District of Columbia)
https://www.fns.usda.gov/sites/default/files/snap/FY17-Maximun-Allotments-Deductions.pdf

by adding $511 and $194. If they are married, their maximum monthly allotment is $649. The reason for the difference is that the marginal benefits for adding another person to the household are different. Adding the father has a marginal benefit of only $138 as opposed to $194 if he were not part of the household. The marriage penalty totals $672 for the year.

Using SNAP allotments as a preliminary basis, suppose the food assistance working group comes up with the following revised maximum monthly allotments:

People in household	Non-married household		Married couple household	
	Maximum monthly allotment	Marginal benefit	Maximum monthly allotment	Marginal benefit
1	$194	$194		
2	$357	$163	$388	$388
3	$511	$154	$551	$163
4	$649	$138	$705	$154

This hypothetical revision divides families into two groups: non-married and married households. By treating spouses equally, the marriage penalty will be eliminated. The maximum monthly allotment for the same couple, if they are not married and report themselves as separate households, is $705 as before. Now, however, if they marry, the benefits would be the same: $705. Therefore, the marriage penalty will be eliminated.

The food assistance working group may choose to keep the maximum monthly allotments simple, such as the hypothetical revision displayed above. Or it may develop more sophisticated revisions, such as accounting for differences in the age of children.

Transitioning to the Food Assistance Module

Current federal law provides inadequate flexibility to allow states to reform the various food assistance programs.[3] Therefore, it will be necessary that Congress provides states with that flexibility to allow Georgia to move forward with this modular reform. If in agreement with the reform vision, the Georgia delegation can work to pass legislation enabling the reform.

In the meantime, the Georgia state government can empanel a working group to start preparing for when Congress finally grants greater flexibility and explore opportunities under current federal law. For example, the working group may be able to develop waivers under existing law for pieces of the reform, or work on improving program integrity by moving to a system with photo ids on EBT cards.

[3] Erik Randolph, *Georgia's Welfare System Reference Guide: Program Bases and Flexibility for Reform Assessment*, Georgia Center for Opportunity, January 2017.

Shelter Assistance Module

Purpose

The purpose of the shelter assistance program is to provide assistance to those who have no other option. The focus will be for households that do not have adults with disabilities.

Scope of Program Consolidation

This proposal for this module does not recommend the consolidation of all housing programs for rental and shelter assistance. It excludes targeted funding for the homeless and disabled adults. Although both these program areas are important, the focus will be on households without the limitations of a disabled adult or the complex problems associated with the homeless population. However, this proposal is presented in full recognition of the overlap between the shelter assistance proposed here and the program areas of homelessness and shelter for adults with disabilities. Certainly, a well- structured general shelter assistance program will reduce the incidence of homelessness. By providing shelter assistance to families, it reduces their risk of homelessness. However, many homeless persons struggle with a myriad of difficulties, including mental health issues. This proposal does not address those needs that must be part of the solution of homelessness. Nevertheless, case workers will still be expected to refer individuals to homeless shelters.

Regarding housing for adults with disabilities, they, too, can benefit from this proposal but their special needs will not be addressed here. Consequently, Housing Opportunities for Persons with AIDS and Supportive Housing for Persons with Disabilities are excluded from this vision. This exclusion does not mean that at some time in the future programs targeting the disabled will not be integrated into the shelter assistance module. After the module is well established with results confirmed by program metrics, a future proposal may recommend expanding the module to include housing for the disabled. [4]

In the meantime, the programs under consideration affect the portions of the Section 8 housing programs, the Rural Rental Assistance Payments, and Supportive Housing for the Elderly that are not dedicated to adults with disabilities.

Streamlining Agency Responsibilities

The Department of Community Affairs along with the ten Georgian public housing authorities that administer the Section 8 programs will cease having the responsibility for those programs. The funding and responsibility will be transferred to the lead agency as part of the shelter assistance module.

Additionally, public housing projects not dedicated to persons with disabilities will be either rededicated for disabled housing or liquidated with the net proceeds benefiting the shelter assistance module and its related responsibilities, including the financing of a study to find ways that government can play a positive role in reducing housing costs. All capital and operating

[4] This proposal includes a housing assistance for a family that has a disabled child.

funding that support the liquidated portion of public housing will be redirected to the lead agency for the shelter assistance module.

DCA's and PHAs' roles will change pursuant to this proposal. PHAs will continue administering housing programs for disabled adults. Additionally, they will continue their efforts to make more affordable housing available through programs like the Low-Income Housing Tax Credit program that leverages private investments. Essentially, their mission will be to increase the supply of affordable housing in addition to provide housing programs for disabled adults. DCA will no longer have any responsibility for administering a rental assistance program.

However, DCA will be commissioned to identify market barriers that make housing more expensive, reporting back to the state legislature with recommendations. Members of the commission will be appointed by the governor and may include non-governmental experts in addition to government employees from other agencies. Specifically, the commission will compile a list of market barriers inhibiting the supply side of housing with public policy recommendations on how to address those barriers—whether the barriers can be eliminated or reduced. The goal is to expand the supply of affordable housing options for low-income Georgians. The economic theory behind this approach is based on the fundamental economic principle that increased supply drives down prices in addition to making more housing available.

In order to help it accomplish its mission, the commission will sponsor studies by research-based organizations. These studies shall address issues related to how government can encourage affordable housing through changes in policies and laws other than direct funding of affordable housing projects. The commission may award grant money for these studies from appropriations it receives as well as a portion of the net proceeds from the liquidation of public housing.

The commission will be directed to provide periodic reports to the legislature on its activities, progress, and findings. Additionally, the commission will forward studies to the legislature, including the sponsored research. These reports will enable the legislature to investigate what policies can be adopted to improve the affordable housing market in Georgia. The goal is to provide the legislature with a list of research-based options to promote affordable housing other than direct investments of tax revenue. Some options may include providing local governments guidelines on how to promote housing, and it may include state preemption of counterproductive housing-related ordinances that unnecessarily restrict supply.

Program Description

A fiscal challenge with including housing in the proposed vision is that demand for housing assistance far exceeds supply. Contrast this to food assistance or medical assistance programs. If a person qualifies for SNAP or Medicaid, that person cannot be denied the benefits of the program. Consequently, these programs are also notorious for being expensive public expenditures. In contrast, Section 8 housing and public housing programs fund just a small percentage of qualifying individuals because they are woefully underfunded. Waiting lists for these programs have become so overwhelming to manage that PHAs routinely keep application periods closed for lengthy periods, violating the fundamental principle of equal opportunity.

The new vision eliminates the need for waiting lists without increased funding by controlling program factors, and the lead agency will be responsible for seeing that dollars dedicated to the program are spread out evenly among all eligible applicants.

The overall framework of the vision described in Part 2 will play an important role in helping the lead agency control consumer demand for the program. The deferral system to employment and natural supports will filter out may applicants. Subsequently, the lead agency will need to develop a list of circumstances that qualify. For example, if it is possible that an applicant can live with family, then assistance is deferred.

The lead agency will not use fair market rents as published by HUD to determine a payment standard. Instead, the lead agency will rely on econometrics to estimate the total cost of shelter assistance that can be spread out evenly and equitably across the target population. From this, it will determine a maximum monthly benefit amount that may be applied for shelter assistance.

Because of the unique situation with shelter assistance, the lead agency will need to monitor the program closely to be sure the funds are spent appropriately and equitably. Congressional appropriations will essentially determine the maximum monthly benefit amounts. The state and other entities may supplement funding, but it is assumed that the federal government is the predominate if not the only funding source. This fact alone will require the lead agency to adjust the maximum monthly benefit to reflect changes in appropriation levels as well as demographic changes.

As the lead agency gains experience, the program may need to be adjusted. Because of all the other changes with the reform, experience may show that current appropriation levels are adequate. Or they may be inadequate, and further adjustments may need to be made.

Consistent with the other modules, shelter assistance amounts will taper off evenly based on earnings and other non-welfare benefit income. The taper rate will be controlled by the eligibility engine team. Therefore, the shelter assistant team working with the econometric calculations will need to coordinate with the eligibility engine team.

Qualifying recipients will receive a stipend, based on the maximum monthly benefit amount relative to earnings per the eligibility engine that can be applied to shelter costs. The amount will not vary based on location like the Section 8 HCV program, and the stipend can be applied to any shelter arrangement.

The goal will be to allow the market to work by relying on entrepreneurship to innovate with affordable housing. Already the demand side has the attributes of a competitive market. The role of government will be to promote the supply side with recommendations of the DCA commission on affordable housing, If the supply side is allowed to become more competitive without unnecessary interference, economic theory promises that the interaction of the supply and demand will produce efficient pricing and allocation of resources.

The lead agency will incorporate helpful hints in IIPs to help individuals find affordable shelter, and it will explain the purpose of shelter assistance. Additionally, the lead agency may choose to

apply time limits on the assistance to reduce the consumer expectation of continual dependency, which will encourage them to find inexpensive housing as well as to advance their financial circumstances.

Transition to the Shelter Assistance Module

Federal legislation will be necessary to enable the shelter assistance module to be implemented. Once Congress acts to allow for the transfer of the programs pursuant to the vision, Georgia can create a shelter assistance task force to work out the details necessary to accomplish the vision. Prior to passage of federal legislation, Georgia may establish a preliminary task force to flush the details further that can be used to help persuade its D.C. delegation to allow states to consolidate and streamline rental assistance programs.

Cash Assistance Module

Purpose

Cash assistance will provide sufficient flexibility to meet the various needs an individual or a family may have. The other assistance modules—nutrition, shelter, child care, and access to health care—will be targeted to specific needs and cannot be used for anything other than those needs. Because it is not possible to enumerate all potential needs, flexible assistance will be necessary beyond the targeted areas, which is the purpose of cash assistance.

Program and Administrative Consolidation

The following programs will be consolidated into the cash module:

- Earned Income Tax Credit
- Supplemental Security Income
- Additional Child Tax Credit
- Temporary Assistance for Needy Families cash aid
- Exclusion of Cash Public Assistance Benefits
- Low Income Home Energy Assistance Program
- Weatherization Assistance

There will be one cash assistance program that allows monthly allotments. Supplemental amounts may be available for disability-related expenses or for adults with incapacitating disabilities who are physically or mentally unable to work. In addition, the lead agency will have the ability to issue one-time emergency loans with the power to forgive them.

Cash assistance is currently administered by three lead agencies: the Internal Revenue Service, the Social Security Administration, and the Georgia Department of Human Services.

Additionally, the Vocation Rehabilitation Agency provides assistance in determining disabilities. The new streamlined arrangement will have only one agency to handle cash assistance, that is, OFI within the Georgia Department of Human Services. The Vocation Rehabilitation Agency will continue its role in determining disabilities but will also provide details to OFI on the extent of the disabilities and any special needs associated with the disabilities.

Refundable Tax Credits (RTC): EITC and ACTC

The welfare programs known as refundable tax credits will no longer be run through the Internal Revenue Service under the reformed system. Instead, federal legislation will transfer the funding required for the refundable tax credits to the state of Georgia to administer the program more effectively and as the welfare program it truly is.

The fundamental purpose of the EITC and ACTC is to provide cash assistance to low-income individuals, but the tax system is a poor mechanism for providing that assistance. The repeal of the EITC advance payments in 2009 eliminated a positive feature of the program that provided the opportunity for low-income individuals to establish regular cash flow. This program was repealed not only because it was underutilized but also because the IRS had difficulties in effectively managing it.

Assigning the program to a welfare agency instead of a tax collection agency will go a long way in making the program responsive to individual needs while ensuring proper safeguards are in place. The lead agency will be a welfare agency with resources to deal properly with the numerous challenges facing the administration of welfare programs. The lead agency will have a better picture of the financial situation and circumstances of recipients than any tax collection agency could ever have, will utilize the skills of caseworkers, and continuously implement and improve upon program integrity efforts absent with tax collection agencies.

Recipients benefit immensely because they will establish cash flow as opposed to waiting to file tax returns for cash assistance. Their situation will be monitored with respect to their total needs, and they will have a plan to escape dependency on government assistance. Without cash flow, the impoverished are relegated to strategies of desperation, subjecting them to ill-advised financial practices, such as relying on payday lenders that government itself is working to shutdown, and purposely overdrafting accounts that come with hefty fees. Cash flow frees them from these acts of desperation and provides a foundation for them to learn basic budgeting skills. Without cash flow, there is nothing to budget.

The lead agency will have established maximum amounts of cash assistance that individuals and families may receive that taper with earnings using the cliff engine and designed so that marriage is not penalized. These will be configured within the context of the other modules, enabling families to have the array of assistance they require. The benefits will never be lavish, and the natural incentives for self-improvement will be preserved, encouraging them to increase earnings.

The lead agency will use best practice for program integrity, ensuring that recipients do not cheat, and it verifies all information from various strategies, including data exchanges and field operations from caseworkers. Good behavior will be encouraged, and abuse will be met with sanctions and loss of benefits. Recipients will be notified of the risks and be made to sign a contract acknowledging they were informed of those policies.

Administering the current refundable tax credit programs as welfare programs will OFI to integrate the cash assistance into the IIPs. It will be subject to the eligibility engine that prevents

disincentives for earning more money and marriage penalties. It will be monitored by case workers. Low-income families will be connected to volunteer community-based services to advise and help them along the way.

Other Cash Assistance: TANF Cash and SSI

Under this proposal, TANF will continue with little change. It currently has more case management than any other welfare program. Under the new system, TANF cash will be integrated as part of IIPs when income levels are low enough to qualify for TANF cash. It will further be subject to the eligibility engine and evaluated to ensure that no work disincentives or marriage penalties are introduced. Finally, it will continue to encourage work and self-sufficiency. Because federal funds for TANF come to Georgia as block grants, no federal legislation will be necessary to integrate TANF into the systemic reform.

SSI, however, is administered by the Social Security Administration. Georgia's role is limited to diagnosing disabilities through the Vocation Rehabilitation Agency. Parental incomes are deemed to disabled children. However, there are no adjustments for the severity of the disability or the actual needs due to a child's disability. In the new system, the amounts received will be tied to specific needs that also will be subject to the eligibility engine that prevents work disincentives and marriage penalties. If a child's disability is severe enough, preventing a parent from being employed, then the compensation will be more. If the child's disability is not as severe, then it will be less.

The subsidies relating to disabilities for children and adults will be treated as supplemental subsidies on top of all other welfare assistance that may be needed. The complexity of adding disabilities will require a special task force to design a schematic of what subsidies are needed in conjunction with other benefits and in collaboration with the task force assigned to ensuring the viability of the eligibility and benefit determination system.

All disability considerations become part of IIPs and will be detailed in a separate section of the plan. While some disabilities are so severe that persons having those disabilities have little to no prospect of becoming self-sufficient, other disabilities can be overcome. Still most persons with disabilities can achieve some sustainable level of independence that have multiple benefits, including finding fulfillment in work and being able to earn a substantial part of their income. For children with disabilities, including mental disabilities, it is important to help them learn skills so they can live and thrive on their own as much as possible given their specific form and severity of disability.

It makes no sense to trap these individuals in a life of dependency if they have the potential to reach self-sufficiency, or come somewhat close to self-sufficiency, just because they have a disability. The disability section of the IIPs will set goals and benchmarks for them to achieve the skills they will need based on reasonable expectations.

Persons with disabilities require more support from the community. Case workers will help to link these individuals to community-based support systems and volunteer organizations to help them cope and develop to their full potential. Information on these organizations will be incorporated into the IIPs, and case workers will help facilitate connection between them.

Federal permission to integrate SSI into systemic reform can be accomplished by Georgia filing for a waiver under Section 1115 of the Social Security law. Approval would be required by the Secretary of Health and Human Services. No state has yet used Section 1115 relative to SSI. Alternatively, Congress can enable the states to integrate SSI into systemic reform through additional legislation.

Maximum Cash Allotments

The lead agency will create a cash assistance working group charged with the duty of establishing the maximum allotment of cash assistance that may be required, assuming no earnings and based on family size. The working group force will be instructed to design the maximum amounts so that married couples are not penalized. This criterion can be accomplished by controlling marginal benefits as the size of the household expands, making sure that the marginal benefits for married partners are equal and that the marginal benefits for additional household members decrease sequentially and incrementally by the same amounts. For example, the table below provides a hypothetical example that follows these rules. The actual amounts will be determined by the working group and will likely be different from the hypothetical below. The working group may decide to add additional criteria, such as geographic regions and ages.

Hypothetical Maximum Allotments for Cash Assistance Avoiding Marriage Penalties

People in household	Non-married household		Married couple household	
	Maximum monthly allotment	Marginal benefit	Maximum monthly allotment	Marginal benefit
1	$300	$300		
2	$450	$150	$600	$600
3	$550	$100	$750	$150
4	$620	$70	$850	$100

As illustrated in the hypothetical example, the marginal benefits for when there are no earnings is $300 for a single parent or $600 for a married couple. The spouses are treated equally relative to the benefits. Therefore, there is no marriage penalty. Each additional child in the two household—whether a single parent household or a married couple—is also treated the same, thus avoiding a marriage penalty for household with children. Non-married couples would be treated the same as a single-parent household to avoid encouraging families where the parents do not marry.

The maximum monthly allotments assume no earnings. As earnings are incurred and increased, the cash benefit amounts will be reduced in a manner that avoids welfare cliffs. The team who manages the eligibility engine and minimum marginal benefit rates will determine the proper tapering of benefits.

Recipients with disabilities may receive supplemental amounts for disability-related expenses or if they are unemployable. The cash assistance task force will not be responsible for determining

these supplemental amounts. They will be determined by the special needs working group in conjunction with the eligibility engine team.

While the modules will be determined independent of each other, the lead agency will have the power to make adjustments to cash assistant amounts as a backup measure to ensure that none of the principles are violated when controlling for marriage penalties and welfare cliffs.

Additionally, this flexibility will give administrators the ability to adjust amounts for programmatic and fiscal needs for those times when appropriated funds are tight.

Recipients will be allowed to exceed maximum allowances for one-time emergency cash loans. Limited to critical care areas, such as loss of electricity or heat in the winter, these loans will be paid back at reasonable payment amounts. The agency will also have the power to forgive loans for truly extraordinary circumstances, such as medical expenses due to serious illness or incapacity when there is little prospect for repayment.

Transition to the Cash Assistance Module

As part of the modular welfare reform, the Governor will establish the cash assistance working group to prepare for when cash assistance is transferred to the state. Federal legislation will be necessary for full implementation.

Georgia already controls TANF cash assistance funds. This program will be easily integrated into the cash assistance module, although Georgia may need to modify its block grant state plan.

The critical step will be integration of the refundable tax credits. Congress will need to pass legislation allowing for the transfer of the tax-based welfare programs to the states, or at least authorize a demonstration project that Georgia can utilize. The funding amount for Georgia will be based on the amount of tax credits already provided to Georgians and transferred to OFI for administration, giving Georgia the flexibility it needs to redefine the program parameters as part of welfare reform.

After Georgia gains experience in administrating the cash assistance module with TANF and the tax-based programs, Georgia will submit a Section 1115 waiver application to allow SSI to be integrated into the cash module. Congress may choose to expedite the process by providing further authorization for the transfer that does not require a waiver. It is recommended that the cash components for SSI be the last piece to be integrated into the modular welfare reform to ensure the administrative structure is functioning and ready to absorb the supplemental cash needs aspect of the module.

Child Care Assistance Module

Introduction

Child care assistance is important to help parents find suitable care for their children while they earn money. It has been a critical component of the TANF program, enabling low-income parents, most frequently but not exclusively single parents, to get training and earn income so

they can learn to become self-sufficient. Moreover, child care assistance extends far beyond the TANF population in helping low-income families struggling to make ends meet, and it is especially important for children with special needs.

Child care assistance poses significant challenges. Foremost, funding is seldom enough. States are either forced to limit coverage or place applicants on waiting lists. Compounding the funding program, child-care welfare cliffs can be the worst among welfare programs. Fiscal realities eliminate the possibility of extending tapered benefits to higher incomes to eliminate welfare cliffs. Exacerbating the program costs further, quality initiatives often are accompanied by higher cost for services of services already costly for low-income families. These realities will require an aggressive strategy to balance the multiple and competing goals of quality, fairness in making the program available to all eligible applicants, eliminating welfare cliffs and marriage penalties, and keeping fiscal costs reasonable.

Defining Agency Roles

Child care assistance is the only module that will have no consolidation of programs. The Child Care and Development Fund Block Grant is the only federal program, and it provides funding to Georgia's CAPS program. Because of the uniqueness of child care to help parents secure employment, and because of the normally high costs associated with child care services, especially difficult for low wage earners, the program deserves its own module.

The Department of Early Care and Learning (DECAL) will continue its important mission to promote safety in daycare centers. However, the subsidy program to help families afford child care must remain with the lead agency as part of the integrated welfare system. OFI will manage the subsidy program as one of the essential modules, determining benefit amounts subject to the eligibility engine so welfare cliffs and marriage penalties are eliminated.

Although losing eligibility determination and funding as a function, DECAL's mission will be expanded to include encouraging innovations that maintain standards while finding cost efficiencies. Furthermore, employers and workplaces will be encouraged to provide child care services for its employees. These may be encouraged by tax breaks but can also be promoted by less-costly recognition programs. For example, DECAL will award certificates to employers who are child-care friendly. Child Care Resource and Referral System agencies may continue providing resources and referral information to clients. However, DHS will handle all eligibility and benefit determinations as already described.

As a part of the reformed welfare process, natural support systems will be encouraged. Caseworkers will work with two-parent families to find solutions to child care without needing subsidies, which may include switching work schedules. When no solutions can be found, then the subsidies are subject to the eligibility engine.

The copayment structure—the family fee schedule—will be restructured to encourage low-cost selections. The out-of-pocket cost to the family must be greater for more expensive option, otherwise it distorts the pricing system.

Redesign of Child Care Assistance

Reducing the cost of child care assistance will be dependent on three strategies. First, the welfare reform will reduce program costs through preliminary screenings in determining natural supports, through seeking child support payments, and by eliminating marriage penalties.

Second, DECAL's new mission—promoting cost efficiencies and encouraging employers to provide or subsidize child care— will reduce demand for government subsidies and help moderate child care costs. Finally, the CAPS payment and fee system will be redesigned to encourage most cost-effective choices by parents who do receive assistance. The effectiveness of the redesign will be found in the details, of which the principles are explained.

Child care subsidy programs promote parental choice in the child care setting. However, the fee structures distort those choices by equalizing the cost to the family. Naturally, all else equal, parents will choose the higher cost setting if their out-of-pocket costs are the same. These distortions drive up program costs by encouraging higher subsidies per eligible family, which in turn make welfare cliffs worse.

Parental choice needs to reflect real-life budgetary choices. Parents may still be given choices, but the cost for more expensive settings must come with greater costs. If the more expensive setting is important to them, then they will make budgetary sacrifices to pay for it.

In essence, total subsidies are reduced for less affordable settings, requiring more parental cost-sharing. In addition, caseworkers will be directed to help recipients think through their possibilities and choose those that are the most cost-effective. Encouraged this way in collaboration with aligning the financial incentives, recipients will gravitate toward those choices. By starting with lower costs, the tapering of benefits to avoid welfare cliffs will diminish sooner up the income ladder.

Transition to the Vision

Because the federal support is already a block grant, Georgia has flexibility to implement these changes. It can simply amend its state plan accordingly.

The Governor should create a child assistance working group to work out the details and can direct the agencies to realign their duties pursuant to this vision. Congress may accelerate the process by making it clear in federal statute so the block grant encourages state to consider cost effectiveness and ways to reflect realistic budgetary choices into their fee schedules.

Medical Assistance Module

Introduction

Reforming medical assistance programs has the additional complication that access to health insurance—and the associated pricing distortions of the American health care system itself—needs reform as well and will likely undergo further transformation at the federal level.

Likewise, because medical assistance programs are a significant part of how many Americans access health care, it is not possible to effectively reform the health insurance system without also reforming medical assistance programs. Medical assistance programs impact pricing and access for others in ways that may not be obvious. Therefore, any serious discussion of reforming medical assistance programs should be discussed in context of the broader system, and *vice versa*.

Although federal policy dominates medical assistance programs, states can still effectuate positive change to several medical assistance programs as well as the broader system itself. Current federal law provides some flexibility for states to experiment with Medicaid and the State Children's Health Insurance Program (SCHIP), and considerable flexibility for health insurance reform under the Affordable Care Act (ACA), enabling very broad reforms to impact both medical assistance programs and health insurance coverage. Besides, states have traditionally regulated health insurance policies, which has long been recognized as a state responsibility.

Therefore, states should not be hesitant to undertake reform when it comes to the health insurance industry and medical assistance programs. Ultimately what matters is developing policies that are in the best interest of their citizenry.

It will be argued here that a consumer-driven, market-based system dovetailed with a functional and empowering safety-net program will provide the best solution. Health insurance products will be portable and geared to consumers without regard to employment. Pricing will be transparent. Consumers will easily shop for best values. Insurers will be free to innovate and compete for customers based on value, benefits, and prices. Medical assistance programs will not distort pricing for those with private insurance. Transitioning off medical assistance programs will be easy without fear of losing coverage. Nonprice and price competition will offer better products not just to the healthy but also to those with special health needs. Universal coverage will be achieved.

The following sections will cover these topics. The first section describes the serious defects with the current health insurance system, including the medical assistance programs, that begs reform. The second section gives detail on flexibility states now have available to them to undertake reform. The third explains why consumer-driven systems offer the best solution. The fourth provides a vision for the best possible health insurance system for the state of Georgia—one relying on a consumer-directed health care system dovetailed with a functional and empowering safety net. The final section provides a fundamental framework on how Georgia can move from the current system to the vision.

Why Pricing and Access to Health Insurance Needs Reform

The American health insurance system is a mixture of private coverage and government programs. It lacks some characteristics of a well-functioning market that begs improvement. According to the U.S. Census Bureau, two-thirds of all Americans in 2015 had private health insurance coverage and most—56 percent of the population—through their employer. Nine percent had no insurance, and the remaining population was covered by government programs.

Medicare covered 16.3 percent of the population, Medicaid covered 19.6 percent, and military health care covered 4.7 percent.[5] The sum of the percentage components exceeds one hundred percent because some individuals have dual coverage, such as the so-called dual eligibles who have both Medicare and Medicaid.

A major market weakness across virtually the entire system is that most health insurance is provided by third parties. Employers provide health insurance for four fifths of private coverage—more than half of the population, and in most cases, employees are offered just one plan to choose from.[6] The government-run programs are single-payer systems where the government is the sole payer. Medicare, Medicaid, and SCHIP are single-payer systems that allow for private providers. For veterans and the military, the government is not only the sole payer but also owns the facilities and employs the providers. Consequently, most Americans have insurance selected for them and largely paid for them by some third party, whether it is their employer or the government.

From a market perspective, third-party payers desensitize consumers to costs and create distortions in pricing behavior, manifested by consumers who shop little for best prices, insufficient innovations in products geared to the needs of the ultimate consumers, and opaque pricing.[7]

The dominance of employer-provided health insurance developed because of an historical accident emanating from the price controls of the 1940s. Subsequent favorable regulatory rulings during that and the following decade reinforced the practice. To attract employees during World War II, when employers were prohibited from raising wages, employers began offering health care insurance to overcome a labor shortage, which began the era of reliance on third-party payers. As a result, an insurance industry developed that tailored their products to employers instead of individuals, and this practice has continued through today, explaining much about our current system and its many problems.[8]

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[5] Barnett, Jessica C. and Marina S. Vornovitsky, "Health Insurance Coverage in the United States: 2015," *Current Population Reports, P60-257(RV)*, U.S. Census Bureau, U.S. Government Printing Office, Washington, DC, 2016, Table 1, page 4: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf.

[6] McLaughlin CG, "Health Care Consumers Choices and Constraints," *Medical Care Research Review* 1999: 56 (suppl1), pp. 40-42.

[7] Willem G. Cornax, "How Third-Party Payers Drive Up Medical Costs,' *Misses Daily Articles*, Mises Institute, September 22, 2014: https://mises.org/library/how-third-party-payers-drive-medical-costs; see also "Third-Party Payer is the Biggest Economic Problem with American's Health Care System, *Freedom Works*: http://www.freedomworks.org/content/third-party-payer-biggest-economic-problem-americas-health-care-system, and Maureen J. Buff and Timothy D. Terrell, "The Role of Third-Party Payers in Medical Cost Increases," *Journal of American Physicians and Surgeons*, Volume 19, Number 2, Summer 2014: http://jpands.org/vol19no3/buff.pdf .

[8] David Blumenthal "Employer-Sponsored Health Insurance in the United States – Origins and Implications." *The New England Journal of Medicine*, July 6, 2006, pp. 82-88.

While employer-provided health insurance has its strengths,[9] especially compared to government-run systems, it also has severe drawbacks beyond the already described problems of creating a third-party payer system. It presupposes a fixed economy dominated by large, stable employers who provide for their employees over their employees' entire careers. If this economy ever existed in America, it is clearly no longer the case. Nationally, large employers with 500 or more employees accounted for only 21.5 percent of total employment in 2015 while small employers with less than 50 employers accounted for more than 40 percent of all employment.

Georgia's numbers are nearly identical to the national.[10] Furthermore, economic history teaches that dominant firms change over time as industries emerge and wane.[11]

Because insurers can spread risk across larger groups of people, the most affordable insurance coverage is offered to larger employers. Conversely, smaller employers and the self-employed have more difficulty finding affordable coverage partly because the risk cannot be spread across larger groups. Because employers are the biggest market, insurance products typically are geared toward employer needs, which do not always meet the specific needs of employees who rely on the coverage.

A significant problem with an employer-based system is what happens when employees lose their jobs. Because their health insurance is linked to their employment, they also lose their coverage. This can be devastating, especially if they have a preexisting condition. Although federal law enables employees who are laid off to purchase their employer's health insurance after termination, they must pay full cost and can only remain on the insurance for only a limited time, normally up to 18 months,[12] and often end up scrambling to find employment that also offers health care.

In summary, an employer-based system simply has inequities favoring large employers and has not achieved, nor can it achieve, universal coverage.[13]

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[9] *2016 Employer Health Benefits Survey*, The Henry J. Kaiser Family Foundation: http://www.kff.org/health-costs/report/2016-employer-health-benefits-survey.

[10] U.S. Census Bureau, *2015 County Business Patterns*, Table CB12000A13: Geography Area Series: County Business Patterns by Employment Size Case, obtained using American Fact Finder, data released April 20, 2017.

[11] Joseph Schumpeter is credited as the first economist to articulate how in capitalistic societies entrepreneurship drives innovation that leads to "creative destruction," a natural process of declining industries being replaced by rising industries. See the entry for "Joseph Alois Schumpeter," *Concise Encyclopedia of Economics*, Library of Economics and Liberty: http://www.econlib.org/library/Enc/bios/Schumpeter.html, accessed June 8, 2017. An instructive illustration is to review how the component companies of the Dow Jones Industrial Average changed over time. Today, only one company from the original twelve remain in the average. See Stuart A. Thompson and William Power, "The Ins and Outs of the Dow Jones Industrial Average: How the Dow has changed over its 120-year journey to 20000 points," *Wall Street Journal*, January 25, 2017: http://www.wsj.com/graphics/djia-components-history.

[12] Employee Benefits Security Administration, U.S. Department of Labor, FAQs on COBRA Continuation Health Coverage, October 2016: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer_0.pdf, accessed May 22, 2017.

[13] Thomas C. Buchmueller and Alan C. Monheit, "Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform,' Working Paper 14839, National Bureau of Economic Research, April 2009: http://www.nber.org/papers/w14839.pdf , accessed June 8, 2017; Uwe E. Reinhardt, "The Illogic of Employer-Sponsored Health Insurance," The Upshot, *The New York Times*, July 1, 2014:

Nationalized systems may solve the issue of universal coverage but perform poorly with quality and innovation, making it a raw deal for those who are now covered privately.[14] Veteran care in the United States is an example of a nationalized system. A 1994 analysis by the National Center for Policy Analysis called Veteran Affairs hospitals the least efficient in the country, pointing out that ninety percent of veterans who could use the system choose otherwise.[15] The situation is no better today.

Recent news coverage on the abysmal care that veterans receive, some even dying while on a waiting list for critical care, highlight typical problems with nationalized systems.[16] Long waits for services are an unfortunate hallmark. Inadequate supply leads to the necessity of rationing services. Distortion of incentives chase away talented providers to other opportunities, either in other fields or by emigrating to a country that provides better compensation. It is no accident that wealthy consumers— from countries such as Canada and Great Britain, who have completely nationalized their health care systems—choose to travel to the United States to receive care. They come to take advantage of America's private system that excels in innovation, quality, and service, not its government-run programs.

Defects with nationalized systems have caused many to advocate for a type of single-payer system that still relies on the private system to deliver the service. The hope is to preserve the innovation and quality associated with the private sector health care system but use the coercive force of government to fund the system for everyone, solving two major obstacles of health

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https://www.nytimes.com/2014/07/03/upshot/the-illogic-of-employer-sponsored-health-insurance.html, accessed June 8, 2017; Avik Roy, "How Employer-Sponsored Insurance Drives Up Health Costs," The Apothecary, *Forbes*, May 12, 2012: https://www.forbes.com/sites/theapothecary/2012/05/12/how-employer-sponsored-insurance-drives-up-health-costs.

[14] Michael D. Tanner, "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World," Policy Analysis No. 613, Cato Institute, March 18, 2008: https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-613.pdf; Michael D. Tanner, "Universal Health Care Not Best Option," Cato Institute, appeared in *The Bulletin*, February 23, 2009: https://www.cato.org/publications/commentary/universal-health-care-not-best-option; Jarret B. Wollstein, "National Health Insurance: A Medical Disaster," Foundation for Economic Education, October 1, 1992: https://fee.org/articles/national-health-insurance-a-medical-disaster.

[15] "In Harm's Way: The VA Health Care System," Brief Analysis No. 140, National Center for Policy Analysis, November 15, 1994, p. 1: http://www.ncpa.org/pdfs/ba140.pdf.

[16] The VA hospital scandal included government investigations and widespread media coverage. The Veteran Administration Office of Inspector General (VAOIG) found systemic problems with scheduling, ethics breakdown, and acknowledged the "personal disappointment, frustration, and loss of faith of individual veterans." VAOIG, "Veterans Health Administration: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System," August 26, 2014: https://www.va.gov/oig/pubs/VAOIG-14-02603-267.pdf. See also "Timeline: The road to VA wait-time scandal," *The Arizona Republic*, published May 9, 2014, updated October 25, 2016: http://www.azcentral.com/story/news/arizona/politics/2014/05/10/timeline-road-va-wait-time-scandal/8932493, accessed June 8, 2017; Dave Boyer, "VA still plagued by problems two years after scandal," The Washington Times, April 13, 2016: http://www.washingtontimes.com/news/2016/apr/3/va-still-plagued-by-problems-two-years-after-scand; Dr. Kim-Lien Nguyen, "Veterans Need to Take Ownership Over Their Health Care," The Apothecary, Forbes, June 27, 2014: https://www.forbes.com/sites/theapothecary/2014/06/27/veterans-need-to-take-ownership-over-their-health-care.

insurance reform—cream skimming by insurers to get the lowest cost consumers and universal coverage. Despite all its promise, this type of a single-payer system falls drastically short of an ideal system by introducing serious problems.

Relying on government to fund the health care system means two things: taxation and governmental control through regulation. The revenue side of the equation is problematic enough. Market structures are dynamic and can adjust quickly to changes in supply and demand.

In contrast, government funding is lethargic, dependent upon political powers and appropriation processes. Politically, it is difficult to increase taxes on constituents, which often leads to underfunded programs. Service providers do not have the same level of incentives to innovate, especially with increasing productivity, as found in private systems. The legislative process is also particularly clumsy in determining needs of consumers and incentivizing innovation and efficiencies.

Because single-payer systems are third-party payer systems, overutilization of the services is a major concern. To address these problems, the government usually promulgates regulations defining which services qualify, limiting usage, and capping payment rates to providers. These actions—which are crucial to preserve the program—work to limit the types of treatments consumers can afford and the amounts providers receive, ultimately impacting the availability of providers, innovation, and the quality of care.[17] Governmental regulations substitute for patient choices and decisions that cannot possibly account for all situations.

Medicare and Medicaid are both single-payer systems that meet this definition. Medicare has its own tax source—payroll taxes—and a dedicated fund. Theoretically, paying these payroll taxes throughout one's career is sufficient to cover a worker's health care needs during retirement. This, however, is nowhere near the truth. The amount of money set aside during a worker's career has been proven to be woefully insufficient for a person's health needs over an average lifespan.[18] As more retirees live longer, the problem is exacerbated. Retirees are relying on current workers paying into the fund to sustain them. This program design is inherently flawed because it is predicated on unsustainable high population growth.

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[17] For a thorough analysis on single-payer systems, see John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, with a foreword by Milton Friedman, *Lives at Risk: Single-Payer National Health Insurance around the World*, Lanham: Rowman & Littlefield Publishers, published in cooperation with the National Center for Policy Analysis, 2004. For shorter analyses, see Robert A. Book, "Single Payer: Why Government-Run Health Care Will Harm Both Patients and Doctors," WebMemo, The Heritage Foundation, No. 2381, April 3, 2009: http://s3.amazonaws.com/thf_media/2009/pdf/wm2381.pdf; A panel discussion sponsored by the Heritage Foundation in 2001 gives a brief background on many of the problems with a single-payer system, which can be found on think tank's website: David Gratzer, Richard Teske, Timothy Evans and James Frogue, "Buyer Beware: The Failure of Single -Payer Health Care," The Heritage Foundation, May 4, 2001: http://www.heritage.org/health-care-reform/report/buyer-beware-the-failure-single-payer-health-care.

[18] C. Eugene Steurle and Caleb Quakenbush, "Social Security and Medicare Taxes and Benefits over a Lifetime," 2015 Update, Urban Institute, September 2015: http://www.urban.org/sites/default/files/publication/66116/2000378-Social-Security-and-Medicare-Lifetime-Benefits-and-Taxes.pdf.

Consequently, long-term solvency of Medicare[19] is a perennial political issue that depends on numerous factors, including growth in medical costs, in the labor force, and in the number of people reliant on Medicare. Another symptom of the underfunding is the limitation on Medicare benefits, which explains why those who can afford it—or if they are fortunate enough to have a prior employer who buys it for them—usually purchase insurance to supplement their Medicare coverage.

Medicaid is in worse shape. Unlike Medicare, it does not have a dedicated revenue source nor a dedicated fund. It must rely on general tax revenue from federal and state governments. The federal government generously matches state funding based on a regulatory formula known as the Federal Medical Assistance Percentage (FMAP) formula—anywhere between 50 and nearly 75 percent, excluding enhanced FMAP rates[20]—while it imposes restrictions on how states may administer the program.

A constant burden on state governments who need to balance their budgets, Medicaid represents one of their largest expenditures. That the challenges of Medicaid spending are a perennial issue for the states can be confirmed by a perusal of the annual state expenditure reports and fiscal surveys of the states by the National Association of State Budget Officers (NASBO).[21]

Moreover, the fiscal impact of Medicaid on the states was a critical factor for the U.S. Supreme Court when it ruled seven-to-two that Congress exceeded its authority with the ACA by attempting to force states to expand Medicaid. In the opinion of the court: "The threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."[22]

Because of the financial burden, states are constantly looking for innovative ways to shift more of the financial burden of Medicaid onto the federal government. They have been successful in coming up with numerous schemes. One such devious scheme is to tax hospitals and other providers, who in return increase their prices to the states. The end result is the federal government pays a larger share for a program cost purposely bloated by the states. In any other

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[19] The most recent actuarial report of the Medicare's Boards of Trustees concludes both short-run and long-run financial inadequacies and estimates fund depletion by 2028 given current trends. See The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2016 Annual Report*, June 22, 2016: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

[20] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services, ASPE FMAP 2017 Report: https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages.

[21] These reports are available on NASBO's website: http://www.nasbo.org/home. See also the April 13, 2011, briefing: Medicaid Cost Containment: Recent Proposals and Trends available online: https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Issue%20Briefs%20/Medicaid%20Cost%20Containment%20-%20Recent%20Proposals%20and%20Trends.pdf.

[22] *National Federation of Independent Business v. Sebelius (NFIB v. Sebelius)*, 567 U.S.11-393, June 2012: https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

area of public policy, this practice would incite the wrath of federal auditors and prosecutors. In this case, if not complicit with the scheme, the federal government looks the other way.[23]

Meanwhile, the federal budget is the victim. The federal government has proven itself incapable of balancing its budget, which economists have argued is inflationary and crowds out private investments,[24] and runs continual deficits largely in part because of growth in health care programs.[25]

Despite the high costs, Medicaid programs have been struggling to maintain quality of care. Numerous studies have demonstrated that health care quality is below that of private markets and even Medicare. In fact, studies have astoundingly shown Medicaid outcomes worse than for the uninsured, which is clearly a factor in why Dr. Avik Roy declared Medicaid to have the poorest health care outcomes of any health insurance system in the industrial world.[26]

A well-known problem with Medicare and Medicaid is the lack of medical practices willing to accept new patients from these programs, thus limiting consumer access to some of the best physicians. To stretch limited resources, Medicare caps payments for services, making it economically infeasible for some practices to accept too many patients from the program, or at least limiting their willingness to accept new patients. Paying less than Medicare despite recent attempts to bring up Medicaid's rates, Medicaid's access to physicians is even more restrictive, perhaps explaining the poor quality of care.[27]

The problem does not end there. The chronic underpayment of providers distorts pricing even more, pushing up prices for those privately covered. Making matters worse, many larger

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[23] The author personally witnessed these games while serving as a special assistant to Pennsylvania's Secretary of Public Welfare from 2011 to 2013.

[24] See, for example, Jonathan Huntley, "The Long-Run Effects of Federal Budget Deficits on National Saving and Private Domestic Investment," Working Paper 2014-02, Congressional Budget Office, February 2014: https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/workingpaper/45140-NSPDI_workingPaper_1.pdf.

[25] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, p. 17-20: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view. See also the Congressional Budget Office's webpage on Health Care: https://www.cbo.gov/topics/health-care.

[26] The abysmal performance of Medicaid is well known. See, for example, the following articles by Avik Roy: "Why Medicaid is a Humanitarian Disaster," The Apothecary, Forbes, March 2, 2011 (https://www.forbes.com/sites/theapothecary/2011/03/02/why-medicaid-is-a-humanitarian-catastrophe), and "How Medicaid Harms the Poor: A Counter Rebuttal" Parts I through III, The Apothecary, Forbes, March 9, 2011, March 10, 2011, and Marcy 11, 2011 (https://www.forbes.com/sites/theapothecary/2011/03/09/how-medicaid-harms-the-poor-a-counter-rebuttal-part-i, https://www.forbes.com/sites/theapothecary/2011/03/10/how-medicaid-harms-the-poor-a-counter-rebuttal-part-ii, and https://www.forbes.com/sites/theapothecary/2011/03/11/how-medicaid-harms-the-poor-a-counter-rebuttal-part-iii); Roy summarizes some of these points in *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, pp. 6, 43-45: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

[27] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, p. 23: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

employers have contractual arrangements to keep down their costs. Those who are individually insured, uninsured, or participating in small group insurance plans suffer from these price distortions.[28] Prices for the very same service vary greatly from patient to patient, depending on coverage, and from facility to facility. Transparency is virtually nonexistent.[29]

Despite its name, the Affordable Care Act of 2010 has not improved the health insurance system. It did not achieve two of its purported goals: universal coverage and affordability of health care. Nine percent of the population remains uninsured.[30] Health insurance prices have grown sixty percent faster than the general inflation rate, medical care services ninety percent faster, and hospital services more than three times as fast—all since the enactment of the ACA.[31]

Although numerous reasons can be listed on why the ACA has failed to meet its goals, they can be summarized with two words: poor design. Foremost among its defects is the reliance on Medicaid—known to have the "poorest health outcomes of any health insurance system in the industrialized world"[32]—to solve the health care needs for the poor. Congress attempted to force all states to expand their Medicaid programs to cover all non-elderly persons up to 138 percent of federal poverty levels, but the Supreme Court of the United States ruled it unconstitutional.[33]

Because Congress enticed states to expand Medicaid by offering generous FMAPs for the newly expanded population, starting at 100 percent for the initial years of expansion and dwindling to 90 percent by the end of the period outlined in the law, and because many state governments desired to decrease their uninsured numbers, 32 states expanded their Medicaid programs pursuant to the act.[34]

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[28] Willem G. Cornax, "How Third-Party Payers Drive Up Medical Costs,' Misses Daily Articles, Mises Institute, September 22, 2014: https://mises.org/library/how-third-party-payers-drive-medical-costs; see also "Third-Party Payer is the Biggest Economic Problem with American's Health Care System," Freedom Works, July 10, 2012: http://www.freedomworks.org/content/third-party-payer-biggest-economic-problem-americas-health-care-system, and Maureen J. Buff and Timothy D. Terrell, "The Role of Third-Party Payers in Medical Cost Increases," *Journal of American Physicians and Surgeons*, Volume 19, Number 2, Summer 2014: http://jpands.org/vol19no3/buff.pdf .

[29] Chapin White, Amelia M. Bond and James D. Reschovshky, "High and Vary Prices for Privately Insured Patients Underscore Hospital Market Power," Research Brief Number 27, Center for Studying Health System Changes, September 2013: http://hschange.org/CONTENT/1375; Sarah Kliff and Dan Keating, "One hospital charges $8,000—another, $38,000," *The Washington Post,* May 8, 2013: www.washingtonpost.com/blogs/wonkblog/wp/2013/05/08/one-hospital-charges-8000-another-38000.

[30] U.S. Census Bureau, 2015 County Business Patterns, Table CB12000A13: Geography Area Series: County Business Patterns by Employment Size Case, obtained using American Fact Finder, data released April 20, 2017.

[31] Inflation rates calculated using the Consumer Price Index of the U.S. Bureau of Labor Statistics from March 2010 to April 2017: CPI-All Urban Consumers, U.S. city average, series ids: CUUR0000SA0, CUUR0000SEME, CUUR0000SAM2, and CUUR0000SEMD01.

[32] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, p. 6: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

[33] *National Federation of Independent Business v. Sebelius (NFIB v. Sebelius)*, 567 U.S.11-393, June 2012: https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[34] The Henry J. Kaiser Family Foundation keeps a running tab on Medicaid expansion: http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

With a broad interpretation of the ACA, some states were able to shift populations already covered by Medicaid to the "newly" covered population to take advantage of higher FMAPs, thereby shifting even more of the program cost onto the federal government.[35] In the short term, it appears to be a good financial deal for the states, but it is a lousy deal for the federal government, helping states balance their budgets but exacerbating its inability to balance its own budget. In the long-term, it will likely be a bad deal for the states as well because the current commitment of the federal government is likely to change, given the federal government's fiscal situation. In short, it is unsustainable.[36] The prospect for a federal rollback is very real, if not imminent.

Not only is focusing on the short-term financial benefit to the states myopic, it also ignores the broader impact of expanding the Medicaid program without undertaking reform. Significantly, because of the ACA, 32 states have expanded *the* government medical assistance program with the worst quality-of-care outcomes onto their poor populations. The problem of cost-shifting and price distortion in the health care system due to Medicaid is also exacerbated because Medicaid now covers a larger proportion of the population. Employers exempt from providing mandated health insurance that hire low-wage workers will be encouraged to dump their employees onto the system. The transition between Medicaid and private coverage is still clumsy for many low-income persons, but now more people will be subject to the clumsiness.

There is one positive aspect with Medicaid expansion—fewer uninsured. Undoubtedly, those individuals now covered by Medicaid are personally better off financially than if they had no insurance at all. However, this observation is not a sufficient justification for expansion because it falsely assumes that other options for covering these individuals were unavailable. It also ignores the potential of subjecting more individuals to welfare cliffs and marriage penalties that tear at the American social fabric.

Sadly, the numbers show that the success of the ACA in reducing the number of the uninsured is due to Medicaid expansion. Any gains in individual coverage were offset by those who lost insurance.[37] Worse, numerous Americans had to give up their plans to be replaced with more expensive plans because the ACA, contrary to its name, made many affordable plans illegal. This impact was fully anticipated by the White House at the time. When President Barack Obama was

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[35] For example, technical support by the State Health Reform Assistance Network provided a worksheet to help states determine the financial impact of Medicaid expansion that included in its recommended analysis "savings from transitioning current Medicaid populations to newly eligible group," enabling states to shift some of their current Medicaid costs to the federal government: Manatt Health Solutions, Center for Health Care Strategies (CHCS), and State Health Access Data Assistance Center (SHADAC), "Medicaid Expansion: Framing and Planning a Financial Impact Analysis," Issue Brief, State Health Reform Assistance Network: Charting the Road to Coverage, September 2012: http://www.statenetwork.org/wp-content/uploads/2014/11/State-Network-Medicaid-Expansion-Framing-and-Planning-a-Financial-Impact-Analysis.pdf.

[36] This risk is discussed more fully in a report studying expansion of Medicaid for the State of Maine when this author was the lead author and the lead developer of a financial model with risk analysis: The Alexander Group, *Feasibility of Medicaid Expansion under the Affordable Care Act: A Review Submitted to the Maine Department of Health and Human Services*, Revised Report, Monday June 30, 2014.

[37] Edmund F. Haislmaier and Drew Gonshorowski, "2014 Health Insurance Enrollment: Increase Due Almost Entirely to Medicaid Expansion," Backgrounder No. 2062, The Heritage Foundation, October 15, 2015: http://thf-reports.s3.amazonaws.com/2015/BG3062.pdf.

campaigning for the presidency and his reelection, his health policy experts were uncomfortable with the breadth of his claim: "if you like your health care plan, you can keep it."[38] However, his political advisors won out, and he successfully used the line during his campaigns.[39] The promise of lower premiums and deductibles[40] is not only unfilled but the opposite happened.

The ACA has simply failed to control costs. Congressional members could have anticipated this impact prior to its passage. In fact, Congress was warned about the potential of rising costs. PricewaterhouseCoopers (PwC) predicted health insurance premiums would increase more rapidly under the proposed bill in 2009. However, the findings of PwC were dismissed as the health insurance lobby attempting to scuttle the bill.[41]

One mind-boggling component of the ACA "cost saving" strategy is the revenue side of the act. The ACA relied on the dubious theory that raising taxes on the industry would contain costs. The usual approach is to lower costs for consumers by subsidizing the industry funded by taxing something other than the industry being subsidized or deriving the revenue from a general across-the-board tax. Given that the price elasticities of demand for health care products are extremely low, the burden of the tax will be borne by the consumer with increased prices and a relatively small drop off in quantity-demanded.[42] For example, imposing taxes on medical devices, such as heart pacers and wheelchairs, would only raise costs for consumers, not lower them. The tax is so unpopular that on December 18, 2015, President Obama signed into law a two-year moratorium on the tax until January 1, 2018.[43]

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[38] Politifact dubbed this line the lie of the year. Angie Drobnic Holan, "Lie of the Year: 'If you like your health care plan, you can keep it," Politifact, December 12, 2013: http://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it.

[39] Colleen McCain Nelson, Peter Nicholas and Carol E. Lee, "Aides Debated Obama Health-Care Coverage Promise: Behind the Scenes, White House Officials Worried About Insurance Pledge," *The Wall Street Journal*, November 2, 2013: https://www.wsj.com/articles/no-headline-available-1383336294.

[40] One of the architects of the ACA, economist Jonathan Gruber predicted in 2009 that by 2016 young people would save 13 percent and older people 31 percent. See Avik Roy, "How Obamacare Dramatically Increases the Cost of Insurance for Young Workers," The Apothecary, March 22, 2012: https://www.forbes.com/sites/theapothecary/2012/03/22/how-obamacare-dramatically-increases-the-cost-of-insurance-for-young-workers.

[41] PriceWaterhouseCoopers, "Potential Impact of Health Reform on the Cost of Private Health Insurance Coverage," October 2009: http://graphics8.nytimes.com/packages/flash/health/pdf/pwc_reporte_on_Costs_final_101109.pdf; Avik Roy, "How ObamaCare Dramatically Increases the Cost of Insurance for Young Workers," The Apothecary, *Forbes*, March 22, 2012: https://www.forbes.com/sites/theapothecary/2012/03/22/how-obamacare-dramatically-increases-the-cost-of-insurance-for-young-workersl; Cici Connolly, "Insurance Group Says Health Bill Will Mean Higher Premiums," *The Washington Post*, October 12, 2009: http://www.washingtonpost.com/wp-dyn/content/article/2009/10/11/AR2009101102207.html.

[42] A joint study by the U.S. Defense Department and the RAND Corporation found in its review of various studies on the price elasticities of demand in health care that these studies consistently showed them to be highly price inelastic centering around −0.17. See Jeanne S. Ringel, Susan D. Hosek Ben A. Vollaard, and Sergej Mahnovski, *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System*, National Defense Research Institute and RAND Health, 2005: https://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf

[43] Division Q Section 174, Consolidated Appropriations Act, 2016 (Public Law 114—113—December 18, 2015: https://www.congress.gov/114/plaws/publ113/PLAW-114publ113.pdf. See also Internal Revenue Service,

The 40 percent tax on "high-cost" employer health care plans, the so-called "Cadillac tax," is also a poor strategy. It is likely to be cost prohibitive for most purchasers, essentially making premium health insurance unavailable. If any premium plans would remain, perhaps because employers or labor unions truly desire to have them, they would become about 40 percent more expensive. This tax is especially costly to labor unions who had negotiated premium health insurance coverage for their members often in lieu of higher wages for their members. It is little wonder labor union leaders flocked to the White House in January 2010 to negotiate an exemption, but President Obama only granted them a temporary one.[44] Not only does labor opposition remain, but the Cadillac tax is also unpopular with employers.[45] Congress postponed implementation of this tax until January 1, 2020.[46]

The ACA directs the federal government to impose regulatory standards on what constitutes a health care plan. It must contain all the essential benefits as determined by federal bureaucrats. Insurers are prohibited from providing new plans to individuals who may want a cheaper plan that does not have all the regulatory elements.

Since implementation of the ACA, consumers in the individual markets on average had their insurance rates more than double.[47] Many found that their insurance plans were illegal under the new law, and the replacement plans were much higher in cost, causing some to forego coverage altogether.[48]

The ACA imposes a community rating on health care plans, stipulating that insurers cannot charge more than three times as much for its most expensive plan than its cheapest plan. The actuarial range is closer to one to six.[49] The impact of the constrictive mandated community rating is that the cost of health insurance went up for younger and healthier people whose real insurance costs are far less. The designers of the ACA recognized this problem but attempted to compensate by forcing younger, healthier Americans to purchase insurance under the mandatory

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"Medical Devise Excise Tax: Tax Law Change to the Medical Device Excise Tax:": https://www.irs.gov/uac/newsroom/medical-device-excise-tax, accessed June 8, 2017.

[44] "Labor's $60 Billion Payoff: a health tax that hits everyone except the Democratic base," Review & Outlook, *Wall Street Journal*, January 16, 2010: https://www.wsj.com/articles/SB10001424052748703657604575004992410621692.

[45] Reed Abelson, "Concern Grows on Health Tax," New York Times, July 22, 2015, page B1, also available online as "Health Care Tax Faces United Opposition From Labor and Employers:" https://www.nytimes.com/2015/07/22/business/labor-and-employers-join-in-opposition-to-a-health-care-tax.html, accessed June 8, 2017.

[46] Division P, Sec. 101, Consolidated Appropriations Act, 2016 (Public Law 114—113—December 18, 2015: https://www.congress.gov/114/plaws/publ113/PLAW-114publ113.pdf.

[47] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, "Individual Market Premium Changes: 2013-2015, *ASPE Data Point*, May 23, 2017: https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

[48] Lisa Myers and Hannah Rappleye, "Obama Administration Knew Millions Could Not Keep Their Health Insurance," NBC News, October 29, 2013: http://www.nbcnews.com/news/other/obama-administration-knew-millions-could-not-keep-their-health-insurance-f8C11485678.

[49] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, pp. 32: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

coverage provision or be subject to a penalty. In a controversial five-to-four decision, the Supreme Court ruled that the penalty is not a penalty at all, despite the language in the law,[50] but a constitutional tax under power to tax.[51]

The ACA is making it harder for smaller medical practices to survive, skewing the market structure to become more highly concentrated. Hospitals are merging and swallowing up doctor practices. Add higher market concentrations to the problem of opaque pricing, and the clear loser is the consumer.[52] Doctors, for example, are prohibited by the ACA from opening up new facilities, which would compete with hospitals.[53] These facilities typically provide high quality of care at prices far less than hospitals, but now new ones are outlawed by the ACA.

The ACA imposes a mandate on large employers to provide health insurance for their employees. All the problems already outlined on employer-provided health insurance are now enshrined in federal law because of the ACA, making third-party payers a government mandate. Insurers tailor their products to please the employer, not necessarily the individual. Many across the political spectrum agree that employer-provided health care system is not ideal,[54] but now the mandate makes very difficult, if not impossible, to transition to a consumer-directed system. Health savings plans were one way Congress sought to introduce consumer-directed health care into the industry to overcome some of the drawbacks of a third-party payment system. The ACA, however, severely limits these plans, reinforcing a preference for third-payer systems that give consumers less choice.[55]

Small employers—under 50 full-time employees—escape the employer mandate. Most businesses are small employers, accounting for 40 percent of all employment.[56] The ACA encourages businesses at the statutory threshold to hold the line on hiring to avoid the employer mandate. This behavioral response is understandable and not new. The number of business firms

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[50] The actual language in the law is as follows: "If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c)." 25 U.S. Code § 5000A: https://www.law.cornell.edu/uscode/text/26/5000A.

[51] *National Federation of Independent Business v. Sebelius (NFIB v. Sebelius)*, 567 U.S.11-393, June 2012: https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[52] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, pp. 81-83: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

[53] David Whelan, "ObamaCare's First Victim: Physician-Owned Specialty Hospitals," *Forbes*, April 5, 2010: https://www.forbes.com/sites/sciencebiz/2010/04/05/obamacares-first-victim-physician-owned-specialty-hospitals.

[54] Peter Ferrara, "The Economics of Replacing ObamaCare: The Good, The Bad, and the Ugly," *Forbes*, June 1, 2014: https://www.forbes.com/sites/peterferrara/2014/06/01/the-economics-of-replacing-obamacare-the-good-the-bad-and-the-ugly.

[55] *What Does Health Reform Mean for You? A Consumer's Guide*, National Center for Policy Analysis, July 27, 2010, pp. 41-42: http://www.ncpa.org/pub/what-does-health-care-reform-mean-for-you.

[56] U.S. Census Bureau, 2015 County Business Patterns, Table CB12000A13: Geography Area Series: County Business Patterns by Employment Size Case, obtained using American Fact Finder, data released April 20, 2017.

in France, for example, with 49 employees is 2.4 times higher than firms with 50 employees so they can avoid France's many labor regulations on businesses.[57]

The ACA solution for those not covered by their employer or by government programs is to route these individuals through health insurance exchanges (HIX). Only governmentally-approved products may be offered on the exchanges. The administrators of the exchanges predetermine eligibility for medical assistance programs, diverting individuals to programs like Medicaid and SCHIP. They are responsible for providing and completing Health Insurance Marketplace Statements, i.e., Form 1095-A, so individuals can prove to the I.R.S. that they had sufficient coverage during a year to avoid the "tax" penalty. They provide estimates and advancements on premium tax credits.[58]

In a free market system, consumers would not be forced to purchase products on a government-run exchange. They can go directly to the sellers. In a free market system, sellers are not required to sell through a government-controlled exchange. They may innovate, come up with new products, and allow customers to buy directly from them.

The premium tax credit is designed to help individuals above the federal poverty line but below 400 percent of the federal poverty line afford health care insurance. [59] However, the rising cost of insurance plus the limited selection of plans is undermining the system.

Insurers have been leaving the exchanges at alarming rates. In 2017, there were 218 insurers across all counties of all states compared to 395 insurers prior to the implementation of the exchanges. In 70 percent of all counties, consumers may choose from only one or two insurers. The number of insurers in Georgia dropped by more than half, from 11 prior to implementation to only five in 2017. As of January 30, 2017, insurers had monopolies in 96 Georgia counties and duopolies in 47 counties. Only 14 counties had three or more insurers participating in the exchanges.[60] Even more alarming, as of this writing, some areas in the country may have no insurers at all in 2018.[61]

The ACA has run into other problems—Including with subsidizing insurers for out-of-pocket costs, small business credits, and health co-ops—that are too numerous to explore here.[62] In

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[57] Gregory Viscusi and Mark Deen, "Why France Has So Many 49-Employee Companies: French companies stay small to escape stifling work rules," originally *BusinessWeek*, now *Bloomberg*, May 3, 2012: https://www.bloomberg.com/news/articles/2012-05-03/why-france-has-so-many-49-employee-companies.

[58] Bernadette Fernandez and Annie L. Mach, "Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)," R42663, Congressional Research Service, January 31, 2013: https://fas.org/sgp/crs/misc/R42663.pdf.

[59] Section 1401 of Public Laws 111-148 & 111-152 (26 U.S. Code § 36B);

[60] Edmund F. Haislmaier and Alyene Senger, "The 2017 Health Insurance Exchanges: Major Decrease in Competition and Choice," Issue Brief No. 4651, The Heritage Foundation, January 30, 2017: http://www.heritage.org/sites/default/files/2017-01/IB4651.pdf.

[61] Anna Wilde Mathews and Louise Radnofsky, "Two Washington State Counties Lack ACA Health Insurer for 2018," *The Wall Street Journal*, June 8, 2017: https://www.wsj.com/articles/two-washington-state-counties-lack-aca-health-insurer-for-2018-1496955152: Missouri, Ohio and Washington may have counties with no insurers in 2018.

[62] Robert Moffit, "Year Six of the Affordable Care Act: Obamacare's Mounting Problems," Backgrounder No. 3109, The Heritage Foundation, April 1, 2016: http://thf-reports.s3.amazonaws.com/2016/BG3109.pdf.

summary, the ACA did not improve the health insurance system in the United States. It made plans less affordable and the current problems of the system worse.

Flexibility for States to Go It Alone

Fortunately, the ACA includes a waiver that some call a super waiver,[63] giving states wide flexibility to design an alternative system. Section 1332 provides states the opportunity to apply for waivers of the following provisions:

- Qualified health plans [Part I of subtitle D of the ACA]
- Health insurance exchanges [Part II of subtitle D of the ACA]
- Out-of-pocket cost-sharing subsidies [Section 1402 of the ACA]
- Refundable tax credits for qualified health plans [Section 36 B of the IRS Code]
- Large employer mandate to provide health insurance [Section 4980 H of the IRS Code]
- Individual mandate to carry health insurance [Section 5000 A of the IRS Code].

Effective January 1, 2017, the ACA gave the HHS secretary the ability to set the time and manner of applications for waivers. The act specifies that a state must provide:

- A comprehensive description of its plan
- A 10-year budget that is revenue neutral for the federal government
- Assurance the state has enacted a law enabling them to implement the plan.

The waiver also allows for a pass-through of individual tax credits, small business tax credits, and cost-sharing subsidies under a state's plan. In other words, the law allows for *federal* funding in addition to giving states flexibility to redesign basic elements of a health insurance system. Specifically, states may modify the following: what constitutes a health plan, the insurance exchanges, the out-of-pocket subsidies, the refundable tax credits for individuals and small businesses, the mandate on large employers, and the mandate on individuals.

Thus far, four states submitted applications for Section 1332 waivers. None of the applications were for comprehensive reform. Approved on December 30, 2016, Hawaii's waiver exempts the state from operating the small business options program. Applying for the same exemption, Vermont's application is not yet approved. Alaska is seeking to establish a community health option and to allow for a federal pass through of tax credits. California withdrew its application on January 18, 2017.[64]

Although no state application has been thus far comprehensive, the door is still open for states to submit comprehensive reform applications. In fact, the Centers for Medicare and Medicaid Services (CMS) mentions on its website that states may submit the waiver in coordination with

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[63] See, for example, the Utah Health Policy Project (http://www.healthpolicyproject.org) memo on "Understanding the Section 1332 Option" (2013): http://www.healthpolicyproject.org/Publications_files/Medicaid/2013/13-06-Waiver%20Self%20Reliance%20Subgroup.pdf

[64] Documentation on the waiver applications and approvals is available online by the Centers for Medicare and Medicaid Services: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html.

Section 3021 and Section 1115 waivers for Medicaid and SCHIP.[65] The implication is clear: states may design an alternative approach for their entire non-elderly civilian population.[66] In summary, the ACA waiver provision allows a state to enact its own legislation to design a system that better serves its population, removing itself from the federalized solution. The alternative to the ACA may be combined with new ways to manage Medicaid and PeachCare.

Because it does not have ownership and has been openly critical of these programs, the new administration may be sympathetic to a state-grown solution relying more on market forces. Thus, even if Congress fails to replace the ACA, states can still experiment with developing and implementing improved systems.

The Best Solution: Consumer-Driven Health Care

Universal health insurance coverage and private markets are not incompatible.[67] For numerous industries across the American economy, evidence shows that competitive markets not only drive prices down, stimulate innovation, and improve quality but also make new and continuously improved products available and affordable for rich and poor households alike.[68]

There is no good reason why Americans cannot figure out how to harness the power of the markets to do the same for the health insurance industry. At the heart of the solution needs to be competition among suppliers and, as popularized by Regina Herzlinger of the Harvard Business School, a consumer-driven system.[69]

A consumer-driven system is broader than simply consumer-directed plans, such as health saving accounts. A consumer-driven system empowers the consumer and changes the focus of insurance marketing. Rather than focus on employers, insurers tailor products to individuals. A consumer-driven system also equalizes the tax disparity in how employer-based and individual health insurance products are treated, helping the other forty percent of the employed who are employed by firms with less than 50 employees. In essence, a true consumer-driven system will better serve families and individuals, bring costs under control, accelerate innovation, and improve quality. [70]

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[65] CMS, Section 1332: State Innovation Waivers: Frequently Asked Questions (FAQs), online, accessed May 25, 2017: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html.

[66] Medicare and veteran care are federal programs wholly outside state responsibility and not subject to any waiver provisions.

[67] Avik Roy, "A Conservative Case for Universal Coverage," *Washington Examiner*, January 17, 2014: http://www.washingtonexaminer.com/a-conservative-case-for-universal-coverage/article/2542091.

[68] W. Michael Cox and Richard Alm describe the advantages of free enterprise and how it benefits everyone in "Time Well Spent: The Declining Real Cost of Living in America," *1997 Annual Report*, Federal Reserve Bank of Dallas, pp. 2-24: https://www.dallasfed.org/assets/documents/fed/annual/1999/ar97.pdf.

[69] Regina Herzlinger, *Who Killed Health Care? America's $2 Trillion Medical Problem—And the Consumer Driven-Cure*, New York: McGraw-Hill, 2007, p. 16.

[70] Fuller explanations on the superior advantages of a consumer-driven health care system can be found in the writings of Regina Herzlinger of the Harvard Business School and Avik Roy of FREEOPP and opinion editor of *Forbes*. See, for example, Regina E. Herzlinger, ed., *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*, San Francisco: Jossey-Bass, A Wiley Imprint, 2004, and Regina Herzlinger, *Who Killed Health Care? America's $2 Trillion Medical Problem—and the Consumer-Driven Cure*, New York: McGraw-Hill, 2007.

A reasonable fear is that market-based solutions will neglect the poor and those with pre-existing conditions. Consequently, the task becomes designing a market-based system that (1) extends access to those who cannot afford it and (2) solves the problem of cream skimming with the least amount of disruption to the those benefitting from the market system. If these two issues are addressed—universal coverage and cream skimming—the issue of pre-existing conditions ceases to exist.[71] Thus, the critical questions become the following: how can a state plan help the poor afford quality health care without emasculating the system itself? How can risk be spread among insurers to avoid cream skimming and its opposite, adverse selection? And, importantly, how do we design the system to easily integrate with other welfare programs so there are no welfare cliffs and marriage penalties?

Because the distortions in the health insurance industry are so pervasive in America, the answers to these questions cannot be found in any one state. Fortunately, many of the principles have been successfully worked out—and continue to be worked out—abroad.[72] Switzerland, the Netherlands, Belgium, Germany, Israel, South Africa, and Singapore all offer important lessons.

Although it is beyond the scope of this proposal to give a full treatment of those systems, important lessons will be highlighted to establish a framework for reform that Georgia or any other state may adopt.

Among the countries mentioned, the Swiss experience perhaps offers the best lessons to solve the problem of universal coverage and pre-existing condition while harnessing the power of markets. The Swiss system is responsive to the consumer, achieves universal coverage, and produces high quality of care. Although a state may not want to adopt the system wholesale, and it may be inadvisable to do so, it can learn from the Swiss experience to design a program that makes sense given the characteristics of each state. In other words, states do not need to wait for the federal government to figure it out. They can and should push forward to retrofit those portions of the Swiss and other international systems that make sense to achieve success for their citizens.

See also the various writings of Avik Roy, including his The Apothecary blog, such as Avik Roy, "Why Switzerland Has the World's Best Health Cary System," *Forbes*, April 28, 2011, and Avik Roy, "Switzerland: A Case Study in Consumer-Driven Health Care," *Forbes*, December 26, 2012.

[71] Edmund Haislmaier, "Addressing Pre-Existing Conditions and Encouraging Continuous Coverage," Issue Brief No. 4685, The Heritage Foundation, April 18, 2017: http://www.heritage.org/sites/default/files/2017-04/IB4685.pdf.

[72] John Goodman, "An International Trend Toward Self-Directed Care," Health Affairs Blog, April 9, 2010: http://healthaffairs.org/blog/2010/04/09/an-international-trend-toward-self-directed-care; John C. Goodman, Linda Gorman, Devon Herrick, and Robert M. Sade, "Health Care Reform: Do Other Countries Have the Answers?" National Center for Policy Analysis, March 10, 2009: http://www.ncpa.org/pdfs/sp_Do_Other_Countries_Have_the_Answers.pdf ; Vidhya Alakeson, "International Developments in Self-Directed Care," *Issues in International Health Policy*, The Commonwealth Fund, February 2010: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Feb/1370_Alakeson_intl_devel_selfdirected_care_ib_v2.pdf.

In an article published by JAMA, a publication of the American Medical Association, Regina E. Herzlinger and Ramin Parsa-Parsi concluded the following about the Swiss system:

> Switzerland's consumer-driven health care system achieves universal insurance and high quality of care at significantly lower costs than the employer-based U.S. system and without the constrained resources that can characterize government-controlled systems.[73]

It is the Swiss consumers who select and buy their insurance plans. Their employers or the government may give them funds to buy insurance, but the consumers select their plans from insurers who market directly to them. The Swiss safety net consists of government subsidies to low-income consumers, based on income and asset tests, who purchase insurance the same way more affluent individuals do.[74]

The Swiss governments—both at the canton and national levels—are involved in supporting the health insurance industry but their involvement is primarily designed to harness the power of the market system. The important features of government involvement can be described as follows. First, the government requires everyone to have a compulsory, basic level of insurance. Second, the safety net consists of the government subsidizing individuals to purchase private insurance only at the basic level. Individuals are free to and most do purchase supplemental policies above that level from a vibrant market. Third, similar to the role played by the U.S. states, the Swiss national government ensures financial solvency of insurers. Fourth, and importantly, the government risk adjusts insurance plans. [75]

The risk adjustments are the ingenious Swiss solution to cream skimming and adverse selection. All insurers participate in a risk equalization fund administered by the federal government. The purpose is to eliminate cream skimming and adverse selection, while enforcing market competition. The method to achieve this outcome is based on actuarial science. Insurers with a disproportional share of lower-risk clientele for each predefined population subgroup pay into the fund while those with a disproportional share of higher-risk clientele receive payments from the fund. The design is intended not to equalize costs, which would benefit less efficient insurers, but to compensate insurers that selected clients with more costly health-care needs.[76]

Although consumer-driven health advocates praise the Swiss system, they still find ways it can be improved. Regina Herzlinger and Ramin Parsa-Parsi, for example, believe the Swiss inhibit the supply-side too much.[77] Also, Avik Roy believes the Swiss too heavily regulates the types of

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[73] Regina E. Herzlinger and Ramin Paras-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland," *JAMA*, Vol. 292, September 9, 2004, p. 1213.
[74] Regina E. Herzlinger and Ramin Paras-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland," *JAMA*, Vol. 292, September 9, 2004, p. 1214-1215.
[75] Regina E. Herzlinger and Ramin Paras-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland," *JAMA*, Vol. 292, September 9, 2004, pp. 1214-1216, and Konstantin Beck, Stefan Spycher, Alberto Holly, and Lucien Gardiol, "Risk Adjustment in Switzerland," *Health Policy*, Vol. 65, April 2002, pp. 63-74.
[76] Konstantin Beck, Stefan Spycher, Alberto Holly, and Lucien Gardiol, "Risk Adjustment in Switzerland," *Health Policy*, Vol. 65, April 2002, pp. 63-74.
[77] Regina E. Herzlinger and Ramin Paras-Parsi, "Consumer-Driven Health Care: Lessons from Switzerland," *JAMA*, Vol. 292, September 9, 2004, p. 1215.

health care services insurers must provide.[78] Even so, the fundamental point is the Swiss system proves it is possible to reach universal coverage using a consumer-directed system that relies heavily on market forces. It further provides lessons that can be used to set up a superior system that escapes the problems of nationalized, single-payer, and employer-based systems.

Sponsored by the Commonwealth Fund, five economists specializing in health policy from the Netherlands and Switzerland wrote an analysis of their systems to help the United States craft a more sensible health insurance policy. Both systems rely on private insurers, regulated markets, and achieve universal coverage. Probably not coincidentally, both countries are among those with the highest life expectancies. In fact, Switzerland has the world's second highest. [79]
Shared features include:

- A requirement that individuals have basic health insurance
- Very low percentage of the population uninsured (less than 1 percent for Switzerland)
- A high percentage of the population that also purchases supplemental coverage
- The right for insured individuals to switch plans during open enrollment periods
- Robust market competition (although market concentration is higher in the Netherlands)
- A mandate that insurers accept all applicants
- Risk spreading among insurers through risk equalization schemes
- And more [80]

Switzerland differs from the Netherlands in several ways: it prohibits insurers from offering collective or group plans and requires that insurers offering basic plans must be non-profit.[81]

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[78] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, p. 22: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

[79] Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets* Pub. No. 1220, , Commonwealth Fund, January 2009, see Table 2 starting on page 20:. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf. See also Avik Roy, "Why Switzerland Has the World's Best Health Cary System," *Forbes*, April 28, 2011.

[80] Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, Pub. No. 1220, Commonwealth Fund,January 2009. See Table 2 starting on page 20: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf

[81] Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, Pub. No. 1220, Commonwealth Fund, January 2009: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf.

Vision for a Market-Based Health Insurance Industry for Georgia

Before we can discuss the framework for how Georgia or any state can transition to a vibrant, cohesive, and regulated market system for health care, it is necessary to lay out a vision of what the ideal system will look like. This proposed vision will focus on the civilian, nonelderly population.[82]

In this ideal system, health insurance will be contracted directly with individuals as opposed to employers, eliminating the major problems of an employer-provided system. However, employers may contribute to their employees' plans as part of compensation packages, enabling the employers to take advantage of favorable federal tax treatment as well as offer compensation packages to attract employees. Although it is desirable and expected that employers will contribute to their employees' plans, there will be no government mandate requiring them to do so.

Although favorable tax treatment of the federal government is beyond what Georgia can control, it is recommended policy that favorable tax treatment for employers for health care must also be provided to individuals and the self-employed.

Switching to an individually-contracted system solves the problem of portability. Georgia policy already recognizes its importance. Georgia has adopted a Money Follows the Person (MFP) Project for long-term care recipients of Medicaid. The proposal here is to extend this concept to the health insurance industry.

By regulation, Georgia will define a basic plan that sets minimum coverage everyone should have. The basic plan will cover only essential benefits as determined by the state of Georgia, not the federal government. The overriding goal is a basic plan with no frills for persons who cannot afford to purchase insurance and are currently covered by Low-Income Medicaid. However, the basic plan will likely differ from the current benefits package of Low-Income Medicaid because Georgia will be freed from federal requirements.

The new system will not have a mandate that individuals must have coverage nor will it penalize individuals who fail to obtain coverage as the ACA does. Instead, it will rely on a public information campaign, lower rates to entice individuals to obtain coverage, and smart design parameters of the insurance products themselves.

Individual mandates are intended to solve two principal problems. First, there is the free-rider problem, where individuals may choose not to have coverage until they know they need a procedure. They secure coverage to undergo the procedure only to cancel their coverage after the procedure. The second principal problem is that healthier, usually younger, individuals may choose no coverage. Because their actuarial costs are less than the general population's actuarial

[82] Although this proposed vision is limited to the nonelderly, civilian population, successful implementation may lead to Medicare reform. See Part Four of Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, 2016.

costs, their choice to not be covered drives up the cost for the remaining population. This is the adverse selection problem that is partly to blame for driving up costs in the ACA exchanges.

The latter problem will be solved by the redesign of the system because the young will no longer compete with older individuals for insurance rates, which is explained fully below. The free-rider problem is trickier to solve, and Georgia will rely on a combination of strategies.

Foremost, it is absolutely necessary that the costs of basic plans remain low. Working with market forces instead of against them, Georgia can positively influence costs. First, it must be careful in defining what constitutes a basic plan. The more benefits mandated by the plan, the higher the cost will be. Therefore, the regulatory panel charged with defining basic plans must be carefully instructed that one of its chief objectives is universal coverage through low prices.

Second, Georgia can impact prices by borrowing from the Swiss system an approach that splits insurance prices into age and gender cells. The Swiss have fifteen age groups for each gender, constituting thirty different cells. Each cell is community rated, meaning it reflects the actuarial cost of all individuals within that cell.[83] Therefore, pricing for younger, healthier individuals are not adversely impacted by older, less healthy age brackets. This approach solves one of the deficiencies with the ACA that imposes a community-rated ratio of one to three, meaning that the most expensive plan cannot be more than three times that of the cheapest plan, which forces young people, who often are not financially established, to pay far more than their true actuarial costs.[84]

Georgia can adopt smart regulations to encourage individuals to obtain and retain insurance. For example, Georgia may require that insurance plans are automatically renewed unless individuals opt out, that the terms of the insurance may be no shorter than to the next enrollment period, and that if individuals cancel without having obtained alternative coverage, they must pay an exit fee. The combination of these requirements encourages individuals to retain coverage.

Finally, there needs to be a public information campaign on the benefits of obtaining coverage. When insurance rates are affordable, and when subsidies for the poor are readily available, it should be easy to persuade individuals on the benefits of having coverage. The campaign can appeal to a person's sense of civic duty to have coverage in addition to a person's self-interest.

While the basic plans will be regulated, the health insurance industry will be much larger, consisting of many supplemental plans and options that are relatively unregulated. Other than certification for actuarial soundness by the Department of Insurance, insurers will be free to offer

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[83] Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, Pub. No. 1220, Commonwealth Fund, January 2009., p. 15: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf.

[84] Avik Roy, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*, The Foundation for Research on Equal Opportunity, Second Edition, 2016, p. 32: https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view.

supplemental plans that add onto and exceed the benefits package of the basic plans. Based on international experience, i.e., the Swiss and Dutch systems, most individuals will purchase supplemental plans.[85]

Individuals will be free to switch plans any time during the year, but insurers offering basic plans must accept any applicant during defined semiannual open enrollment periods at the community-rated price. This does not mean that the government sets these prices. It means that the insurer must offer the same price to everyone in each cell. This provision helps stimulate competition among insurers but also solves the exclusion of persons with pre-existing conditions by requiring acceptance of applicants.

To compensate insurers who end up with statistically higher-risk clients for their cells because of the acceptance requirement, Georgia will create a risk equalization fund. It will be designed to measure differences in risks for each cell—perhaps a blend of the Swiss and Dutch systems to start, recognizing that the methodology will be tweaked as Georgia gains experience in managing the fund. Those insurers with low-risk clients will be assessed a fee to contribute to the fund while insurers with higher risk clients will be compensated by the fund. The fund will be self-sustaining through insurer risk equalization fees; i.e., no general tax revenue will support the fund. The purpose of the fund will be to eliminate the problems of cream skimming and adverse selection. It will further create incentives to innovate, develop, and offer products to higher-risk populations.

Insurers will be free to market their products directly to consumers, eliminating the need to participate in any health insurance exchange. However, consistent with current practice, insurers will be allowed to offer only products reviewed by the Georgia Department of Insurance for actuarial soundness. Consumers, of course, will be free to visit any insurer to purchase or switch carriers.

The brilliance of the risk equalization scheme is that insurers can spread the risk across a large swath of the population for each defined cell. Even if Georgia is divided into insurance rating regions, such as the sixteen regions under the ACA, it still provides a large population base for each cell to spread the risk. Contrast this system with an employer-provided approach that gives an advantage to the largest firms that can spread risk over a larger employee base.

The various medical assistance programs—Medicaid, PeachCare, and the ACA HIX subsidies—will be streamlined into a single program, thus addressing the current problem of dividing family members into different programs. This single program will help low-income persons afford private health insurance, and it will be administered through the Department of Human Services as part of welfare reform. All funds supporting Low-Income Medicaid and PeachCare will be

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[85] Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, Pub. No. 1220, Commonwealth Fund, January 2009., p. viii: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Jan/The%20Swiss%20and%20Dutch%20Health%20Insurance%20Systems%20%20Universal%20Coverage%20and%20Regulated%20Competitive%20Insurance/Leu_swissdutchhltinssystems_1220%20pdf.pdf.

transferred to the Department of Human Services to be administered as part of the single program in a manner that avoids welfare cliffs and marriage penalties. Additionally, Georgia will apply for and receive a Section 1332 waiver, absent receiving greater flexibility from Congress, allowing a pass-through of the out-of-pocket subsidies and tax credits into this single subsidy program.

Medicaid also funds long-term care, i.e., nursery home care, and special needs for persons with developmental disabilities. This proposal excludes funds for these Medicaid programs. Medicaid for the Aged, Blind and Disabled will be reconfigured to allow these individuals to purchase supplemental insurance.

Georgia currently utilizes private Care Management Organizations (CMOs) for its medical assistance programs. Under the current arrangement, Georgians who qualify for Medicaid may choose among four CMOs that have contracted with the state.[86] These CMOs currently receive a fee directly from the state on a per member per month basis known as capitation payments.

Under the new arrangement, recipients may select any insurance plan approved by the Department of Insurance, and there will be no need for any provider to contract directly with the state. Recipients will be free to shop around and will be responsible for any costs above their subsidies, and they may switch plans to save money or gain additional benefits.

Under the proposed plan, because the insurance policy is contracted with individuals and based on community-rated cells, it will follow the person, no matter if they change jobs or no longer qualify for government subsidies. They may retain their policy, or, as always, select different ones. The streamlined program will allow continuity in care without the need to change assistance programs as a person may "age out" or as income levels change.

In the end, the civilian non-elderly population will be covered by private insurance. Portability will be achieved because plans are contracted directly with individuals. Employers contribute to employee plans, not the other way around. The problems of pre-existing conditions and adverse selection are solved because of the Swiss design using community ratings by risk cell in combination with a risk equalization scheme for insurers on the back end that is invisible to consumers. The Swiss design also promotes innovation among insurers to develop products for those with higher health risk, helping these individuals receive the special care they need. The poor are protected because they will receive subsidies through the welfare system to help them purchase their insurance in the private market. These subsidies will taper off based on the cliff engine; that is, they will have no embedded work disincentives and no marriage penalties. Once subsidies end, those who had received them may elect to have the same insurance coverage because the basic plans are the same for everyone. The industry will offer supplemental plans with more benefits and frills, and most people will likely elect to purchase supplemental plans.

Price and nonprice competition among insurers will develop innovative products that enhance quality, target groups with special needs, promote efficiency, and help control prices. The

[86] Georgia Department of Community Health, *Care Management Organizations (CMO)*, online information page, accessed June 7, 2017: https://dch.georgia.gov/care-management-organizations-cmo.

combination of the preceding attributes along with smart regulations and a public information campaign will achieve near universal coverage.

Framework for Transitioning to the Vision

Federal waivers wisely require states to have thought-out plans. This requirement necessitates that states think through the details, formulate plans, and pass legislation enabling the changes. Therefore, it is necessary to set up a politically-endorsed structure utilizing community resources to work out the details to move Georgia to a more rational health insurance system, i.e., the vision described in the prior section.

In this regard, Georgia should establish its own administrative organization to regulate the health care insurance industry as a sensible, integrated system. Legislation will need to define the responsibilities for the various parts, clearly establishing the duties of each state agency.

Either directed by the legislature or on his own executive authority, the governor should create an ad-hoc commission for the sole purpose of developing a comprehensive and feasible plan to accomplish the vision. The commission will be responsible for developing all the pieces necessary to allow Georgia to transition to the vision.

More specifically, the commission will act as a steering committee, directing the progress of several task forces, or panels, charged with solving specific issues using accepted project management techniques. The commission will actively oversee and facilitate coordination among the task forces. Each panel will be assigned to develop a comprehensive plan that will include a description of how the system will operate, defined agency roles, and a timeline with benchmarks to transition to the vision. Additionally, each panel will be tasked with preparing draft legislation and, if necessary, draft waiver applications.

The commission will be responsible for combining all plans into a coherent single document with draft legislation and waiver applications as attachments. Upon approval by the governor, the plan will be submitted to the legislature for enactment.

During the process, the commission will have the power to create new task forces, reassign them, merge them, or eliminate them. To start the process, the following panels are recommended.

- Basic insurance plan
- Insurance cells and risk equalization fund
- Smart regulation strategy
- Conversion from an employer-provided system to an individually-contracted system
- Single medical assistance program

The basic insurance task force will define what benefits constitute the basic plan that everyone should have. It will need to balance the necessary components of the safety net with keeping the plans affordable. It will also determine which state agencies should be charged with controlling and monitoring the definition.

Basic insurance is central to reform. This step is similar to the ACA's essential health benefits, but it will be under the control of Georgia as opposed to bureaucrats in Washington, D.C. For the

reform to work well, the basic plans will be more narrowly and reasonably defined, recognizing that insurers will be offering supplemental plans. In general, the benefits will cover services and pharmaceuticals for wellness visits, emergencies, and catastrophic illnesses for an average, nondisabled person. This will be a basic plan that everyone should have. The task force may also provide variations on basic plans depending on age and gender.

The insurance cell and risk equalization fund task force is also central to the reform. Based on actuarial science, this task force will recommend the number of insurance cells and the factors that determine those cells. Additionally, they will develop the formula to be used for risk equalization and make recommendations on how the Department of Insurance, which is part of the Office of Insurance and Safety Fire Commissioner, will be administratively structured to handle this new assignment. The panel will need to investigate systems of foreign nations, especially Switzerland and the Netherlands, to help it make its determination. In addition, panel members will be expected to make personal interviews and be familiar with literature on the topic.

This task force will need to understand the purpose of the fund is to solve the problem of cream skimming and adverse selection. No general revenue from taxpayers will be sunk into the fund. Instead, all revenue will come from fee assessments on insurers who fall below the actuarially-determined risk level for each cell. These fees must sustain the system in equalizing risk for insurers who acquired higher-risk clientele for identical cells.

Additionally, in devising the system, the task force will establish program metrics to measure effectiveness to avoid inadvertently creating a cost-adjustment scheme instead of a true risk-adjustment scheme. There will need to be periodic review, and the Department of Insurance will need the power to tweak the methodology from time to time to fine-tune the effectiveness.

Finally, the task force will need to determine a fee assessment structure to jumpstart the process. One possibility would be to assess insurers initially as they enroll clients, and then to implement a true-up system after risk differences are determined. In this regard, investigation of the Swiss, Dutch, and other systems may prove critical.

The purpose of the smart regulation task force will be to devise a strategy to entice individuals to obtain and retain coverage. It will consider requirements for insurance plans, such as exit fees for cancellation of a policy if the person does not have an alternative plan. Additionally, it will produce an outline for a public information campaign.

The purpose of the conversion task force will be to think through the process and issues involved in moving from an employer-provided system to an individually-contracted system where employees, the self-employed, and individuals may purchase insurance. Insurers need to be given a timeframe over a long horizon when policies must be converted to an individually-contracted market. As policies flip, employers will then contribute to employee plans.

Additionally, employer plans will likely exceed requirements for basic insurance plans.

The last task force will be also a crucial component of the plan. It will develop a plan for a single medical assistance program to be administered by the Department of Human Services. It will recommend levels of support and the tapering of benefits by requiring cost sharing as income of the recipient increases. The maximum level of subsidy shall be equal to the cost of the basic plan when an individual has no income. The tapering of benefits will be necessary to avoid welfare cliffs, and the subsidies must be designed to avoid marriage penalties. This task force will prepare draft legislation and applications for federal waivers to implement the change.

The single medical assistance task force will also explore and make recommendations on the important topic of how the Medicaid program for the aged, blind, and disabled will be reconfigured to allow the purchase of supplemental insurance for these individuals.

This task force can also be commissioned by itself, i.e., without a complete health insurance industry overhaul. In this case, it will still make recommendations for streamlining the three medical assistance programs into a single program by utilizing federal waivers, which shall include an overall plan for cost sharing. Recommendations will likely include expanding participation beyond the three CMOs and allow unfettered shopping by participants of any insurer offering an actuarially-approved basic plan. The consolidated subsidy program will have similar tapering and structure as with the broader reform. However, unlike the task force with the broader reform, this task force would have the additional responsibility of reviewing current benefit packages offered by the assistance program with many of the same parameters of the basic insurance plan task force.

Conclusion

In the interest of their citizenry, states should undertake health insurance reform and revamp their medical assistance programs. To state it bluntly, the current health insurance system in the United States is a mess. It is a strange mix of an employer-provided system and government single-payer systems that together create economic distortions impacting the remaining industry for individuals and small businesses.

Recent federal attempts to improve the system, i.e., the ACA, only exacerbated the problems. It reinforced the inequities and drawbacks of the employer-provided system, relied on the expansion of a government program with the worst quality-of-care outcomes, i.e., Medicaid, and its scheme for health insurance exchanges is on the verge of implosion as prices climb and insurers cease to participate. The principal aims of the ACA, i.e., affordability and universal coverage, have not come anywhere near to being achieved.

Even before the ACA, states were responsible for overseeing the health insurance industry. Even without additional flexibility from Congress, states may use waiver provisions in the ACA and in the Social Security Act for Medicaid and SCHIP to reconfigure significant portions of their health insurance industry and medical assistance programs. These provisions—along with an administration sympathetic to change—provide states opportunities to undertake much needed comprehensive reform.

To avoid welfare cliffs and marriage penalties, reform of medical assistance programs needs to be integrated with broader welfare system. These reforms can be undertaken without broader health insurance reform, but it would be far better if the two are coordinated and pursued simultaneously.

Moreover, medical assistance programs cannot be designed to work in contradiction to a healthy, vibrant competitive market. The more medical assistance programs look like products found in the private marketplace, the less likely they will interfere with innovation, consumer choice, and market pricing. For these reasons, it is important to pursue the broader health insurance reform in concert with medical assistance programs reforms.

Although no state in the union provides an example of how to reconfigure the health insurance industry, lessons from overseas provide important clues that can help states develop plans to reform their systems. Risk equalization funds, such as those deployed by the Swiss system, are ingenious ways to tap the superior advantages of private markets to deliver health insurance while attaining universal coverage and solving the problems of cream skimming and adverse selection.

This proposal presents a vision for Georgia to move to a vibrant health insurance industry that will achieve near-universal coverage and solve the problems of pre-existing conditions, cream skimming, and adverse selection. It will help the poor acquire private insurance without the trappings of current programs. It relies to the greatest extent possible on market forces to deliver affordable insurance within a regulatory framework. It moves from the problematic employer-provided system to one where individuals contract directly with insurers. The state of Georgia, not the federal government, defines a basic insurance plan as a minimum for every citizen. Poor individuals receive subsidies to contract directly with private insurers for a basic insurance plan.

It requires insurers to accept all applicants for basic plans during enrollment periods regardless of pre-existing conditions based on sensible community ratings but compensates insurers by deploying a Swiss-like system of equalizing risks. Young, healthier individuals are not stuck with insurance costs far above their actuarial costs, as with the ACA. There is no individual mandate, but individuals are enticed to obtain coverage by the combination of low prices, smart regulation, and a public information campaign. Health insurance attains portability and follows the person regardless of change in employment or government assistance.

Either by legislative directive or upon his own executive authority, the Georgia governor should create a commission to develop a plan to reform the state's health insurance industry and streamline medical assistance programs pursuant to this vision. The plan will provide a roadmap to convert to the vision, and the task forces of the commission will prepare critical pieces of the plans, timetables, draft legislation, and draft waiver applications pursuant to federal law.

Since the dawn of the industrial revolution, America led and still leads the world in inventions and innovation across many industries because governmental policies relied on entrepreneurship and free markets. Except for a lack of political will and cohesiveness, there is no reason why states and the federal government cannot figure out a way to harness entrepreneurship and market power to attain universal coverage of health care, lower its costs, and continue to enhance

its quality. Single-payer systems and government-run systems may superficially achieve universal coverage but at a cost to quality and innovation. A market-based, consumer driven system dovetailed with a functional and empowering safety-net program and administered by the states offers the best hope for achieving a truly responsive and innovative system that attains near-universal coverage.

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