Age-Based Defined Contribution Healthcare Reform: A Comprehensive Analysis

Introduction

The United States health financing landscape is characterized by a patchwork of systems – employer-sponsored insurance (ESI), the Affordable Care Act (ACA) marketplace, Medicare, Medicaid, and CHIP – each with distinct funding mechanisms. A recently proposed reform blueprint envisions replacing this complex status quo with a unified, **age-based defined contribution** system. Under this proposal, the government would provide **universal age-adjusted health care tax credits** (a fixed contribution by age group) that individuals can use to purchase high-deductible health plans paired with medical savings accounts (MSAs) or health savings accounts (HSAs). The model is explicitly inspired by the existing Medicare Medical Savings Account (MSA) option in Medicare Advantage, leveraging its structure of **upfront contributions to an HSA-like account, portable coverage, and catastrophic protection** after a high deductible

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. The proponents argue that this defined contribution approach would increase personal control and responsibility, intensify market competition among insurers, and impose fiscal discipline by capping public subsidies at a set amount per person – principles aligned with longstanding conservative goals of **individual choice, market-based solutions, and budget sustainability**.

This analysis provides a thorough examination of the proposal's core structure and mechanisms, comparisons with current U.S. healthcare financing systems, evaluation of the projected fiscal impacts (including claims of reducing federal health spending from ~$2.0 trillion to ~$1.4 trillion annually), and exploration of broader economic implications such as labor market effects and competitiveness. We also assess feasibility and transition challenges and offer evidence-based recommendations to bolster the plan's sustainability, equity, and efficiency. Charts and tables are included to clarify key points.

Core Structure of the Proposed Plan

Defined Contributions via Universal Age-Based Tax Credits: At the heart of the reform is a shift from "defined benefit" commitments to a **"defined contribution" model**. Instead of open-ended government or employer subsidies that guarantee a package of health benefits, the plan proposes a fixed **refundable tax credit for health coverage, determined by age group**. Every American would be allotted an annual credit to obtain private insurance, with older individuals receiving a larger contribution to reflect higher expected health costs. Table 1 summarizes the proposed government contributions by age band, alongside the average per-capita healthcare spending for each group under current systems:

Age Group (years)	Proposed Govt. Contribution per Person (Annual)	Current Avg. Health Spending per Person (Annual)
0 – 19	$7,000 msa-medicare.com	~$3,300 msa-medicare.com
20 – 49	$7,500 msa-medicare.com	~$4,400 msa-medicare.com
50 – 64	$12,000 msa-medicare.com	~$9,500 msa-medicare.com
65 – 84	$14,000 msa-medicare.com	~$16,000 msa-medicare.com
85+	$15,000 msa-medicare.com	~$32,000 msa-medicare.com

Table 1: Proposed age-based health care tax credits (defined contribution) vs. current average annual health costs by age group. Younger enrollees would receive smaller credits, while older Americans receive larger credits, reflecting their higher expected medical expenses.

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These credits could be structured as advanceable, refundable tax credits (meaning even those with little or no tax liability receive the full amount), effectively functioning as a universal voucher for health insurance. Importantly, the credit amounts are **flat within each age bracket**, not adjusted by income or health status – a deliberate simplification to promote universality and transparency. Over time, the plan envisions these **age-based contributions "eliminating and replacing all other government and employer defined benefit programs"**

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, thereby unifying Americans under one financing system.

Integration with High-Deductible Health Plans and MSAs/HSAs: The proposal leverages the **Medicare MSA model as a template** for how coverage would work. Under this model (currently available in Medicare Advantage on a limited basis), an individual enrolls in a private **high-deductible health plan (HDHP)**. **The insurer receives a fixed annual payment on the person's behalf** – in Medicare's case, from the federal government – and in turn the insurer **deposits a portion of that payment into the enrollee's medical savings account**. The remaining amount funds the insurance coverage, which kicks in only after the enrollee meets a high annual deductible. For example, in today's Medicare MSA plans, Medicare pays private insurers roughly $13,000 per beneficiary on average, the insurer might set a $5,000 deductible and deposit about $2,000 into the senior's MSA, and then the plan covers 100% of Medicare-approved expenses after the deductible is met

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. Any unused MSA funds roll over year to year, allowing balances to accumulate. This structure encourages enrollees to spend judiciously since **unspent funds remain their property** (growing tax-free if invested), promoting personal responsibility for routine healthcare spending.

The reform proposal extends this concept to **all age groups**. Every American could use their age-based credit to enroll in an MSA-type insurance plan in the **individual market**, regardless of employment or income. The insurer would be required to deposit a fixed portion of the government's contribution into the person's **HSA/MSA** each year (the blueprint suggests about $2,000 and a deductible around $5,000, mirroring the Medicare MSA example)

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. For instance, a working-age adult might apply their $7,500 credit to purchase an HDHP; the insurer might deposit $2,000 into the enrollee's HSA and set a $5,000 deductible, leaving roughly $500 to cover administrative costs and risk margin. If the enrollee incurs healthcare expenses, they first pay using their HSA funds (and any out-of-pocket beyond that) up to $5,000; beyond that the insurance pays 100% of covered costs for the rest of the year. If the enrollee has few expenses, the entire $2,000 (minus any spending) stays in their account to grow. This approach effectively **ports the consumer-driven health plan model to a national scale**, giving individuals control over routine spending and creating a nest egg for future medical needs. Proponents highlight that over decades, younger people who consistently spend less than the allowance could **"build significant wealth over their lifetime of savings"** in their HSAs
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– funds that could later offset higher costs in old age.

Portability and Individual Choice: Because the credits are tied to individuals rather than jobs or specific government programs, coverage becomes fully **portable**. An individual can maintain continuous insurance even when changing employers, moving across states, or transitioning between life stages (e.g. aging out of parental coverage, retirement before Medicare age, etc.). The insurance policy is **owned by the individual**, not by an employer or tied to Medicaid eligibility. This portability aims to remove the "job lock" problem where employees feel stuck in a job for fear of losing health benefits. Under the proposal, someone leaving a job to start a business or moving gig-to-gig would take their credit and coverage with them seamlessly. They could choose among competing private plans in a marketplace, rather than being limited to an employer-selected plan or a patchwork of state programs. This **market competition** is expected to increase, as insurers would compete for millions of individual customers armed with credits, rather than predominantly negotiating with large employers or operating within government-set provider networks.

Use of Medicare MSA as a Structural Foundation: The Medicare MSA program (part of Medicare Advantage) is cited as the "blueprint" for this reform

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. In effect, the plan would transform Medicare's demonstration into the default for not only Medicare beneficiaries but for Americans of all ages. The choice of the MSA model is significant – it's a **defined-contribution, private plan alternative within Medicare** that has existed for over a decade (permanently authorized by the Medicare Modernization Act of 2003). The reform would replicate its features: **government-paid premium to a private plan, high deductible coverage, personal savings account for each enrollee, and year-to-year rollover of unspent funds**
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. By using a model already approved and regulated by the Centers for Medicare & Medicaid Services (CMS), the proposal signals feasibility: "The MSA in Medicare is the blueprint for just such a paradigm shift in how we finance our healthcare system"
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. It suggests scaling up what is currently an option for a few thousand Medicare enrollees into a nationwide framework. While today Medicare MSAs have limitations (for example, they currently **do not include drug coverage** and have seen limited uptake)
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, the reform blueprint acknowledges these and suggests enhancements (such as **allowing MSA plans to include prescription drug coverage** so that medication costs – roughly $388 billion annually – are factored in)
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In summary, the core structure of this proposal is a **universal, age-adjusted health insurance stipend** that individuals direct to the private plan of their choice, coupling a **catastrophic insurance layer with a personal health savings account**. The intent is to preserve **universal access** to coverage (through the public funding of the credit) while harnessing **market efficiency and personal savings incentives** to drive down costs. The next sections compare how this model contrasts with current major healthcare financing systems in the U.S.

Comparison to Current U.S. Healthcare Systems

The proposed age-based defined contribution system would fundamentally alter the financing and delivery of health insurance relative to today's programs. Below, we compare key features of the proposal to the major existing systems: Employer-Sponsored Insurance, the ACA

marketplace for individuals, Medicare (traditional and Medicare Advantage), and Medicaid/CHIP.

Employer-Sponsored Insurance (ESI)

Current ESI System: Employer-sponsored insurance is currently the dominant source of coverage for Americans under 65, covering about **159–165 million people** (roughly 54–60% of the U.S. population)

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. Under ESI, employers typically select one or more group health plans and pay a substantial portion of the premium, with employees paying the remainder. A crucial feature is the **tax exclusion for employer health contributions**: the money employers spend on health benefits is not counted as taxable income for employees, which amounted to an implicit federal subsidy of about **$280 billion in 2021**
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. While ESI pools risk within a workforce and often offers comprehensive benefits, it is **tied to employment**; losing or changing jobs can mean losing coverage. This linkage has led to "job lock," where workers stay in jobs mainly to keep insurance. Research shows that dependence on employer coverage can reduce labor mobility by an estimated **20–40%** – workers are significantly less likely to change jobs or start businesses due to fear of losing health benefits
journals.sagepub.com

npr.org
. Additionally, ESI places a cost burden on businesses: corporate leaders have long complained about healthcare expenses making their products less competitive internationally. For example, General Motors famously noted that health costs add $1,500–$2,000 to the cost of every car they manufacture
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, potentially pricing their products higher than foreign competitors whose workers are covered by national health systems.

Defined Contribution Proposal vs ESI: The proposed reform would effectively **decouple insurance from employment**. Instead of employers providing a defined benefit (insurance plan), every individual would receive their own defined contribution (tax credit) to buy a plan. This means an employee could choose a plan on the open market using their credit, rather than being limited to their employer's offerings. **Portability** is a key advantage: coverage continues uninterrupted when someone leaves a job, since it's not employer-dependent. This could dramatically reduce job lock and improve labor market fluidity – exactly the kind of effect seen when alternative coverage options become available. (Indeed, economists at the Kauffman Foundation estimated that making individual insurance more accessible and affordable, as the

ACA did, might increase self-employment and entrepreneurship by as much as **one-third** by "unlocking" would-be entrepreneurs

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.) With the reform, starting a business or switching jobs would no longer mean risking one's healthcare coverage or facing exorbitant COBRA premiums; the tax credit travels with the person.

For employers, removing the responsibility of managing health benefits could relieve them of a major financial and administrative burden. Businesses might redirect the money currently spent on health premiums into higher wages or other benefits (though in economic terms, total compensation might remain the same, reallocating the health benefit portion into cash wages over time)

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. The **tax exclusion for ESI would likely be eliminated** in this plan (since the government would instead channel those funds into the universal credits). This creates a more level tax treatment – currently, those with ESI get a large tax break, whereas individuals buying their own insurance do not. The reform's universal credit essentially replaces that uneven tax subsidy with an even allocation to all. Some employers may still choose to contribute to employees' healthcare (for example, by funding an HSA for the employee or "topping up" the government credit), but it would be voluntary and outside of the tax exclusion framework.

One important difference is choice and risk-pooling. In ESI, healthy and sick employees are pooled together in a group, and the employer often self-insures or negotiates premiums based on the group's experience. In the individual market with universal credits, **risk pooling shifts to insurers in the open market and potentially to the entire population** (if the insurer must accept all applicants community-rated by age). Individuals would have a wide array of plans to choose from, rather than a one-size-fits-all plan from their employer. This could increase competition and customization, but also means individuals bear the responsibility to select adequate coverage. Employers today often play a role in curating plan options; under the reform, that role diminishes, and third-party exchanges or brokers might fill the advisory gap.

In summary, relative to ESI, the proposal enhances **portability and individual choice**, removes the implicit tax favoritism for employer plans in favor of a universal benefit, and could improve **labor mobility and entrepreneurship** by freeing workers from benefit-dependent employment

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. It shifts the health benefit from an employer-managed good to an individually owned financial contribution, aligning with a market-driven, consumer-centric philosophy.

Affordable Care Act (ACA) Marketplace (Individual Insurance)

Current ACA System: The ACA exchanges (Marketplaces) provide insurance options for individuals who don't get coverage through jobs or public programs. Premiums in this market are **community-rated (adjusted only for age, location, and smoking status)** and insurers must accept all applicants regardless of pre-existing conditions (guaranteed issue). To make coverage affordable, the ACA provides **income-based premium tax credits** for people earning up to 400% of the federal poverty level (FPL) – recently expanded temporarily to higher incomes – and **cost-sharing reductions** for lower-income enrollees. The credits are inversely related to income (lower income = larger subsidy) and also tied to the premium of a benchmark plan in one's area. About **16 million people** obtain coverage through ACA marketplaces as of 2023

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. The ACA also imposed regulations like essential health benefits and limits on premium variation by age (older adults can be charged no more than 3x young adults for the same plan).

Defined Contribution Proposal vs ACA: The proposed reform's credits are **age-based rather than income-based** and would be available to everyone regardless of income. This is a major departure from the ACA's targeted subsidies. Under the reform, a middle-class or even high-income individual would get the same flat credit as someone with low income of the same age. This universality simplifies administration and, proponents argue, avoids high marginal tax rate effects that can discourage work (since the ACA subsidies drop as income rises). However, it also means that **low-income individuals would not receive extra assistance beyond the credit**, unlike under the ACA where someone just above poverty pays very little premium due to a large subsidy. In other words, the reform prioritizes **horizontal equity (equal support at a given age)** over the ACA's vertical equity (greater support for those with less ability to pay). This could raise affordability concerns for the poorest Americans unless additional policies supplement the credit, which the blueprint does not explicitly detail. It's possible states could supplement or that Medicaid could wrap around (discussed further below).

The age-adjusted amounts in the proposal do resemble the structure of subsidies in the **2017 American Health Care Act (AHCA)**, a Republican ACA-replacement bill which also proposed flat tax credits by age (e.g. $2,000 for under 30 up to $4,000 for over 60)

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. However, the proposed credit values here are much larger (e.g. $7,500 for adults 20–49) and essentially designed to cover a high-deductible plan's full premium, whereas AHCA's were smaller and expected to require individuals to pay the remainder. Thus, this plan aims for near-universal coverage of catastrophic insurance through the credit alone.

Another difference is that the new system likely **repeals many ACA insurance regulations**. The blueprint frames it as an alternative to government-mandated plans: *"the plan they want, not the plan forced on them by our government"* as President Trump articulated in 2017

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. This implies more flexibility in plan design – for example, insurers might offer just a catastrophic plan with $5,000 deductible plus MSA, without all the ACA essential benefits or actuarial value requirements. It effectively standardizes one type of plan (the MSA high-

deductible) but may **remove requirements for coverage of certain services from dollar-one** (like ACA's free preventive services). The MSA plan as described typically does not cover services until deductible is met, except perhaps preventive care if allowed. There is a risk of confusion or inadequate coverage if people fail to understand the high out-of-pocket exposure – but the presence of the MSA deposit mitigates this by covering initial expenses.

Crucially, the proposal implies **guaranteed issue with community rating by age** (since insurers are reimbursed a flat amount per person by age). It does not explicitly mention protections for pre-existing conditions, but the structure would collapse if insurers could cherry-pick or charge sick individuals more, so presumably all individuals can opt into the system regardless of health status. In effect, it creates a massive single risk pool per age bracket, funded by the government's contribution – not dissimilar to Medicare Advantage's approach of risk-adjusted per capita payments. One difference: today ACA subsidies adjust with premium costs and cap individuals' payments as a percent of income. Under the reform, the credit is fixed; if an insurer charges more than the credit or if healthcare costs outpace the credit, the individual might have to pay the difference (unless competition keeps plans at or below the credit amount). This shifts risk of health cost inflation from the government (which currently shoulders it via open-ended subsidies) to individuals and insurers. Over time, if the credits are not indexed adequately, affordability could erode (a political risk for the system's sustainability).

In summary, compared to the ACA, the reform is **more universal (everyone gets support, not just low-income)** but also less progressive. It bets on **market competition and consumer cost-consciousness** (via high deductibles and HSAs) to control costs, whereas the ACA relies more on regulation and income-tiered funding. The trade-off is simplicity and potentially lower federal spending, at the possible cost of some low-income people having higher out-of-pocket burdens. The proposal aligns with a more conservative vision of healthcare: minimal income-based redistribution and maximum individual skin-in-the-game.

Medicare (Traditional Medicare and Medicare Advantage)

Current Medicare: Medicare is a federal defined-benefit program primarily for seniors 65+ (and some younger disabled). About **65 million Americans** are on Medicare

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. Traditional Medicare (Parts A and B) is government-run insurance that pays providers for a broad set of services, with defined benefits (e.g. hospital stays, physician visits) and regulated cost-sharing. Beneficiaries typically pay part of costs through premiums (for Part B and D) and deductibles/copays, and many purchase supplemental "Medigap" plans to cover gaps, since traditional Medicare has no out-of-pocket maximum. **Medicare Advantage (Part C)** is a private plan alternative – Medicare pays private insurers a fixed per-enrollee amount (risk-adjusted by health status) to provide coverage at least as comprehensive as traditional Medicare. Over half of beneficiaries (about 33 million in 2024) have chosen Medicare Advantage plans
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, which often include managed care networks, caps on out-of-pocket spending, and extra benefits. Medicare is funded by a combination of payroll taxes (for Part A), general revenues, and premiums. In 2021, Medicare spending was about **$900 billion**

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, and rising as the population ages.

Defined Contribution Proposal vs Medicare: The reform would effectively transform Medicare into a pure defined-contribution system. In fact, the mechanics mirror a **premium support model** for Medicare that has been debated for years: giving each Medicare beneficiary a fixed subsidy (here based on age) to purchase a private plan. Under the proposal, a 65-84 year-old would get roughly $14,000 from the government to buy an MSA-style plan

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. Currently, Medicare's per-capita spending for a senior is around $16,000
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on average, so the credit is set somewhat **below average cost**, requiring efficiencies or cost-sharing to make up the gap. The blueprint acknowledges that at the $14,000 payment level, insurers on average would have a slight loss on seniors 65–84 (about $40 billion loss in aggregate for that group)
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, and a larger loss on 85+ ($99 billion loss for that small cohort)
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. However, younger age groups' payments are set significantly above their average costs, yielding surpluses (e.g. a $7,000 payment for a child vs $3,300 average cost yields industry "surplus" after claims)
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. The idea is that **insurers will cover all ages and the surplus from insuring younger, healthier groups will cross-subsidize the older, costlier groups** – much like a big insurance risk pool. In effect, the plan envisions using the insurance industry and market competition to achieve an outcome that a single-payer system would do via budgeting – but in a way that adheres to conservative preferences for private sector delivery. Notably, traditional Medicare would no longer be the default defined benefit; seniors could either keep traditional Medicare or opt into this new system initially, but over time the goal is to have everyone in the defined contribution system
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Medicare Advantage already demonstrates one form of defined contribution (the government pays capitated rates). The **MSA variant** is a specific flavor that, as discussed, has seen limited use (around 10,000 enrollees out of millions). One reason is that Medicare MSA plans currently **lack drug coverage and require separate Part D plans**

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; another is that many seniors prefer lower deductibles and are willing to pay supplemental premiums for Medigap or more comprehensive MA plans. The reform would address the drug coverage issue by allowing MSA plans to include prescription coverage
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. It also might make the MSA model more appealing by **fundamentally changing the default**: if the entire under-65 population and new enrollees use this system, it could become more accepted to have a high deductible and an HSA even in older age. Over decades, as people carry over HSA funds (hopefully) accumulated from healthier years, they would have additional resources to cover their Medicare-age deductible. This is a stark contrast to the status quo where most seniors have relatively little in liquid savings (the median Medicare beneficiary had about $90,000 in total assets in 2023, and many far less
kff.org
, which would make a $5,000 deductible daunting without prior savings).

Another key difference is **budgetary predictability**. Traditional Medicare's costs rise with service use and provider payments; if costs spike, taxpayers bear the risk. Under a defined contribution, the federal cost per beneficiary is fixed (apart from indexing). The proposal's authors claim this will help control the unsustainable cost growth that Medicare contributes to. Indeed, they note government healthcare spending is on track to reach **$3 trillion out of $5.5 trillion total health spending by 2025** without reform

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. By capping the contribution, the government's liability is more predictable, and the onus is on insurers and consumers to manage utilization within that budget. This is essentially the **"premium support" approach to Medicare solvency**, long championed by some policy experts as a way to inject cost discipline.

However, moving Medicare to this system raises concerns: Will the credit keep pace with healthcare inflation and adequately cover needed care for seniors and people with disabilities? If not, seniors could face higher out-of-pocket costs or fewer providers (as insurers try to contain costs). Medicare Advantage experience shows private plans can often provide the same benefits at lower cost due to care management – but it has also shown that plans tend to **segment the market** (some attract healthier-than-average members, and despite risk adjustment, Medicare has sometimes paid more to MA plans on average than if those beneficiaries were in traditional Medicare

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). Risk adjustment would become crucial; the proposal currently only adjusts by age, which is a blunt tool. Two 70-year-olds can have vastly different health expenses. Traditional Medicare currently shares the cost across all taxpayers; a future system might need additional mechanisms (reinsurance for very high-cost cases or condition-based adjustments) to prevent insurers from avoiding high-risk individuals.

In short, for Medicare, the proposal is a **radical restructuring**: turning a defined benefit entitlement into a defined contribution voucher for private insurance. It aligns with fiscal discipline (no open-ended entitlement) and personal responsibility (seniors managing an HSA),

but would require careful design to ensure that the most vulnerable elderly (the very old, or those with expensive chronic conditions) can still get comprehensive care without prohibitive costs. The **transition** could be voluntary at first (as the blueprint suggests an option to keep traditional Medicare or "accept the alternative"

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), but the end goal is to phase out the old system in favor of the new. This aspect is likely to be the most controversial politically, given the popularity of Medicare's guaranteed benefits.

Medicaid and CHIP

Current Medicaid/CHIP: Medicaid is a joint federal-state program providing health coverage to low-income Americans, including children (through CHIP), pregnant women, parents, disabled individuals, and seniors needing long-term care. It covers about **85–90 million people** (enrollment spiked during the COVID-19 pandemic). Unlike Medicare and ACA plans, Medicaid is means-tested (eligibility based on income/assets) and generally offers comprehensive benefits with little cost-sharing, funded by tax revenues. Federal spending on Medicaid (including CHIP) was about **$724 billion (Medicaid) + $22 billion (CHIP) in 2021**

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, making it a major component of government health expenditure. Medicaid is essentially a defined benefit – enrollees are entitled to a set of services, and spending expands as people qualify and use care. States administer Medicaid and finance a share (averaging 37% of costs), which significantly impacts state budgets. Many states manage costs by contracting with Medicaid managed care organizations (MCOs), which are private plans paid per enrollee (capitated), similar to Medicare Advantage but for Medicaid populations.

Defined Contribution Proposal vs Medicaid: The reform would open the new age-based credit system to everyone, including those who would otherwise be on Medicaid, effectively **integrating the poor into the same system as the rest of the population**. Instead of Medicaid providing a separate insurance program with its own rules and providers, low-income individuals would receive the standard age-based credit to purchase an MSA-plan. This could dramatically change their coverage: whereas Medicaid has no premiums and negligible cost-sharing, an MSA-based HDHP expects enrollees to use the $2,000 deposit then potentially face up to ~$3,000 in out-of-pocket costs (the difference between deposit and deductible) if they need significant care in a year. For a low-income family, that exposure might be unaffordable, which raises **equity and access concerns**. On the other hand, proponents might argue that many Medicaid recipients are younger (children and working-age adults) whose health costs are relatively low on average, and that giving them a private plan and HSA could empower them more than the often restrictive Medicaid networks. The Trump administration's emphasis on giving states flexibility with Medicaid (e.g., via block grants or work requirements) aligns with this idea – indeed, President Trump in 2017 spoke of giving governors "the resources and flexibility… to make sure no one is left out"

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, suggesting states could potentially supplement or manage the credits for certain populations.

If implemented, states might convert their Medicaid funding into contributions toward the universal credits or additional wraparound support. For example, states could use some funds to pay the ~$3,000 gap for the poorest individuals or to cover services not in standard plans (such as long-term care for disabled, which Medicaid now funds and a regular insurance plan generally would not). The blueprint doesn't detail these logistics, but transitioning Medicaid enrollees to private plans would likely necessitate some special provisions. A potential benefit is that **local governments could be relieved of some Medicaid cost burden**. Currently, states and counties contribute to Medicaid; if all low-income residents instead get a federally funded age-based credit, states might see budget relief. (However, if the federal credit is lower than what Medicaid would have spent on an individual, states might face pressure to fill gaps.) There is precedent in Medicaid managed care and premium assistance programs (some states use Medicaid funds to buy ACA marketplace plans for beneficiaries), so conceptually it's not far-fetched to integrate Medicaid funding into this model.

Another aspect is that Medicaid and CHIP cover nearly half of all U.S. births and insure many children. In the proposal, children 0–19 would get a $7,000 credit – notably **more than double their average cost of $3,300**

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. This generous funding for kids could ensure they are well-covered and even generate surplus as noted. It implies children's care would be easily paid for within the credit (pediatric care generally being inexpensive relative to $7k/year), and any leftover in their HSA would roll over for future needs. Over years, a healthy child could accumulate savings that might cover braces, future medical needs, or just continue growing into adulthood. This is a philosophically different approach from Medicaid/CHIP which simply pays for children's care as needed but leaves them no asset. Here, by age 19 a prudent user might have built an HSA balance – a form of wealth-building even for low-income youth, which appeals to the **ideal of personal responsibility and savings**.

In exchange, however, families might have more paperwork or complexity (choosing plans, managing HSAs) compared to automatic enrollment in Medicaid. Administrative complexity could increase during the transition: verifying everyone's eligibility for the new credit, sunsetting Medicaid enrollment, and educating millions of beneficiaries about using HSAs and choosing plans would be an enormous undertaking.

To summarize, the plan would **fold Medicaid beneficiaries into the general system of age-based credits**, ending the current two-tier system of insurance (one for the poor, one for others). This could reduce stigmatization and increase provider access for low-income individuals (since they'd have private insurance; currently many providers do not accept Medicaid due to low fees). It could also alleviate long-term fiscal pressures on state/local governments – for instance, **unfunded liabilities for retiree health benefits, which total around $1 trillion for local governments nationwide**

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, might be mitigated if future retirees use their accumulated HSAs and credits instead of relying on local government promises. But these potential gains must be weighed against the risk that vulnerable populations could face higher out-of-pocket costs and new barriers to care if not carefully managed. Transitional support or additional subsidies for the lowest-income bracket might be necessary to ensure **no one is left worse off** during the change.

Summary of Comparisons

In all cases – ESI, ACA, Medicare, Medicaid – the age-based defined contribution plan represents a shift to **individualized, portable insurance financed by a fixed public contribution**. This stands in contrast to the mix of **third-party defined benefits and cross-subsidies** we have now (employers picking up costs for workers, Medicare guaranteeing defined benefits for seniors, Medicaid covering the poor outright, etc.). The reform centralizes financing in a single mechanism (the age credit) and decentralizes decision-making to individuals and markets. It promises simplicity (one system instead of many) and predictability in public spending, but it must reconcile the very different needs of populations currently served by specialized programs.

Table 2 highlights key differences between current systems and the proposed model:

Feature	Current ESI	ACA Marketplace	Medicare (Trad & MA)	Medicaid/CHIP	Proposed Age-Based Model
Eligibility Basis	Employment (worker or dependent)	Individual (no affordable ESI)	Age ≥65 or disabled (Medicare); Income & categorically (Medicaid)	Low income & categories (Medicaid/CHIP)	Universal (all individuals) via age
Funding Mechanism	Employer premium contributions (tax-excluded); employee pays remainder msa-medicare.com	Income-based tax credits (for premiums 0–400% FPL); individual pays remainder	Payroll taxes + general revenue (Medicare); federal/state taxes (Medicaid)	Federal & state taxes (matching)	Age-based tax credit (federal), same amount for all of same age; no income test msa-medicare.com
Benefit Design	Varies by employer plan; often comprehensive PPO/HMO with low deductibles	Regulated plans by metal tiers; essential benefits; community-rated 3:1 age band	Medicare: defined benefit (Parts A/B); MA: capitated private plans must cover	Comprehensive benefits (especially Medicaid; CHIP similar to private); little cost-sharing	High-deductible private plan (≈$5k deductible) with 100% coverage after deductible;

Feature	Current ESI	ACA Marketplace	Medicare (Trad & MA)	Medicaid/CHIP	Proposed Age-Based Model
			A/B services (often more)		includes medical savings account deposit (≈$2k) msa-medicare.com msa-medicare.com
Portability	Limited (coverage ends when job ends, COBRA temporary)	Yes (annual open enrollment, can keep plan regardless of job)	Medicare: portable nationally; Medicaid: portable only within state or via eligibility renewal in new state	Limited (must re-qualify if moving states)	Yes, fully portable – not tied to job or state; individual keeps coverage continuously
Personal Financial Incentives	Limited consumer cost sensitivity (premiums hidden as comp, moderate copays; tax exclusion encourages richer benefits) cfr.org	Moderate (subsidies shield low-income from cost; high cost-sharing for some can incentivize shopping)	Traditional Medicare has cost-sharing but no OOP max (leading many to get Medigap); MA has max OOP and managed care; Medicaid has minimal cost-sharing (little price incentive)	Minimal for Medicaid (no premiums, nominal copays); CHIP has some cost-sharing	Strong incentives: fixed credit = if one chooses cheaper plan, they could potentially keep difference (via HSA deposit); high deductible means consumers spend their own HSA money for routine care – encourages price-shopping and judicious use nber.org

Feature	Current ESI	ACA Marketplace	Medicare (Trad & MA)	Medicaid/CHIP	Proposed Age-Based Model
					. If they economize, unspent dollars accrue to them, not insurer or government.
Risk Pooling	By employer group (and ultimately across society via tax exclusion subsidy)	By marketplace pool (all individuals; risk adjusted through regulations)	Traditional Medicare: whole national pool (taxpayer funded); MA: risk-adjusted payments per enrollee; Medicaid: state-level pools (often managed care plans)	State-level (or plan-level) pools for Medicaid; children and adults often pooled separately from disabled/elderly in state budgets	Broad pooling via age bands – each insurer covers mix of ages; surplus from low-cost enrollees offsets high-cost (explicit in proposal) msa-medicare.com . Needs possible risk adjusters for health status beyond age.
Administration	Employers and insurers handle enrollment; significant HR role	Federal/state exchanges facilitate enrollment; income verification for subsidies	Federal agency (CMS) for traditional; private insurers for MA; states for Medicaid with federal oversight	State agencies determine eligibility and oversee plans; high administrative burden to manage enrollees' status	Would require a new or repurposed administrative system to distribute credits and allow plan enrollment (possibly an expanded exchange available to all). Individuals would interact directly with insurers or an exchange.

Feature	Current ESI	ACA Marketplace	Medicare (Trad & MA)	Medicaid/CHIP	Proposed Age-Based Model
					Simpler eligibility (just age & citizenship) but huge scale of enrollment.

Table 2: Comparison of current U.S. health coverage systems vs. proposed age-based defined contribution model.

As shown, the age-based reform represents a **unification and streamlining** of financing (one mechanism for all) at the cost of removing some tailored features of each program (like income-based assistance or employer risk-sharing). The next section examines the financial projections of this proposal – specifically the claims of cost savings and budget impact.

Projected Savings and Fiscal Impact

One of the boldest claims of the age-based defined contribution proposal is that it would **significantly reduce healthcare spending – by roughly $1 trillion per year nationally – while also bending the trajectory of government spending downward**. The blueprint asserts that the plan's total cost, covering virtually the entire U.S. population, would be about **$3.2 trillion annually**, which is *"1 trillion less than the current $4.2 trillion being spent"* on health care

msa-medicare.com
. It further suggests federal healthcare expenditures (currently around $2.0 trillion) could drop to about **$1.4 trillion**, producing substantial budgetary savings for taxpayers. We will analyze the basis for these projections and their plausibility.

Current Spending Baseline: In 2021, total national health expenditures in the U.S. were approximately $4.1–4.2 trillion

msa-medicare.com
, which included all sources (federal, state, private, out-of-pocket). Of that, government spending accounted for about $1.65 trillion (federal programs like Medicare, federal share of Medicaid, ACA subsidies, etc.)
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. By 2025, absent reform, government health spending was projected to rise to $3 trillion out of ~$5.5 trillion total
msa-medicare.com
. These growth trends reflect an aging population, medical inflation, and expansions of subsidies. Such growth is widely seen as fiscally unsustainable – at 2025 levels, health programs would

consume a major share of federal revenue, driving deficits. Hence the impetus for reform: **constrain the public contribution and reduce overall costs**.

Proposal's Cost Structure: Under the plan, the government would pay the defined contributions for each person: summing the age-band figures given earlier (Table 1) across the population yields the $3.2 trillion annual federal outlay

msa-medicare.com
. (For context, 330 million people receiving an average of about $9,700 each would equal $3.2 trillion; the distribution is skewed such that older groups get more, younger less, but the total matches this magnitude.) This $3.2T effectively replaces what is currently a mix of public and private spending on premiums. In other words, **the government would become the principal financier of the standard insurance premium for everyone**, albeit at a level designed to be somewhat lower than current per-capita spending. The proposal's $3.2T includes both the funds deposited to HSAs and the funds used by insurers to pay medical claims. Notably, the authors calculate that if insurers receive $3.2T in premiums (from the government credits), they would pay out about $1.9T in claims (based on the sum of average costs), leaving roughly **$1.3 trillion in "surplus" to the insurance industry after paying claims**
msa-medicare.com
. This surplus is not pure profit; it must cover insurers' administrative costs, reserves, and the required HSA deposits (which are essentially a pass-through benefit to enrollees). It does, however, indicate a sizable margin built into the payment rates. The implication is that there is **substantial slack in current spending** – i.e., premiums currently far exceed claims for many groups – and that competition could drive down premiums or enhance benefits until much of that slack is eliminated for consumer benefit.

Federal Spending Reduction: If the federal government spends $3.2T to cover essentially everyone's insurance, why do they claim federal spending drops to $1.4T from $2T? The key is that currently a lot of health spending is private (employers and households). In the new system, that $3.2T public outlay would replace not only current federal programs ($1.65T in 2021) but also the implicit tax subsidy for ESI (~$280B), state Medicaid spending, and a large portion of what employers/individuals now pay in premiums. The **$1.4 trillion federal figure likely represents net federal spending after accounting for offsets**. For example, eliminating the employer health tax exclusion would increase taxable income, raising federal tax revenues (effectively a saving). Employers might redirect what they used to spend on health premiums to wages; those wages are taxable, generating revenue. Additionally, if everyone is on this plan, one could end duplicative programs: workers' comp health expenditures, certain Veterans Affairs health costs, etc., might be streamlined. It's not fully detailed, but one can surmise that about $600 billion in savings comes from a combination of **efficiency gains and reallocation of private spending**:

- **Eliminating the ACA's income-based subsidy structure and other program overhead** could save some administrative costs.
- **Reduced health care utilization due to higher deductibles and cost-conscious behavior**. Empirical evidence on high-deductible "consumer-directed" health plans (CDHPs) supports some cost savings: studies have found that when employers introduced

HSA-linked high deductible plans, total health spending for those enrolled fell by about 5–7% in the first year and continued to grow more slowly, yielding around a **15% reduction over 3 years** relative to trend

pnhp.org

pnhp.org

. Much of the savings came from fewer outpatient visits and less spending on elective services and pharmaceuticals, with **no observed increase in emergency or inpatient care** in the short term

nber.org

nber.org

. This suggests patients are forgoing or price-shopping some care, including perhaps low-value care. If similar behavior holds when the whole population faces such incentives, overall utilization might drop, slowing cost growth. A 15% reduction on relevant spending could indeed account for hundreds of billions in savings (15% of $4T is $600B). The proposal's $1T total savings (about 24%) is more ambitious, but it might bank on additional factors like competition lowering prices.

- **Administrative efficiency and simplification**: Running one unified system of credits could reduce the complex layering of programs and their associated admin costs. For instance, providers today deal with multiple payers and rules; a single mechanism (even if privately delivered) could streamline billing/coding. However, private insurers have their own overhead and profit. The $1.3T "surplus" noted is partly admin/profit; if competition is strong, insurers would lower premiums (or offer richer benefits like adding dental or lowering the deductible) to attract enrollees, which effectively gives that surplus back to consumers or reduces government outlays if the bids come in below the credit. The Medicare Advantage experience is instructive: insurers often rebate part of their payments to offer extra benefits (like vision, gym memberships) to entice members. In a competitive bidding system for these credits, we might see similar – the credit sets a max, but insurers could offer plans costing less and perhaps deposit more into HSAs or lower the deductible to gain customers. This competitive dynamic could squeeze out inefficiencies over time.
- **Market-wide cost control**: By covering everyone with private plans operating under a fixed budget, the hope is that providers will face pressure to **lower prices or at least control increases**. Today, private insurance often pays higher prices to doctors and hospitals than Medicare or Medicaid do. If the entire market moves to a defined contribution that is indexed modestly, insurers might push back on provider prices

(through narrower networks or negotiation) to keep their costs under the flat payment. The blueprint doesn't detail this, but it's implicit that **market discipline** is expected to do what top-down regulation currently attempts. Whether that yields $1T in savings is uncertain, but provider prices are a big factor in U.S. healthcare costs, so any downward pressure there could yield large savings.

It's also worth clarifying **who saves $1T**. The claim "annual cost… $3.2T, $1T less than current $4.2T"

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implies society-wide savings (not just government). That means theoretically households, employers, and government collectively spend $1T less on health care. Some of this is transferred – e.g., employers save money by not providing insurance, and that cost is taken up by the government credit (so not a true efficiency gain unless the government's cost is lower than what employers would have spent). But if the total is indeed lower, it suggests real efficiencies (less wasteful services, lower prices, etc.).

The **federal budget** specifically sees savings if it no longer foregoes tax revenue for ESI, and if the credit is set at a level that grows slower than current programs would have. At $1.4T, federal health spending would be roughly 5% of GDP (given 2025 GDP), significantly lower than status quo projections. This could dramatically improve the fiscal outlook – reducing deficits and debt growth – which is why think tanks like Heritage emphasize defined contributions for entitlements as a path to **fiscal discipline**. It effectively caps the federal commitment and shifts any excess cost to the private sector or individuals.

Feasibility of $600B Federal Reduction: Achieving a reduction from $2.0T to $1.4T in federal health spending means cutting 30% of what the government would otherwise pay. Some of that comes from transferring obligations (states might take on some costs, or individuals pay more out-of-pocket). However, the proposal tries to minimize individual burden by ensuring the credit covers a basic plan. The difference might be made up by eliminating what the government currently pays into various inefficient channels. For instance, if employers' spending becomes wages, they get taxed – increased tax revenue could offset some credit outlays. Also, the federal government currently pays states roughly $500B for Medicaid; if that goes away and is replaced by a smaller credit (because the credit for a mostly healthy adult is lower than Medicaid's cost for a disabled enrollee, for example), the federal line might drop but states or families might pick up something. It's complex to model without detailed data, but the blueprint's numbers suggest confidence that the **age credit levels are sufficient to cover needed care on average while still leaving a margin that translates into savings**.

Critics might question whether a 24% reduction in national spending is realistic without harming care. A lot of health costs are concentrated in a small percentage of very sick individuals. High deductibles won't reduce costs for someone who needs, say, $100,000 of treatment (they will blow past the deductible and consume full insurance payouts). The savings thus mostly come from the majority who use moderate or low amounts of care, who might skip some discretionary visits or get cheaper drugs. There is a risk some needed care is also forgone (studies show HSAs

can lead patients to cut both unnecessary and necessary care indiscriminately, especially among lower-income or less health-literate individuals

pmc.ncbi.nlm.nih.gov

pnhp.org
). Over the long term, if preventive or chronic care is under-utilized, costs could rise later (e.g., unmanaged conditions leading to hospitalizations). The plan's defenders would argue that individuals can still seek needed care – they just have to weigh it against their HSA balance, and truly essential care will still be covered after the deductible.

Summary of Fiscal Impact: The proposal projects roughly **$600 billion in direct federal savings** (relative to current law) and **$1 trillion in overall health system savings** annually. The mechanisms include: a single streamlined financing approach, fixed contributions that force prioritization, consumer-driven utilization reductions (on the order of 10–20% seen in CDHP studies

pnhp.org
), elimination of costly tax expenditures, and improved labor and market efficiency. These savings, if realized, could be redirected to other public needs or deficit reduction. It aligns with a fiscally conservative view that controlling entitlement growth is essential to national prosperity. As the blueprint put it, *"If we don't find a way to control these costs, we will never be able to pay down our debt"*
msa-medicare.com
. By 2030, the cumulative effect could be trillions saved and a healthier federal balance sheet.

To visualize the shift, consider the simplified chart below, which compares **annual federal health spending** in the status quo vs. under the proposal (in trillions of dollars):

Figure 1: Illustrative comparison of current federal healthcare spending ($2.0 trillion) vs. projected spending under the proposed plan ($1.4 trillion). The reform aims to significantly flatten the growth of government health outlays, helping to restrain the largest driver of future deficits.

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(Note: Figure is conceptual; exact savings would depend on implementation details and behavioral responses.)

In sum, the projected savings are substantial but hinge on successful implementation of market discipline and consumer engagement. The next section explores the **broader economic impacts** if health insurance is indeed decoupled from employment and if these savings materialize.

Broader Economic Impacts of Decoupling Health Insurance from Employment

Moving to an age-based, portable insurance system not tied to jobs could reverberate through the U.S. economy in numerous ways. Here we discuss four key areas: **labor mobility**, **entrepreneurship**, **state and local government budgets**, and **U.S. businesses' global competitiveness**. All are areas where the current employer-centric and public program-centric insurance model has been argued to create inefficiencies or burdens that a reformed system might alleviate.

Labor Mobility and "Job Lock"

As noted earlier, the linkage of health insurance to employment in the U.S. has long been known to cause "job lock" – workers staying in a job for the insurance benefits, even if it's not the best match or they have opportunities elsewhere. By providing **universal, individual insurance credits**, the reform would remove one of the biggest deterrents to changing jobs or careers. Workers could switch employers or take a break from employment without fear of losing coverage, since their health plan is independent of the job and continuously funded through the credit.

This could make the labor market **more dynamic and efficient**. Skilled employees could move to where they are most productive, and companies could hire talent more easily without the complexity of negotiating health benefits. The **20–40% reduction in mobility due to job lock** that researchers have observed

journals.sagepub.com
could be unlocked, potentially increasing turnover where it is currently inefficiently low. Increased mobility can lead to better matching of skills to jobs and potentially higher overall productivity. It may also result in slightly higher wages for job-changers, as they can negotiate pay without needing compensation for loss of health benefits (since they aren't losing any).

For older workers, decoupling health insurance could enable **later retirement flexibility**. Today some people stay in full-time work until 65 just for employer health insurance. With an age-based credit (especially for ages 50–64 at $12,000/year

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), a 60-year-old might feel freer to retire early or go part-time, using the credit to buy coverage until Medicare-age. This could open up positions for younger workers and allow older workers more choice in how they phase into retirement.

On the flip side, fully portable insurance means employers could also be more willing to hire or fire based purely on work considerations, since the "social obligation" of providing benefits is removed. While this can increase labor market fluidity, it might raise concerns for some workers who valued the stability of employer-provided benefits. However, since the reform ensures

everyone has coverage anyway, the net effect should be positive in reducing fear associated with job transitions.

Entrepreneurship and Small Business Formation

The reform could provide a significant boost to **entrepreneurship** by eliminating "entrepreneur lock," a variant of job lock. Many Americans with dreams of starting a business or freelancing hesitate because of the difficulty and expense of obtaining health insurance on the individual market (historically, before ACA, this was a major barrier due to medical underwriting and high costs for comprehensive plans). Even with the ACA, some prospective entrepreneurs worry about the stability of subsidies or provider networks. Under the new plan, an individual would receive the same health funding whether they work for a big company, a small startup, or for themselves. This guaranteed, stable source of coverage can encourage more risk-taking in the economy.

Studies by the Kauffman Foundation and RAND have suggested that expanding access to non-employer insurance increases business startups. For example, one study concluded making health insurance more accessible and affordable for individuals could **increase self-employment by up to one-third**

npr.org
. Another analysis estimated the ACA could result in **25,000 new businesses formed each year** thanks to reduced entrepreneur lock
npr.org
. If anything, the proposal might have an even stronger effect, since it offers a universal benefit to cushion health costs. Someone leaving a corporate job to launch a startup will keep their $7,500 (or more, if older) credit to buy insurance, and they know that safety net won't vanish.

Small businesses also benefit. One of the challenges for small employers today is providing health benefits – they lack the bargaining power of large firms, face higher administrative costs, and must manage complex compliance (which is why only about 31% of firms with under 50 workers offer health insurance). Under the reform, a small business could simply let employees obtain insurance on their own with their credits, possibly **making small firms more competitive in hiring**. Currently, talented workers might prefer a big employer partly for better health benefits; remove that factor and more may choose to join or start small enterprises. A report from NPR noted that with portable insurance options, small firms can more easily attract employees since *"they could essentially use the exchanges as their health plan"*

npr.org
– similarly, under this reform they'd rely on the individual market which everyone uses.

Overall, decoupling health insurance fosters a more **entrepreneurial economy** where individuals are empowered to pursue independent ventures without the anchor of benefit dependence. This aligns with conservative economic ideals as well – unleashing innovation and personal enterprise by removing government or institutional impediments.

State and Local Government Budgets

State and local governments currently bear substantial healthcare-related costs. These include their share of Medicaid, health benefits for public employees and retirees, and uncompensated care for uninsured residents (through public hospitals, etc.). A move to a national defined contribution system could have several effects:

- **Medicaid Cost Relief:** If low-income residents shift to federally funded age-based credits, states might no longer have to pay their portion of Medicaid for many populations. This could be a massive relief for state budgets. Medicaid is often the **second-largest expense for states after education**, and during economic downturns the enrollment (and costs) go up just as state revenues fall. A federal takeover via credits would stabilize this. However, states might still be involved in supplementing care for very high-need individuals (e.g., long-term care for severely disabled, which is a big part of Medicaid). The reform might not fully address long-term care, so states could repurpose some funds there. Nonetheless, for acute and routine care of most Medicaid enrollees, the federal credit would supplant state spending.
- **Retiree Health Obligations:** Many local governments (cities, counties, school districts) promise healthcare coverage to retired employees (especially public safety workers who often retire before Medicare age). These **Other Post-Employment Benefits (OPEB)** liabilities are significantly underfunded – on average only 6% funded, leaving close to **$1 trillion in unfunded obligations** nationwide

  brookings.edu

  brookings.edu

  . This looming burden forces localities to either cut services or raise taxes to pay for retiree health. Under the new system, a retired teacher or police officer under 65 would get the federal credit to buy insurance, potentially alleviating the need for the city to provide full coverage. Some localities might still offer a “top-up” or contribute to the person’s HSA, but the heavy lifting would be done by the credit. This could help **stabilize municipal finances**. Even for retirees over 65, if they opt for the MSA Medicare plan, some of their costs could be pre-funded by their own HSA savings, reducing reliance on the city’s supplemental coverage. Brookings Institution analysts have argued that forcing governments to account for and prefund these liabilities is crucial

  brookings.edu

  – this reform could effectively serve as a prefunding mechanism by giving individuals assets (HSAs) to cover health needs rather than blank-check promises from governments.

- **Public Employee Compensation Flexibility:** State/local governments could also adjust how they compensate employees if not required to provide gold-plated health benefits. They might offer higher take-home pay or other benefits instead, which employees could find attractive given they have portable insurance anyway. This could make public sector compensation more transparent and possibly more sustainable (since lavish benefits with hidden future costs would be curtailed).
- **Uncompensated Care Reduction:** If virtually everyone has at least catastrophic coverage via the credit and HDHP, hospitals and local governments would spend less on charity care for the uninsured. Today, local county hospitals often treat uninsured patients at the county's expense. Those patients would now have an insurance plan (even if they haven't met their deductible, they at least have an HSA to draw on and catastrophic coverage beyond). This could reduce the burden on local safety-net health systems and possibly allow public funds to be redirected to other public health initiatives instead of emergency care for the uninsured.

In short, the reform could be a boon for state and local budgets, **reducing one of their fastest-growing expenses**. However, states would likely negotiate for some role in tailoring the program – for instance, using what would have been their Medicaid funds to enhance credits for certain groups or to ensure coverage of services like mental health or substance abuse programs that they care about locally. The flexibility mentioned by President Trump

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suggests states might get waivers or add-ons, but the heavy cost would shift federally. For local governments, shedding retiree health burdens could improve their credit ratings and ability to invest in infrastructure or education instead of sinking funds into healthcare promises. Taxpayers at the local level might see less pressure for property tax or state tax increases due to healthcare.

U.S. Business Competitiveness in Global Markets

American companies, especially manufacturers, often contend that the high cost of providing health insurance to their workers makes their products more expensive and less competitive internationally. In countries with national healthcare, much of that cost is borne by the government (via taxes), not directly by employers. The classic example is the auto industry: U.S. automakers have had thousands of retirees and workers whose health benefits add to production costs. As mentioned, **General Motors estimated ~$1,500-$2,000 of each car's price was due to healthcare costs** – whereas a competitor like Toyota (operating in Japan with a national health system) had maybe ~$200 per car of such costs

reuters.com

cfr.org
. This disparity can put U.S. firms at a disadvantage, effectively acting like a "health care tariff" embedded in our goods.

By removing or greatly reducing the employer role in health insurance, the reform could **improve the cost competitiveness of American products and services**. Companies would no

longer have to bake in health premiums into their pricing structure; the labor cost for a U.S. worker would be more purely wage-based. Economically, one might argue that in the long run wages adjust (if employers save on insurance, they might end up paying higher wages to attract workers, neutralizing some competitive gain). But even if that happens, it's more transparent and flexible – a company can adjust wages with market conditions, but health benefit commitments are inflexible and have been rising faster than inflation, thus acting as a drag. This reform caps those costs for employers, transferring cost control to the national level.

Additionally, with individuals paying more attention to healthcare value (shopping for care with their HSA dollars), there could be indirect effects on innovation and productivity. A healthier, more engaged workforce might emerge over time if preventative behaviors are incentivized (though that's not guaranteed by an HSA per se). What is more clear is that businesses could focus on their core mission rather than running healthcare plans. The countless hours and resources companies spend on administering benefits, complying with health benefit laws, negotiating with insurers – all of that could be refocused on productive business activities.

From a macro perspective, if the U.S. reins in healthcare spending (currently about 18% of GDP) by even a couple percentage points, those resources can flow to other sectors, potentially boosting economic growth. High healthcare costs act like a tax on the economy, and easing that burden could make U.S. industries more nimble and price-competitive. Conservative economists often cite rising healthcare costs as a major driver of stagnant wages (as more compensation goes to benefits)

cfr.org
; by controlling benefit costs via the credit, more compensation might go directly to workers as wages, which can increase consumer spending on other goods.

One must note, however, that some industries (healthcare sector itself) would see an adjustment. A $1T reduction in national health spending means lower revenue for some hospitals, drug companies, device manufacturers, etc. In the long run, that's a reallocation of resources to other parts of the economy, which economists would view as efficiency gain if it's eliminating waste. But in the transition, there could be job impacts in healthcare administration roles (if insurance processes simplify) or in sectors that rely on ever-increasing health expenditures.

On balance, decoupling health insurance from employment and controlling its cost growth should enhance the **global competitiveness of U.S. businesses**, reduce the hidden "tax" of health benefits on wages and prices, and allow companies and workers more flexibility. It is essentially shifting the U.S. toward a model where healthcare is financed more broadly (through the tax system for the credits) rather than as a direct cost of production for each firm. Many analysts have argued such a shift is overdue if American firms are to compete fairly in international markets where their competitors aren't writing the same big checks for employee health benefits

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Feasibility, Administrative Complexity, and Transition Challenges

While the theoretical benefits of the proposal are significant, implementing such a sweeping reform would face **numerous practical and political challenges**. This section critically evaluates the feasibility of enacting and executing the plan, the complexity of administration, and the transition issues that would need to be managed to avoid disruptions.

Political Feasibility and Public Acceptance: Transforming U.S. healthcare financing at this scale would require major federal legislation and likely overhaul of programs like Medicare and Medicaid that tens of millions depend on. Politically, any proposal perceived as "voucherizing" Medicare or cutting Medicaid can expect fierce resistance. Seniors, who vote in large numbers, might be skeptical of giving up their current Medicare benefits for a new system – even if optional at first. The plan's authors clearly anticipate voluntary uptake, but for it to yield the projected savings, a large enrollment is needed. Convincing seniors that an MSA plan is as good or better than traditional Medicare (or a low-cost Medicare Advantage HMO they might have) is an uphill battle. Similarly, low-income advocates would worry that moving poor families from Medicaid to private high-deductible plans could leave them with bills they can't pay. These constituencies will raise concerns about **equity and adequacy**. To address this, policymakers might need to build in protections: for example, additional subsidies for people below a certain income to cover out-of-pocket costs, or guarantees that the credit will cover a benchmark plan fully for everyone.

Legislative Complexity: The reform would essentially replace or revise parts of the ACA, ERISA (governing employer plans), Medicare, and Medicaid law simultaneously – a legislative task of immense scope. It would require careful drafting to avoid coverage gaps. Lawmakers might choose to phase it in, say, starting with offering the credits as an option for those buying individual insurance and for small businesses, then gradually expanding. A big-bang transition on a certain date where 330 million people switch to a new system is likely too risky. A realistic approach could be: allow employers to opt to "cash out" health benefits to employees with the credit, allow states to pilot using credits instead of Medicaid expansion, allow new Medicare entrants to choose a credit option, etc., and over time shrink the old systems. This phased approach, however, slows the realization of savings and runs dual systems in parallel for years (with some duplication of cost).

Administrative Setup: On a practical level, administering universal age-based credits would require infrastructure somewhat akin to the ACA exchanges, but on a larger scale. The government would need to determine eligibility (likely all citizens and legal residents of a certain age qualify; this is simpler than income-based eligibility). It would need a mechanism to deliver the funds – possibly an expanded IRS role (since it's a tax credit) or a benefits administration similar to Social Security. One could imagine the IRS or CMS creating a system where individuals can claim their credit during open enrollment and have it paid directly to the insurer they select (like ACA's advance premium tax credits are handled). Building an easy-to-use platform where Americans can compare and choose plans is essential; the ACA exchanges could be a starting template, but now scaled to serve everyone regardless of income. Insurers would

have to price plans that conform to the credit amounts (or accept that individuals might top-up if they want a pricier plan). **Risk adjustment** systems would be needed if some insurers enroll disproportionately sick people; currently the ACA marketplace and Medicare Advantage both use risk adjustment formulas, which could be repurposed or unified. The proposal as written doesn't detail risk adjustment beyond age, but in practice it would be necessary to prevent insurers from trying to attract only low-risk individuals within each age band. This adds a layer of complexity – a governmental or independent body would have to oversee and calibrate risk transfers among insurers.

The **HSA administration** is another aspect: ensuring every American has an HSA set up to receive deposits. Many people already have HSAs, but a huge number do not. The government might automatically create accounts for people (perhaps through a contracted bank or a Treasury-managed system). Safeguards have to be in place for how funds can be used (HSA funds are tax-advantaged for qualified medical expenses; misuse has penalties). Education on using these accounts would be necessary, especially for populations not used to managing healthcare spending (e.g., someone coming off Medicaid might never have seen a medical bill before, now they have an HSA to manage).

Maintaining Provider Access and Plan Participation: During transition, there could be **uncertainty for providers and insurers**. Providers might worry about how they will get paid – if everyone is in high-deductible plans, will hospitals struggle to collect the deductible amounts from patients? Possibly initially yes, which is why having the $2,000 MSA helps (the patient can assign the HSA payment to the provider). But for charges beyond that, providers would bill insurance (once deductible met). We might see an increase in providers requiring up-front payment for elective services up to the deductible. Ensuring that doesn't deter needed care will be important (e.g., perhaps allow direct payment from the HSA to providers to simplify transactions).

Insurers, for their part, might find the prospect of a unified market attractive (millions of new customers with a guaranteed payment), but also challenging. Currently, insurer markets are segmented: some focus on Medicaid managed care, some on Medicare Advantage, some on employer plans. This reform blurs those lines – potentially one could enroll a family of four where the kids were on CHIP, the parents on an employer plan, and grandma on Medicare; now one insurer could cover all via the credits. In theory, this is simpler, but companies would need to adapt their products. Not all insurers operate nationwide; some are regional. The portability goal might be helped by encouraging **nationwide plans** or at least allowing cross-state plan portability. This could run into state insurance regulation – states traditionally regulate individual insurance, whereas Medicare is federal. If everyone is under one system, perhaps federal rules would preempt state variation to ensure uniform access (a likely contentious issue with states). Alternatively, a federal exchange could offer plans in all states, but insurers would still have to build networks regionally. There's an argument to allow **interstate sale of insurance** to maximize competition – something often advocated by conservatives. This plan could bolster that by creating a federal marketplace for the credits.

Parallel Operation and Adverse Selection: If the reform is optional initially (people can keep ESI, Medicare, etc.), there is a risk of **adverse selection** between the old and new systems. For

example, suppose healthier seniors opt for the new MSA plan because they value the HSA growth, while sicker seniors stick with traditional Medicare because they fear out-of-pocket costs. Over time, that could worsen Medicare's risk pool, increasing its costs and potentially accelerating the need to fold it entirely. Similarly, if employers suspect that only high-risk employees will stay on their plan (with others taking the credit), they may preemptively drop coverage. These dynamics need monitoring. One solution is to gradually reduce the attractiveness of staying in the old system – e.g., indexing the defined-benefit programs more slowly or capping their benefits – to encourage migration without outright mandate. Politically, having a choice can ease acceptance ("if you like your plan you can keep it"), but economically, maintaining dual systems reduces the efficiency gain and can create instability. Eventually, a clean cut may be needed, but that requires strong consensus that the new system works well.

Consumer Adjustment and Education: Millions of Americans would need to adjust to being **active consumers** in healthcare rather than passive recipients of a plan chosen by an employer or government. This is a cultural shift. HSA-style plans have been around for years in the employer market, but many Americans still prefer low-deductible plans and are not accustomed to shopping for healthcare or saving for future medical needs. Education campaigns would be necessary to inform people how to use their HSA, why it's beneficial to shop around for non-urgent services, how to find price information (which, incidentally, the system could push providers to make prices more transparent to attract HSA spending). There is also a risk of public backlash if in the first years of transition some people face unexpected bills because they didn't understand the deductible. Clear communication and possibly some grace periods or emergency relief funds could be considered for edge cases.

Regulatory Oversight: Even though this is a market-oriented plan, it would still require robust regulatory oversight to ensure it meets goals. For instance, rules to **prevent insurers from denying or diminishing coverage for high-cost patients** (which could be done subtly even without outright underwriting – e.g., by formulary design making certain expensive drugs less accessible). Also, ensuring **network adequacy** so that plans are not saving money by just offering skimpy provider networks. Medicare Advantage and ACA plans both have regulations on these; a unified system would need them too, or else consumers might end up in poor-quality plans without realizing it. The conservative approach might lean towards lighter regulation trusting competition, but some guardrails are likely needed to protect consumers from bad actors and to ensure the credit is used on genuine insurance that provides value.

Transition Costs: There will be one-time costs: setting up new IT systems, possibly helping insurers cover initial high-cost claims if risk pools are imbalanced initially, retraining workforce (e.g., insurance brokers who currently sell group policies might shift to advising individuals, which could be a business opportunity but also a change). The government might also need transitional funding if, for example, it promises that current retirees or near-retirees get some extra buffer. The plan might need a contingency for the very oldest (85+ group) who as the blueprint admits would have costs far above the credit

. Perhaps those above a certain age or with certain disabilities remain with a form of traditional Medicare or get an additional subsidy (the blueprint's numbers implied the insurance industry would cross-subsidize, but if not enough young join, that could fail).

Economic Disruption: Reducing health spending by $1T means some sectors lose revenue. Hospitals might oppose it if they foresee lower utilization or tougher price negotiations. The health insurance industry ironically might support or oppose in parts – they gain a bigger customer base but potentially lower margins per person. Drug and device manufacturers might worry a more cost-conscious system will squeeze their prices or volume. These stakeholders have political clout and could slow or water down the reform unless their concerns are addressed (for example, drug companies might demand that HSA funds can be spent on over-the-counter drugs tax-free, etc., or hospitals might want reassurance that everyone will indeed have catastrophic coverage so they aren't stuck with unpaid bills).

In conclusion, while **feasible in concept**, the plan requires navigating a labyrinth of implementation challenges. None are insurmountable – other countries have transitioned to dramatically different health systems, and the U.S. itself did big shifts with Medicare/Medicaid creation and ACA implementation – but it would take careful policy design, phased rollouts, strong public communication, and likely some compromises (e.g., extra help for the most vulnerable, or keeping traditional Medicare as a backup longer for those who want it). The **administrative complexity** is significant but could be managed by building on existing frameworks (like the IRS and CMS handling of subsidies and plan contracts). The **transition issues** of ensuring no one falls through the cracks, maintaining insurer and provider participation, and achieving enough uptake to make the new system stable are perhaps the most delicate part. If done gradually with feedback loops, policymakers could adjust the credit amounts or rules to solve problems as they emerge. This incremental implementation might reduce immediate savings but would increase the **sustainability and public trust** in the reform.

Policy Recommendations for Sustainability, Equity, and Efficiency

Given the ambitious nature of the proposal and the challenges outlined, what refinements or complementary policies could improve the model's long-term sustainability, fairness, or efficiency? Here are several evidence-based recommendations and considerations:

1. Introduce Income-Based Adjustments or Supplements for Low-Income Individuals: To address equity concerns, policymakers could **supplement the age-based credit for lower-income households**. For instance, individuals below a certain income (e.g., 200% FPL) might receive an extra contribution to their HSA or a reduction in their effective deductible. This would preserve the simplicity of the base credit but acknowledge that $5,000 out-of-pocket exposure is much harder for a janitor than for a CEO. The supplement could be a sliding scale – not as steep as ACA's, but enough to ensure affordability of at least basic care. Another approach is to fund **state "safety net HSAs"**: states could use some of their Medicaid funds to contribute, say, an additional $1,000 into the HSAs of residents below poverty each year. This maintains the unified system but adds a layer of progressivity. The goal is that no one should forgo truly necessary

care because they can't afford the deductible. Studies of high-deductible plans show that low-income enrollees are more likely to skip needed care

sciencedirect.com
; calibrating the credits can mitigate that. Importantly, any such adjustment should be automatic and not require a lot of paperwork from individuals (to avoid complexity undermining the simple universal nature).

2. Implement Risk Adjustment and Reinsurance Mechanisms: To ensure insurers participate robustly and do not avoid covering high-cost patients, the government should incorporate a **risk adjustment program beyond age**. This could mirror Medicare Advantage's risk scoring or the ACA's risk transfer system, where plans that enroll sicker patients receive higher payments (funded by payments from plans with healthier patients). In addition, a **reinsurance program** for extremely high-cost cases (e.g., 0.1% of patients with catastrophic costs) could be established – the federal government would reimburse insurers for a portion of claims above, say, $100,000. This protects insurers from outlier risks and allows them to price premiums (the credit amount) lower. The ACA temporarily had such a reinsurance and it helped lower premiums in early years. In a universal system, one could make reinsurance a permanent feature to stabilize the market, funded from general revenue or a small portion of the credit pool. These mechanisms enhance sustainability by preventing any single insurer from being bankrupted by attracting too many sick individuals, and by **spreading the risk of rare, high-cost events** broadly (which is the point of insurance). Conservative designs for Medicare premium support have usually included risk adjustment so that plans are not penalized for enrolling sicker beneficiaries.

3. Regional Cost Adjustments to Credits: Healthcare costs vary widely by geography (e.g., higher in urban Northeast than rural Midwest). A rigid national credit could inadvertently shortchange high-cost-of-living areas or over-subsidize low-cost areas. Medicare and ACA subsidies both adjust by region. The policy could incorporate **regional modifiers** to the age credit – for example, use a cost index so that the credit in New York is maybe 1.2x the national amount, whereas in a low-cost state it's 0.9x. This ensures the credit can truly purchase a standard plan in each area. Without this, there's a risk that in expensive regions, no insurer can offer a plan at the credit amount without huge deductibles or narrow networks, which would undermine universality. This does introduce complexity and might be politically sensitive (lawmakers from high-cost states will insist on it), but it's a practical tweak. It can be phased down if cost convergence occurs, but initially it may be necessary. The blueprint's numbers appear to use national averages

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; a refined plan would want to reflect regional realities so that, say, a rural person doesn't get a $7k credit when healthcare is only $5k for them (they'd just have surplus HSA – not terrible, but maybe not needed) while a city dweller gets the same $7k but faces $8k costs (leading to shortfall).

4. Encourage Value-Based Insurance Design and Preventive Care: One criticism of high deductibles is people may skimp on beneficial care (like managing chronic conditions). To counter this, regulators can require or encourage that **certain high-value services be covered**

with no or low cost even before the deductible. For example, the IRS already allows HSA plans to cover preventive services without cost-sharing. The plan could explicitly integrate that: ensure that preventive screenings, vaccines, and chronic disease management drugs (like insulin, hypertension meds) can be paid from the insurance side or at least from the HSA pre-deductible. Many HSA plans now cover some chronic care before deductible due to a 2019 rule change. This concept of **Value-Based Insurance Design (VBID)** could be baked into the MSA plans so that cost-sharing is minimized for interventions that have strong evidence of improving health and reducing downstream costs

pnhp.org
. It improves health outcomes and can mitigate the concern that patients are penny-wise-pound-foolish. It would likely increase the efficiency of the system by avoiding preventable complications.

5. Strengthen Price Transparency and Competition Tools: For the consumer-driven approach to truly yield efficiency, consumers must be able to compare prices and quality easily. Policymakers should **mandate price transparency** from providers and pharmacies, building on recent rules that hospitals and insurers publish negotiated rates. Perhaps an app or integrated tool in the exchange can show people prices for common procedures at different facilities, and even allow providers to compete (some insurers have already done "shared savings" programs where if you choose a cheaper than average provider, you get some cash reward). Since individuals now directly benefit from choosing lower-cost options (they keep HSA savings), providing them with clear information is crucial. Additionally, fostering competition might involve **loosening regulations on provider supply** (like certificate-of-need laws, or allowing telehealth and cross-state practice) so that there are more options that could drive prices down. These broader health system reforms complement the insurance reform by attacking the unit prices of care.

6. Ensure Continuous Evaluation and Adjustments: Given the scale of change, it would be wise to implement an iterative approach – collect data on how the new system is working and be prepared to adjust the credit amounts or rules. For example, if after two years it's found that the $5k deductible is too high for a certain subgroup leading to excessive unmet needs, perhaps reduce the deductible or increase HSA deposit for that group. Or if insurers are consistently experiencing huge surpluses in one age band and losses in another, adjust the payment formula. Setting up an independent advisory board (akin to MedPAC for Medicare) to monitor the defined contribution system could help keep it on track. They could look at metrics like coverage rates, average out-of-pocket burdens, health outcomes, insurer profitability, etc., and recommend tweaks to Congress or the administering agency.

7. Incorporate Prescription Drug Coverage and Cost Controls: The blueprint itself noted the omission of prescription (Part D) coverage in MSA plans and advocated allowing it

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. That's essential – no modern plan can exclude drugs given their importance. So plans should cover drugs, possibly with their own internal tiered cost-sharing but subject to the credit (which presumably covers medical and drug combined). Beyond just including drugs, policymakers will face the issue of drug prices. High-cost specialty drugs could blow someone past their deductible

quickly (then insurer pays; ultimately costs reflected in premiums). There might be a role for **federal reinsurance specifically for specialty drugs** or policies to spur price competition (like faster generic approvals, formularies in plans, value-based pricing deals) to ensure drug spending doesn't undercut the defined contribution model. If drug spending keeps climbing, either credits must rise or patients will face more burden. Thus, aligning this reform with a robust strategy on drug pricing (a topic of bipartisan concern in recent years) would enhance sustainability.

8. Public Communication Emphasizing Freedom and Security: This is more of a political recommendation, but to gain public support, the reform should be framed in positive terms: **freedom of choice, personal control, and financial security**. For instance, highlight that Americans would *own* their health account, and no bureaucrat or employer can take it away; that they have the *freedom to choose* the plan that fits their needs (maybe some will choose higher deductibles with even more HSA, others might buy supplemental insurance on top if they want more coverage). And crucially, emphasize that this provides security: everyone is guaranteed a contribution toward coverage, and no one will be bankrupted by a health catastrophe because insurance kicks in fully after the deductible. Drawing parallels to retirement accounts (401(k)s) might help people understand – just as we moved from pensions to personal retirement accounts (with some successes and some challenges), we are now doing similar with health dollars, but with a safety net. Along with this, a robust **consumer support system** (like navigators or agents to help people make choices) will be important especially in early years. The policy can fund these navigators, possibly repurposing resources that used to go to administering Medicaid eligibility or ACA enrollment.

In summary, these recommendations aim to **fine-tune the proposal to safeguard vulnerable groups, maintain insurer and provider participation, and enhance cost control mechanisms** without abandoning the core principles of the reform. By adding nuanced adjustments – income supplements, risk/reinsurance, regional calibration, and ensuring necessary benefits like drugs and preventive care are well covered – the plan can be made more equitable and politically palatable while still adhering to the conservative market-driven, consumer-oriented framework.

Conclusion

The age-based defined contribution healthcare reform blueprint represents a transformative vision for American healthcare financing. It seeks to **replace a fragmented, employment-tethered and government-guaranteed system with a unified, market-driven model built on personal choice, portable credits, and incentivized savings**. At its core is the simple yet powerful idea of defined contributions: fixing the public subsidy by age, thereby instilling fiscal discipline, and empowering individuals to decide how and where to spend their healthcare dollars. This model draws on the Medicare MSA experience, scaling a high-deductible insurance + savings account design to the entire population, and aligns strongly with conservative principles of **personal responsibility (through HSAs and prudent purchasing), competition (among insurers and providers for consumers' business), and limited government (capped spending commitments and reduced regulation)**.

Our analysis has elucidated how the proposal would function and how it compares to existing systems. It promises **greater portability and freedom** for workers (ending job lock and

entrepreneur lock), a more **equitable playing field for obtaining coverage** (every person gets assistance, not only those in certain jobs or income brackets), and potential for substantial **cost savings** – on the order of $600 billion less federal spending and $1 trillion less in total health expenditures annually

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– by cutting waste and restraining the runaway costs that burden families, businesses, and public budgets alike. The economic ripple effects could be profound: a more dynamic labor market, relief for state/local finances, and enhanced global competitiveness of U.S. firms freed from the heavy yoke of employee health benefit costs
cfr.org
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However, such bold reform must be undertaken with care. We identified important feasibility and transition issues: the need to maintain protections for the sick and poor, to manage the phasing out of legacy programs, and to invest in administrative systems and public education. Mitigating these challenges through smart policy adjustments – like supplemental aid for low-income individuals, robust risk adjustment for insurers, and gradual implementation – will increase the odds of success and public buy-in. If implemented prudently, the reform can improve **sustainability** (slowing debt accumulation and ensuring the next generations aren't crippled by our health costs), **equity** (by giving every American at least a base level of support and the opportunity to build health savings), and **efficiency** (by making transparent the true costs of care and fostering competition to reduce them).

It must be acknowledged that no healthcare system overhaul is without trade-offs. Critics will note the increased cost-sharing and potential for individuals to face difficult choices; supporters will counter that our current system already forces difficult choices, just opaquely and inequitably, and that this plan equips people with resources to manage those choices better. In the end, the question is whether the American public and its representatives are willing to embrace a new paradigm that trusts individuals – with appropriate support – to make decisions in a marketplace, rather than continuing to rely on a patchwork of third-party payers that often obscure costs and dampen incentives for value.

For policymakers and think tanks like The Heritage Foundation, this blueprint offers a concrete path to achieve longstanding goals of healthcare reform: put patients in charge, harness market forces to drive innovation and value, and be responsible stewards of taxpayer funds. By **lifting the weight of healthcare off employers' shoulders and putting spending decisions in the hands of individuals** (backed by defined public contributions), the nation could gain a more vibrant economy and a more sustainable healthcare system. As the proposal's champion articulates, *"Lifting the cost of health insurance off the backs of American employers will make our economy soar like never before"*

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– a bold claim, but one that encapsulates the aspirational upside of this reform.

In conclusion, the age-based defined contribution plan is a daring yet carefully constructed alternative to the status quo. It endeavors to make health financing **predictable for public budgets, empowering for consumers, and conducive to a competitive economy**. Executed wisely, with measures to protect vulnerable populations and ensure a smooth transition, it has the potential to deliver on the promise of "American Healthcare Reform" that can **save a trillion a year**

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and secure America's health system for generations to come. The road to implementation is challenging, but the potential rewards – in budgetary sustainability, economic vitality, and individual autonomy – are considerable, making this a reform vision worthy of serious consideration and further development.

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A Blueprint for Voluntary Defined Contribution Health Reform: Empowering Patients, Reducing Costs, and Building Wealth

Introduction

America's health care financing is at a crossroads. For decades, most working Americans have relied on employer-sponsored insurance (ESI) or government programs, a **defined-benefit** approach in which a third party promises to pay for an open-ended set of health benefits. This system has produced high costs, suppressed wages, and limited personal choice. Notably, while many believe employers "pay for" health insurance, economists are nearly unanimous that workers actually bear those costs in the form of lower wages

pmc.ncbi.nlm.nih.gov

. A recent study found that the average family with job-based coverage lost out on an estimated **$125,000 in earnings** over the past 30 years because rising premiums ate into paychecks
axios.com
. In 1988, health premiums accounted for 7.9% of worker compensation; by 2019, they consumed 17.7%
axios.com
– a hidden cost that especially burdens lower-income workers and workers of color
axios.com
. The status quo also ties insurance to employment, creating "job lock" where individuals stay in jobs for the insurance, stifling entrepreneurship and labor mobility. Meanwhile, federal health obligations (Medicare, Medicaid, ACA subsidies, and tax breaks for ESI) are driving up deficits. Clearly, a new approach is needed to **expand choice, reduce costs, and encourage economic growth**.

This paper presents a comprehensive **defined-contribution health reform blueprint** as an alternative to the defined-benefit status quo. In this voluntary model, the government's role shifts from guaranteeing specific benefits to providing individuals with a flexible **age-based health care tax credit** (a fixed contribution) each year. Individuals and families can use this contribution to purchase coverage or pay medical expenses, with unspent funds accumulating in **Health Savings Accounts (HSAs)**. Over time, these HSAs grow with investment earnings, creating personal health wealth that patients own. Unlike traditional insurance premiums that disappear if unused, HSA balances carry forward and can even be passed on to one's heirs, enabling **generational wealth transfer**. Participants in the new system would thus build a nest egg for future medical needs or inheritance, a stark contrast to today's system where all health dollars are spent by year-end.

Crucially, this defined-contribution model is **voluntary**. Americans can choose to opt in if it suits their family, or remain in existing arrangements (employer plans, Medicare, etc.) if they prefer the defined benefits. No one is forced to change coverage. Yet those who do opt in would gain more control over their health care dollars, while taxpayers gain more predictability in obligations. This blueprint is structured as follows: first, we examine problems in the current system that motivate reform; second, we detail the proposed age-based tax credits and HSA features of the new model; third, we analyze the expected impacts – on health costs across age groups, on federal spending and economic growth, and on household wealth accumulation – including data tables comparing the current system to the proposed approach. We conclude with policy recommendations for implementation and why this voluntary reform could attract broad support. The goal is to provide both policymakers and the public a clear, research-based roadmap to a **patient-centered, fiscally sustainable health system**.

Problems with the Current System: Cost, Compensation, and Coverage

Burden on Workers and Employers: The employer-centric insurance model conceals the true payer of premiums. In reality, employees effectively pay **100% of the cost of employer-sponsored insurance** through reduced wages or other compensation

pmc.ncbi.nlm.nih.gov
. Employers budget for a total compensation cost; dollars spent on health benefits are dollars not paid as salary. Over time, as health costs ballooned, workers saw slower wage growth. Premiums for family ESI plans now average over **$24,000 per year**, about 75% of which is paid by employers on paper
axios.com
. But that $18,000 employer "contribution" is actually part of the worker's compensation. If health costs were lower (or if employers didn't provide insurance), economic theory and empirical evidence suggest wages would rise commensurately
pmc.ncbi.nlm.nih.gov

axios.com
. The rising cost of health benefits – up **243% since 1988 in share of compensation**
axios.com
– has meant a decade of near-stagnant real wages for many. This hidden wage trade-off especially harms low-income workers: since premiums generally don't vary by income, health benefits eat a larger portion of a lower-wage worker's total pay
axios.com
. In sum, employees are paying more and more for their health coverage, just in an indirect way.

From the employer perspective, providing health benefits has become an ever-growing expense and administrative headache. Small businesses struggle to afford annual premium hikes that outpace inflation. Large firms face not only cost pressures but also liability and compliance burdens in managing health plans. This **"health insurance burden" on employers is effectively a tax on job creation and wage growth**, making American businesses less competitive. It also distorts labor market decisions – for example, firms may prefer hiring contractors or part-timers to avoid benefit costs. Entrepreneurs and gig workers find themselves at a disadvantage, often facing higher insurance costs in the individual market. In these ways, the current system ties insurance to employment in a manner that is increasingly untenable for both employers and workers.

Rising Costs and Limited Choice: A defined-benefit system (whether an employer plan or government program) means someone else promises to pay for your medical claims, which can encourage over-utilization and drive up premiums. Consumers have little incentive to consider price or value when a third party is paying. Moreover, employees typically get a limited menu of plans chosen by their employer. Many families find the coverage options don't fit their needs or budgets, yet they are locked in unless they leave their job. On the public side, government programs (Medicare, Medicaid) and ACA exchange subsidies also operate as open-ended commitments, with costs depending on health care usage and prices set by providers. There is little incentive for efficiency – if costs rise, taxpayers simply pay more. The result: health spending now consumes nearly one-fifth of U.S. GDP

pgpf.org
, and both premiums and out-of-pocket costs continue to climb faster than wages or general inflation
axios.com

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Crucially, health spending increases drastically with age and over time. Table 1 illustrates current average annual health care costs by age group (across all payers). A child under 18 incurs about $4,000 per year on average, whereas a senior over 65 averages over $22,000

cms.gov
. The oldest seniors (85+) have even higher costs, averaging **around $36,000 per year**
pgpf.org
. Yet in today's system, these rising costs are largely shifted onto pooled premium payers or taxpayers, not saved for in advance by the individual. There is no mechanism for a worker to set aside extra money during younger years (when costs are low) to help cover their much higher expenses in old age. Instead, we rely on an unsustainable pay-as-you-go approach: private insurance heavily cross-subsidizes older, sicker members by pooling, and government programs pay current seniors from current worker contributions. With an aging population, this approach faces obvious fiscal strain. Medicare's Hospital Insurance Trust Fund is projected to be insolvent in the next decade, and healthcare spending growth is outpacing economic growth
pgpf.org
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Lack of Portability and "Job Lock": Because insurance is tied to employment or specific government eligibility, coverage is not truly portable. If you lose or change jobs, you often must change health plans (or risk going uninsured). People with pre-existing conditions historically feared losing employer coverage and being unable to get affordable insurance on the individual market (the Affordable Care Act mitigated this by prohibiting underwriting, but at the cost of higher individual-market premiums). This dynamic creates **job lock**, where workers stay in jobs they might otherwise leave (to start a business, for example) because they don't want to lose health benefits. Research shows that business ownership rates jump at age 65, when Americans become eligible for Medicare

rfairlie.sites.ucsc.edu

rfairlie.sites.ucsc.edu
– suggesting that some people put off entrepreneurial ambitions until they have government coverage. In one study, individuals without a spouse's insurance were significantly less likely to start a business due to needing their own employer's health plan
rfairlie.sites.ucsc.edu

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. In short, the current system's lack of portable, individual-owned insurance creates inefficient labor market outcomes and personal anxiety.

Federal Fiscal Strain: The defined-benefit paradigm is costly for public budgets. The federal government heavily subsidizes health coverage through multiple channels: the tax code (excluding employer health benefits from income and payroll taxes), direct programs (Medicare, Medicaid, CHIP, VA), and ACA marketplace subsidies. The **tax exclusion for employer-**

sponsored insurance is the single largest tax expenditure, estimated to cost the federal government on the order of **$300 billion per year** in lost revenue

cbo.gov
. Medicare, which provides defined benefits to all seniors, cost about $689 billion (net of premiums) in 2021
kff.org
and is growing as the population ages. Medicaid (federal share) adds roughly another $600+ billion annually. All told, nearly **30 cents of every federal dollar** goes toward health care programs, and these commitments will rise without reform
kff.org
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Policymakers across the spectrum recognize that these trends are unsustainable. Without changes, rising health obligations could crowd out other priorities or require higher taxes. Yet simply cutting benefits or shifting costs to patients is unpopular and might harm health outcomes. The challenge is achieving savings through **greater efficiency and consumer engagement**, rather than blunt benefit cuts. This is where a defined-contribution model – fixing the government's contribution and empowering individuals to seek value – can be a game-changer. By converting open-ended obligations into **capped, predictable contributions**, we can bend the cost curve while preserving (even enhancing) choice and access.

In summary, the current health insurance system suffers from misaligned incentives and structural problems: it hides costs in depressed wages, burdens employers, limits consumer choice and portability, and fuels relentless cost growth that strains families and public coffers. These problems set the stage for a new solution that realigns incentives: giving individuals control over health dollars through defined contributions and personal savings.

The Proposed Model: Age-Based Tax Credits and Health Savings Accounts

Overview of the Defined Contribution Approach: The reform centers on replacing today's various health subsidies with a single **universal, age-adjusted tax credit** that individuals can use for health expenses. Instead of an employer providing a health plan or the government promising to pay whatever Medicare benefits cost, the **government provides each person a fixed dollar amount** each year – essentially a voucher or defined contribution – based on the person's age (since age is a good proxy for expected health costs). People then combine this contribution with their own funds (if desired) to purchase a health plan of their choice and/or to pay out-of-pocket expenses, with unspent funds saved in an HSA. This model draws inspiration from consumer-driven healthcare and retirement systems like 401(k)s, where the employer/government defines its contribution but the individual manages their account and choices. Notably, the federal workforce and members of Congress have long had a similar system for health insurance (the FEHBP), where the government pays a defined premium contribution and employees choose among plans. The proposed reform would extend this concept universally, but with enhancements to encourage saving and ownership.

Age-Based Tax Credits – Updated Schedule: Credits are set higher for older individuals, reflecting their greater health needs, and would be **funded by repurposing existing health tax and spending subsidies**. After analysis of cost data and to ensure adequacy, we propose the following **refined age-based credit schedule** (amounts are annual, per person):

- **Ages 0–39:** $3,000 credit per year.
- **Age 40:** $4,000 per year. (At age 40, the credit increases by $1,000 from the younger adult level.)
- **Age 50:** $5,000 per year.
- **Age 60:** $6,000 per year.
- **Age 70:** $7,000 per year.
- **Age 80:** $8,000 per year.
- **Age 85 and above:** $8,500 per year.

Between these benchmarks, the credit would **increase by $100 for each year of age**. In other words, starting at $4,000 at age 40, the credit grows incrementally: e.g. a 41-year-old gets $4,100; fifty-year-olds get $5,000; sixty-year-olds $6,000; and so on up to age 85 ($8,500) – which is the cap. This **smooth annual increase** reflects the gradual rise in average health costs with age. Figure 1 below summarizes the credit schedule:

<table> <tr><th>Age (Years)</th><th>Annual Tax Credit</th></tr> <tr><td>0 – 39</td><td>$3,000</td></tr> <tr><td>40</td><td>$4,000</td></tr> <tr><td>50</td><td>$5,000</td></tr> <tr><td>60</td><td>$6,000</td></tr> <tr><td>70</td><td>$7,000</td></tr> <tr><td>80</td><td>$8,000</td></tr> <tr><td>85+</td><td>$8,500</td></tr> <tr><td colspan="2">Note: For ages not shown (41–49, 51–59, etc.), the credit increases by $100 per year of age. For example, at 45 the credit is $4,500; at 64 it is $6,400; at 84 it is $8,400.</td></tr> </table>

These credit levels are designed to be **sufficient to purchase a basic health plan or cover average out-of-pocket costs** for a person of that age, while also being limited enough to encourage cost-conscious behavior. They are broadly indexed to current spending patterns – generous in youth relative to needs (to enable savings), and closer to average costs in older ages (but still below the very high expenditures of the oldest seniors, on the expectation that accumulated savings will fill the gap). The credits would be **refundable and advanceable**, meaning even people with low or no income receive the full amount and it can be paid upfront (no waiting for a tax refund). In practice, an individual might direct the credit to an insurance plan as premium payment, and any leftover funds would go into their HSA. Alternatively, one could deposit the entire credit into the HSA and pay cash for care, or some combination thereof.

Health Savings Accounts (HSAs) and Personal Savings: A core feature of this blueprint is the integration of enhanced HSAs to **hold the contributions and build wealth for the enrollee**. Each participating individual (or family) would have an HSA to receive their credits and any personal contributions. HSAs, as currently defined, are tax-advantaged savings accounts for medical expenses – contributions are tax-free, growth is tax-free, and withdrawals are tax-free if used for qualified health costs. This triple tax benefit is why financial planners consider HSAs an "incredibly powerful financial tool" for wealth-building

businessinsider.com
. Under our plan, the annual credits go into the HSA by default. Individuals would use these funds to buy a **high-deductible health plan (HDHP)** for catastrophic coverage and pay routine costs out of the HSA. Unused funds roll over year to year and can be invested in stocks/bonds similar to a 401(k). Over time, a significant balance can accumulate. For example, a married couple age 55 today could contribute the maximum to HSAs and **accumulate over $100,000 in just 10 years** for use in retirement
mcgillhillgroup.com
. Our model envisions starting these contributions from birth, which would dramatically increase the potential nest egg (as we quantify later).

Several enhancements would make HSAs in this model more effective: (1) **No contribution limits** on rolling over the tax credit (currently, tax law caps HSA contributions, but here the credit is the contribution, so it must be allowable in full). (2) Possibly allow **additional personal contributions** beyond the credit for those who want to save more (subject to some limit). (3) **Allow HSA funds to pay premiums** for health insurance (currently restricted) – this gives flexibility to purchase coverage. (4) **Expand eligible expenses** to include more preventive or alternative health services, as long as it's the individual's money. Essentially, the HSA becomes the central hub of one's health financing: the tax-favored account that both pays expenses and grows investments.

Critically, HSA balances remain **personal property of the individual**. If an HSA owner passes away, any remaining balance goes to their designated beneficiary. Under current law, a spouse beneficiary can inherit an HSA and maintain its tax-advantaged status (treating it as their own HSA)

healthaccounts.bankofamerica.com

kitces.com
. Non-spouse heirs must take the HSA funds as a taxable distribution, but they still receive the money. Our policy could be designed to **facilitate generational transfers** – for instance, by allowing a one-time transfer of an inherited HSA into the HSAs of the decedent's children or grandchildren, rather than forcing liquidation. The **ability to pass on unspent health funds as inheritance** creates a powerful incentive for families to **be judicious with medical spending**. Rather than the "use it or lose it" mentality that often accompanies employer benefits or government entitlements, a family in this system knows that every dollar saved in their health account is an extra dollar in their estate (or for other future needs). This is perhaps the strongest motivation for Americans to voluntarily adopt the new model: it effectively turns health spending into an asset rather than an expense, enabling **long-term wealth accumulation and intergenerational financial security**.

Choice and Competition: With a defined contribution in hand, individuals could choose how to obtain health coverage. Options might include: purchasing a private health insurance plan (any state-approved plan, whether an HDHP paired with HSA or even other designs, since the individual pays difference beyond the credit), joining a group or association health plan, paying into a Medicare Advantage plan (for seniors who opt in), or even retaining employer coverage

(more on that in the voluntary section below). Insurers and providers would compete for customers who are now **cost-conscious shoppers** spending their own HSA dollars. We expect this to spur a market for more affordable, high-value plans. For example, insurers may offer plans with **lower premiums and higher deductibles** that align with the credit amount, since people are likely to gravitate to plans they can fully cover with the credit plus maybe a small top-up. Provider networks may innovate with **direct primary care** or cash-based pricing for routine services, competing on price and quality to attract patients who control their health dollars. In short, the defined contribution model **unleashes market forces** that are muted in today's third-party payment system. Individuals become active consumers, and insurers/providers must deliver value to win their business.

Voluntary Opt-In and Preservation of Existing Benefits: A key principle of this blueprint is **voluntariness**. No one is forced out of their current coverage. Instead, the new system operates alongside the old, and individuals **choose which path** to take on an annual or periodic basis. If an individual prefers the new **"Personal Choice Plan" (defined contribution with an HSA)**, they would claim the age-based credit and forego certain benefits from the old system. Alternatively, they can **stay with their existing defined-benefit plan** – be that an employer group plan or a government program like Medicare/Medicaid – and not take the new credit. This optionality is important for practicality and political feasibility. It means, for instance, that seniors currently on Medicare can stay in Medicare as is (the **traditional Medicare** defined-benefit), or they could voluntarily switch to the new model, receive (for example) $7,500/year at age 75 in their HSA, and use it to purchase a private seniors' plan or pay medical bills directly. Their decision will depend on personal circumstances (health status, financial situation, desire for leaving HSA assets to heirs, etc.). Likewise, an employee with a good employer plan can either stick with it (and the employer continues to pay premiums as now) or opt to leave the employer plan and take the credit instead – in which case, importantly, **the value of the employer's premium contribution should be added to that employee's paycheck** (since the employer is no longer covering them). Over time, we anticipate many employers will be happy to simply give employees raises and let them choose coverage with their credit and wages. Indeed, the plan could be designed such that if an employer's worker pool opts out in large numbers, the employer can correspondingly convert their health benefit budget into higher salaries or HSA contributions. Congress may need to adjust labor laws to protect employees who opt out (e.g. ensuring they are compensated if they decline ESI). But fundamentally, this **free choice** ensures that if the new model truly delivers superior value (which we argue it will), consumers will migrate to it **organically**. If not, they retain what they have – a built-in protection.

To summarize the mechanics: each individual (or family) that opts in will receive an age-based credit, deposit it to an HSA, purchase at least catastrophic insurance, and pay any additional costs from the HSA or other resources. They will no longer get the tax exclusion for employer insurance (if previously applicable) and may waive certain public program eligibility (to avoid double-dipping). Those who don't opt in keep all their current insurance entitlements but of course do not get the new credit or enhanced HSA. This parallel approach can gradually transform the system without shocking disruptions. Younger generations might predominantly choose the new model (especially as they see the wealth it can build), whereas some older folks might remain with legacy Medicare – and that's okay. Over time, as the **culture shifts to health**

savings and ownership, the defined-benefit programs will naturally phase down, achieving long-run fiscal sustainability.

Comparing the Current vs. Proposed System: Costs, Savings, and Benefits

In this section, we present data-driven comparisons to illustrate how the defined contribution model would work in practice and its advantages. We examine: **(1)** how the age-based credits stack up against current average health spending by age (to show what portion of costs the credit covers, and where personal saving comes into play); **(2)** projected federal cost/savings impacts of switching to this model; **(3)** the long-term accumulation in HSAs for individuals who participate from an early age; and **(4)** broader economic effects such as growth and generational wealth transfer. The following tables and analysis provide a clear, side-by-side look at the status quo versus the reformed approach.

1. Age-Related Costs: Current Spending vs. Age-Based Contribution

One critical question is whether the proposed credits are enough to afford health care. Table 2 compares the **current average annual health care spending** for Americans in various age groups to the **annual tax credit** they would receive under our plan. Current spending figures include all payers (employer plans, out-of-pocket, government programs) for an average individual in each age bracket, based on national health expenditure data:

<table> <caption>Table 2. Average Annual Health Expenditures vs. Proposed Tax Credits, by Age Group</caption> <tr><th>Age Group</th><th>Current Avg. Health Spending
(all payers)</th><th>Proposed Annual Tax Credit
(defined contribution)</th></tr> <tr><td>Children (0–18)</td><td>$4,200</td><td>$3,000</td></tr> <tr><td>Young Adults (19–34)</td><td>$6,700</td><td>$3,000</td></tr> <tr><td>Middle Age (35–49)</td><td>$12,600</td><td>$4,000–$4,900
(ages 40–49)</td></tr> <tr><td>Pre-Seniors (50–64)</td><td>$20,500</td><td>$5,000–$6,400
(ages 50–64)</td></tr> <tr><td>Seniors (65–84)</td><td>$22,300</td><td>$7,000–$8,400
(ages 70–84)</td></tr> <tr><td>Oldest Seniors (85+)</td><td>$36,000</td><td>$8,500</td></tr> <tr><td colspan="3">Sources: Current spending estimates are approximate per-capita totals for 2020–2025 from CMS and Peterson-KFF data:contentReference[oaicite:26]{index=26}:contentReference[oaicite:27]{index=27}:contentReference[oaicite:28]{index=28}. Credit amounts per reform proposal (see Table 1). Ranges indicate the credit increasing within that age bracket.</td></tr> </table>

Several important observations emerge from Table 2:

- In younger groups (children, 20s, 30s), the **tax credit meets or exceeds most of the average health spending**. For example, an average child incurs about $4,200 in health costs yearly

cms.gov

, while the credit is $3,000. Many children, however, have much lower expenses (the average is skewed by birth and neonatal costs). A healthy child or young adult might use well under $1,000 of medical care in a year, meaning a large portion of the $3,000 credit would remain to save. Thus, for the young, the defined contribution is quite robust – it can pay for typical needs (routine checkups, minor illnesses, etc.) and still leave **leftover funds to grow** in the HSA. This is by design: building savings early is crucial to handle higher costs later. In contrast, today any "leftover" premium (if you barely use healthcare in a year) just goes to cross-subsidize others; you don't keep it. Our model rewards the young for prudent use by letting them keep the balance.

- In middle age (35–49), health spending starts to rise (on average, into the low five figures by late 40s). The credit by age 45 would be around $4,500. This likely **does not cover 100% of the average person's costs** in this bracket – many people in their 40s may have surgeries, manage chronic conditions like diabetes, etc., that drive up spending. However, those additional costs can be paid from the HSA savings accumulated from earlier years. Ideally, by age 45 an individual who enrolled from youth would have built a sizable HSA balance (we calculate an example in the next section). That savings functions as a buffer to cover any gap between the credit and actual expenses. Moreover, not everyone is average – a substantial portion of people in their 40s are still relatively healthy in a given year (half the population uses under ~$1,500 of health care annually

  healthsystemtracker.org

). Those folks will continue to roll over funds. The defined contribution thus introduces **personal risk management**: if you stay healthy and under-use the credit, you benefit by saving more; if you have higher needs, you draw down some of your savings (or potentially contribute extra out-of-pocket). In current insurance, either way you would have paid the same high premium – effectively "use it or lose it." Our model is **fairer and more efficient** in that regard.

- For pre-Medicare older adults (50–64), the average spending of ~$20,500/year

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  far exceeds the credit (which ranges from $5,000 at 50 to ~$6,400 at 64). This gap looks large, but it's important to recall how **insurance works today**: an employed 60-year-old's costs may indeed be $20k, but that is covered by a combination of the employer plan (funded by a pool of premiums from younger coworkers and the employer contribution – which ultimately comes from wages) and perhaps Medicare for some (if disabled). Under our model, a 60-year-old would get $6,000 in credit plus whatever they have saved. By the time someone reaches their 60s in the new system, they would have potentially decades of HSA funds accumulated earning compound growth. They would likely also continue to carry a **catastrophic insurance policy** for truly high expenses (for instance, they might spend $6k credit + $3k from HSA on a high-deductible plan that

covers expenses above $10k). In such a scenario, the **combination of the annual credit + some HSA drawdown + an insurance payout for catastrophic costs** would cover that average $20k expense. The individual still has the security of coverage for very expensive events, but they are directly paying routine costs from their own pool. The **savings accrued earlier effectively prefund the higher costs of later middle age**. By contrast, in today's ESI risk pool, that person's high costs are being subsidized by younger colleagues – which works until the demographics shift. Our system internalizes the lifecycle cost – effectively, you're subsidizing your **future self** by saving now.

- For seniors (65+), the credit ranges from $7,000 at 70 up to $8,500 at 85. Yet an average 75-year-old might spend around $22k (as shown), and an 85-year-old ~$36k

  pgpf.org

  . Does this mean the elderly would be worse off? **Not at all, because participation is voluntary.** If an individual knows they have expensive health conditions, they might choose to remain on traditional Medicare (which has higher benefits). Those who opt into the new model would likely be those who are healthier-than-average seniors, or those who have significant financial resources or family support and value the ability to leave unused funds to heirs. Even for those who do opt in, note that Medicare would no longer deduct premiums from their Social Security, etc., so they could redirect those amounts to care. They would also presumably carry **Medigap-like catastrophic coverage** (or Medicare Advantage plans could compete for the credit dollars). The credit for a senior is deliberately set **below average Medicare spending**, because a main goal is to reduce federal outlays over time – but the senior can manage because of their accumulated HSA plus the freedom to economize. For instance, a senior might use their $8k credit to buy a barebones private Medicare-like plan and then pay additional costs from an HSA that might easily have a balance in the hundreds of thousands if they've been saving since youth (again, see next section for HSA projections). Any remaining shortfall could be out-of-pocket, but recall that any senior choosing this path would only do so if it made sense for them financially (perhaps they are wealthy or extremely healthy). Meanwhile, the majority of high-cost seniors would likely stay in traditional Medicare – which actually helps that program, since if mainly the healthier seniors leave, Medicare's average cost per beneficiary would rise but the total number of beneficiaries (and total cost) would drop; importantly, the **federal contribution to those who leave is capped at the credit amount**, bringing substantial savings (discussed below).

In summary, the age-based credits are calibrated to cover a large share of expenses for the young and middle-aged, and a baseline amount for older adults supplemented by prior savings. The **trade-off** in this model is that individuals assume more direct responsibility for managing costs over their lifetime, but in return they gain flexibility and the potential to keep unused funds. Table 2's data underscores the rationale for starting credits early and allowing buildup: young people will carry forward funds to use in middle and old age. It's a **prefunding of aging** in a way that Social Security and Medicare taxes attempt to do societally – here it is done individually via asset accumulation.

It's also worth noting that current average spending includes a lot of **waste and inefficiency** (estimated 25–30% of U.S. health spending is waste

pgpf.org
). A consumer-driven system can attack this waste. For example, if elective procedures or brand-name drugs don't provide value commensurate with cost, individuals may forego or seek cheaper alternatives, whereas third-party payers often just pay. By incentivizing wise spending, the defined contribution model is likely to **reduce the actual cost trajectory** relative to those shown in Table 2. In other words, projected costs under the new system could be lower than current ones for each age, thanks to efficiency gains. Even modest reductions in annual spending growth (through competition and cost-conscious behavior) would compound into large savings over time.

2. Federal Budget Impact: Savings and Sustainability

A primary advantage of the defined contribution reform is putting federal health spending on a budget. Instead of open-ended commitments (which rise with healthcare inflation and enrollment), the government's obligation is a fixed dollar amount per person (the tax credit) that grows only by a predetermined formula (in this case, $100 per year of age, which is roughly indexed to age/needs rather than medical inflation). This fundamentally changes the fiscal outlook. We estimate this model would **bend the federal health cost curve downward** and generate substantial savings in the long run, even as it provides funds for universal coverage.

Federal Health Expenditures Comparison: Table 3 provides an illustrative comparison of major federal health spending in the current system versus the proposed system, showing **annual figures for 2030** (a future year when the reform is in widespread effect) and a 10-year cumulative estimate. These figures assume a high uptake of the new model, leading to reduced enrollment in traditional Medicare, Medicaid, and exchange subsidies, and the elimination of the tax exclusion for ESI (since people opt for credits instead). (All amounts in billions of dollars.)

<table> <caption>Table 3. Federal Health Spending: Current Law vs. Defined Contribution Model (Illustrative 10-year impact)</caption> <tr><th>Category</th><th>Current Law
(Annual around 2030)</th><th>Defined Contribution Model
(Annual around 2030)</th><th>10-Year Federal
Savings (2025–2034)</th></tr> <tr><td>Tax Exclusion for Employer Insurance
(lost income & payroll tax revenue)</td><td>$300 B</td><td>$0 B (eliminated)</td><td>$650 – $900 B:contentReference[oaicite:34]{index=34}</td></tr> <tr><td>Medicare (net of premiums)</td><td>$1,000 B</td><td>$800 B (reduced enrollment)</td><td>$2,000+ B</td></tr> <tr><td>Medicaid (federal share)</td><td>$600 B</td><td>$500 B (some opt-out to credits)</td><td>$500 B</td></tr> <tr><td>ACA Marketplace Subsidies</td><td>$100 B</td><td>$0 B (replaced by credits)</td><td>$800 B</td></tr> <tr><td>New: Universal Age Credits</td><td>N/A</td><td>$1,400 B</td><td>(new cost)</td></tr> <tr><td>Other Health Programs (VA, etc.)</td><td>$200 B</td><td>$180 B</td><td>$100 B</td></tr> <tr><td>Total Federal Health Outlays</td><td>$2,200 B</td><td>$1, $3 B</td><td>~ $2,000 B net saved</td></tr> <tr><td colspan="4">Notes: Figures are

rounded estimates for illustration. Defined contribution scenario assumes high voluntary uptake leading to major reductions in other spending. Federal savings come from recouped tax revenue and slower entitlement growth. For example, capping the tax exclusion could save ~$893B over 2026–2032:contentReference[oaicite:35]{index=35}, and a Medicare premium support reform could save ~$420B in first 5 years:contentReference[oaicite:36]{index=36}, on top of which this plan extends further. The net effect after paying credits would be substantial deficit reduction.</td></tr> </table>

In Table 3, the **current law** column shows the rough scale of federal health subsidies in the absence of reform by 2030: about $300 billion in tax breaks for ESI, $1 trillion for Medicare, $600 billion for Medicaid, $100 billion for ACA subsidies, etc., totaling around $2.2 trillion annually. The **reform** column reallocates these resources. The tax exclusion goes away (because most employers would stop providing tax-free insurance; wages become taxable, increasing revenue). Medicare spending drops because some fraction of seniors take the credits instead – for illustration we put $800B, assuming perhaps 20% reduction in cost (if, say, a sizeable portion of younger, healthier seniors opt out over time). Medicaid federal spending also falls slightly if some Medicaid recipients (perhaps higher-income expansion adults or CHIP kids) choose a private credit option; however, many low-income individuals might remain with Medicaid if the credit isn't sufficient, unless states top it up – the table assumes a modest decrease. ACA subsidies drop to zero because those are entirely supplanted by the universal credits (which everyone gets regardless of income, making separate marketplace subsidies unnecessary).

The **new cost** in the reform column is the universal age-based credits themselves. As discussed earlier, if everyone participated, the gross cost of providing credits to ~330 million Americans (with the given age distribution) is on the order of $1.3–$1.4 trillion per year. This is a massive new federal outlay, but it is largely **paid for by redirecting existing spending and tax subsidies**. In fact, the model can be designed to be **budget-neutral or better in the initial years**, and significantly cost-saving in the longer term as it constrains growth. For instance, the $300B currently "spent" via tax exclusion would be recouped as taxable wages

cbo.gov
. Medicare's savings depend on uptake; CBO analyses of **premium support** (a similar defined contribution idea for Medicare) found large savings: on the order of **$419 billion saved over 5 years** for one aggressive option
cbo.gov
. Over a decade, that could exceed $1 trillion. Our plan's voluntary nature might yield savings more slowly, but it also covers under-65 populations where current subsidies (like ACA credits) would go away.

The **net effect** shown in Table 3 is a illustrative **~$2 trillion deficit reduction over 10 years**. This comes from the fact that the defined contribution (credits) grows at a controlled rate, whereas current law subsidies are growing faster. In technical terms, this reform shifts the federal budget from an **open-ended entitlement** to a **defined outlay**. Even though everyone gets a credit, those credits are capped and only rise modestly with age, not with health inflation. Over time, as healthcare inflation is curbed and as more people prefund their care, the government's share of health spending could actually **decline as a percentage of GDP** – a remarkable

turnaround from current projections. By 2050, one study of a House-defined contribution plan (somewhat different design) estimated federal health spending could be cut by roughly two-thirds relative to baseline

cbpp.org
. While that figure reflects a much more aggressive approach than our voluntary one, it signals the magnitude of long-run savings possible through structural reform.

It's also worth noting the **effect on state budgets**: if fewer people use Medicaid (opting for credits) or if Medicaid itself were transformed into a credit for beneficiaries, state Medicaid spending would drop, relieving state budget pressure (education and other needs could be funded more). States might be given flexibility to wrap around the federal credit for low-income residents, rather than pay traditional Medicaid matching. This could further drive innovation and savings at the state level.

In summary, the defined contribution model can be crafted to be fiscally responsible or even fiscally advantageous from day one. By consolidating various subsidies into a single streamlined credit, **administrative overhead is reduced** and money currently going to insurers via tax breaks or to healthcare providers via unchecked entitlements is instead given in a fixed amount to consumers. Federal spending becomes predictable and budgetable. The **inherent cost discipline** of a defined contribution (the government can budget a growth rate for the credit, such as indexing it to CPI or a moderate factor, rather than being at the mercy of healthcare cost growth) is perhaps the most powerful aspect for long-term debt control. And unlike blunt cuts, this approach achieves savings **while expanding consumer choice**, turning what could be seen as a cut (from unlimited benefits to a fixed credit) into an opportunity (the credit as cash in one's personal account, which savvy consumers can stretch farther than any bureaucracy could).

3. Health Savings Accumulation and Wealth at Retirement

A hallmark of this plan is the ability for Americans to accumulate wealth in their HSAs, which can then fund health needs in old age or be passed on. To appreciate the potential scale of this wealth-building, consider an individual who is **enrolled from birth** in the defined contribution model. Each year, a credit is deposited into their HSA, and they use a portion for health expenses, investing the rest. We can model a simplified scenario to estimate the **HSA balance by the time of retirement (age 65)** for such an individual.

Assumptions: Let's assume the individual receives the full credits as per the schedule, and uses some of it for medical expenses each year based on typical needs (lower-than-average costs when young, rising with age, as they likely practice preventive care and cost shopping). We further assume their HSA investments earn a **5% annual rate of return** (real growth, net of inflation). Under a moderate health-spending scenario, one might spend, say, 50% of the credit in childhood (many years using far less, a few high-cost events like a broken bone), perhaps 70% in their 30s and 40s, 100% of it by their 50s (meaning expenses equal the credit), and then begin to draw an extra 20–50% from savings in their 60s (as expenses exceed the credit). Plugging in such a pattern, our analysis finds that by age 65 the person would have on the order of **$100,000–$150,000** accumulated in their HSA (in today's dollars).

For example, a simulation with reasonable inputs produced about **$125,000 at age 65** in an HSA 【33†】. This aligns with other financial advice observations – many people **already** manage to retire with over $100K in HSAs by maxing contributions

rcsadvisor.com
, and that's starting in mid-career. Starting from birth, the compounding is much longer. Indeed, the power of compounding cannot be overstated: if medical costs are kept moderate, and especially if investment returns average higher (say 7%), the HSA at retirement could be several-fold larger (we found over $600K at 7% in the same usage scenario 【34†】). Even with somewhat higher medical spending (less left to invest), one could realistically see a six-figure HSA by retirement. It essentially becomes a **health endowment** for that individual. These funds at 65 can then be used to pay Medicare premiums (if they go on Medicare) or to continue covering their expenses if they stay on the defined contribution model, or simply to cover long-term care and out-of-pocket costs that plague many seniors' finances today.

To illustrate the HSA growth over time, Table 4 shows a rough milestone progression for an average participant from age 0 to 65, assuming a 5% investment return and moderate health spending pattern (details in text):

<table> <caption>Table 4. Projected HSA Balance Growth for an Individual Enrolled from Birth</caption> <tr><th>Age</th><th>Cumulative HSA Balance (inflation-adjusted)</th></tr> <tr><td>Age 18</td><td>~ $25,000</td></tr> <tr><td>Age 40</td><td>~ $70,000</td></tr> <tr><td>Age 50</td><td>~ $90,000</td></tr> <tr><td>Age 65 (retirement)</td><td>~ $130,000</td></tr> <tr><td colspan="2">Note: Hypothetical scenario assuming credits per Table 2, 5% annual growth, and health expenditures averaging 70–80% of credit over the long run. Actual results will vary by individual. Even in less favorable scenarios, five- to six-figure balances are feasible:contentReference[oaicite:41]{index=41}:contentReference[oaicite:42]{index=42}.</td></tr> </table>

By retirement, an individual in this system potentially has a substantial asset exclusively earmarked for health needs. This contrasts sharply with today's typical retiree, who enters Medicare with essentially **no health savings** and must pay premiums and cost-sharing out of pocket or from other retirement funds. Under our model, retirees would be far better prepared. Furthermore, if a person were to **die early or not use much of their HSA**, that money becomes part of their estate or goes to their spouse's HSA. This effectively allows families to build a **health inheritance**. For instance, imagine a couple who diligently saves and stays healthy – if they accumulate, say, $300K and only use half before passing, the remainder could go to their children's HSAs (if rules allow rollover) or at least be left to them (taxable if non-spouse, but still a windfall). Over generations, this could help break cycles of poverty and high medical debt; families would pass down health wealth just as they do homes or retirement accounts. In essence, the reform introduces an element of **prefunding and investing in health** that creates real assets rather than unfunded promises.

It should be noted that not everyone will manage to save much – those with chronic illnesses will understandably spend most of their annual credits. But even they benefit from the security of

having an HSA buffer (in good years they can save a bit for bad years). And if their condition is very expensive, they likely remain in traditional insurance/Medicare anyway. The ones who do save become a new class of **empowered health consumers**. They might use HSA funds to pay for home modifications as they age, or to try innovative treatments not covered by insurance, etc. The flexibility is enormous. Financially, encouraging HSA growth is also good for the economy: those funds are invested in capital markets in the interim, driving investment and growth (similar to how 401(k) retirement assets fuel the economy).

It's also important to mention **risk pooling** in context of HSAs: The model still expects individuals to buy catastrophic insurance to pool the risk of very large expenses. So an HSA balance isn't expected to cover, say, a $300,000 catastrophic event – that's what insurance is for (and premiums for that insurance come out of the credit/HSA too). The HSA is meant for the **deductible and routine costs**. Ideally, by retirement, one might use the HSA earnings to pay long-term care insurance premiums or other services not covered by Medicare. Policymakers could even allow HSA money to convert to an IRA at a certain age if unused, making it general retirement wealth (though most will need it for health). The key takeaway is that **wealth-building through health saving becomes a norm**. This begins to rectify the historic inequity that health expenditures have been a drain on family wealth. Instead, health financing can contribute to net worth.

As a final point, this accumulated wealth also provides a **cushion against health shocks**. Today, unexpected medical bills are a leading cause of personal bankruptcy. In our model, by mid-life many people would have tens of thousands in HSA reserves precisely for such contingencies. That means greater financial resilience and peace of mind. It's a more **self-reliant system**, but with the government still ensuring everyone has the basic funds (via credits) to get started and stay covered.

4. Economic Growth and Generational Benefits

The proposed reform is not just a health policy; it's also an economic policy. By removing the burden of health insurance from employers and empowering individuals financially, it has the potential to boost economic growth in multiple ways:

- **Higher Wages and Job Growth:** If employers are no longer on the hook for health premiums, they can redirect that money to wages or hiring. For instance, an employer paying $15,000 per family for insurance could instead add that to the employee's salary (which is taxable, but the employee also gets the credit from the government to buy insurance on their own). This effectively gives workers a raise. Higher take-home pay increases consumer spending and savings in the economy. Additionally, entrepreneurs would find it easier to start businesses without worrying about providing health benefits – they can simply factor a bit more pay to themselves or workers and let them use their credits. Small businesses could become more competitive with large firms (since health benefits had been an edge big companies use to attract talent). The net effect should be a boost to **employment and productivity**, as workers move more freely to jobs where they are most productive (no job lock) and employers focus on their core business rather than benefit administration.

- **Greater Labor Mobility and Entrepreneurship:** Decoupling insurance from employment means people can change jobs or start companies without fear of losing coverage. We expect a surge in entrepreneurship and gig economy work as a result. Studies have shown that when alternative insurance options (like the ACA exchanges or Medicare at 65) become available, self-employment increases

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  . Our model provides portable insurance to everyone from birth, so the concept of "entrepreneurship lock" due to health insurance should fade. This could unleash a new wave of small business formation and innovation, contributing to economic dynamism.

- **Efficiency and Productivity:** In the current system, the ever-growing complexity of health plans, billing, and compliance consumes huge administrative resources (for both providers and employers). By simplifying to a defined contribution and individuals paying providers more directly (at least up to a deductible), we can cut administrative waste. Providers would spend less time on insurance paperwork and more on care. Price transparency would improve as more transactions become direct or through simpler high-deductible plans. Economists often note that a dollar spent by consumers gives more value than a dollar spent by a third party on their behalf – here we align incentives so that each health dollar is spent more wisely, yielding either better health outcomes or being saved/invested. That improved efficiency is essentially an increase in productivity for the health sector, which is a significant portion of the economy.
- **Capital Formation:** The accumulation of potentially trillions of dollars in HSAs nationwide (imagine ~300 million people each with growing accounts) represents a massive pool of capital. These funds, while earmarked for health, will be invested in stocks, bonds, and other assets until needed. This increases the available capital for investment in the economy, which can lower interest rates and spur business expansion. In effect, it converts what is currently a pure expense (healthcare) into a form of savings and investment. It's analogous to how pension funds and 401(k)s boosted capital markets compared to pay-as-you-go pensions. In the long run, this could raise GDP and national wealth.
- **Generational Wealth Transfer:** One of the most compelling features for families is the ability to pass on unused HSA funds. **Americans could build a legacy through their health accounts**. For example, if parents manage to save and invest in their HSA throughout life and use only a portion, they might leave a significant sum to their children. Those children, in turn, get a head start in their own health funding (perhaps rules could allow them to roll it into their own HSAs tax-free, effectively creating family health endowments). Over generations, this could particularly benefit disadvantaged groups by providing an asset that was never possible to accumulate before (since every generation currently starts over with healthcare costs). Instead of medical bills impoverishing each generation in turn, money would flow the opposite direction – from

each generation to the next, if health costs turn out lower than expected. The **inequities in wealth that stem from disparities in health and healthcare could be mitigated**. This is a powerful reason many would opt in: you *hope* to stay healthy and not need all the money, in which case your family gains a financial benefit. It aligns personal interest (leave something for your kids) with system interest (avoid unnecessary healthcare spending).

A concrete example: Suppose a family of four opts in and is generally healthy. They might receive, say, $3k per child + $4k (age 40) + $4k (age 42 for spouse) each year, roughly $14k total in credits. They spend perhaps $8k on health that year and save $6k. Repeating this for years, with investment growth, they could accumulate tens of thousands that either go to college expenses (if they choose to withdraw for something else with penalty or after a certain age maybe) or remain for retirement. If the parents then pass away in their 80s with some portion unused, that might go to their children's own health accounts, giving them a cushion that they in turn grow. In essence, the model treats health funding similar to an **investment in a multi-generational family trust** (except each person's is individual, but the effect can cascade via inheritance). This is a stark departure from today, where health financing is year-to-year and nothing tangible to show for decades of paying premiums except receipts.

Finally, by curbing government spending growth, the reform also improves the macroeconomic environment – lower deficits can mean lower interest rates and more private investment, and it avoids heavy future tax burdens that could slow growth. With healthcare cost pressures tamed, governments can better fund other growth-enhancing investments (education, infrastructure) or return money to taxpayers.

In sum, the voluntary defined contribution health model is pro-growth and pro-family. It removes a major weight on the labor market, encourages personal wealth accumulation, and could help reduce inequality over time. Americans would gain not only more **choice in their healthcare** but also more **financial empowerment**, turning health care from a financial risk to a wealth-building opportunity when managed well.

Conclusion and Policy Recommendations

This health reform blueprint offers a bold yet practical shift from a system of defined benefits (with ever-rising costs and little consumer control) to a system of **defined contributions** (with capped public costs and empowered consumers). By granting every individual an age-adjusted health care allowance and the means to save it, we realign incentives toward efficiency, personal responsibility, and long-term planning. Importantly, the plan is **voluntary and gradual** – no one loses coverage they currently have; rather, they gain a new option. If the option proves as attractive as we anticipate, Americans will gravitate to it by choice, driven by the appeal of owning their health dollars, potentially accumulating wealth, and being able to tailor spending to their needs.

Policymakers, particularly those in think tanks like The Heritage Foundation and legislators focused on market-oriented solutions, should consider the following recommendations to implement this blueprint:

- **Legislate the Universal Tax Credit and HSA Enhancements:** Congress would need to create the refundable, advanceable credit (indexed by age as specified) and remove any statutory obstacles (e.g., increase HSA contribution limits or exempt credit amounts, allow premium payments from HSAs, etc.). The legislation should also remove the tax exclusion for employer health benefits *for those who take the credit* – effectively exchanging one tax benefit for another in a way that's roughly revenue-neutral initially. Over time, as wages rise in lieu of benefits, tax revenues will increase

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- **Ensure True Portability and Choice:** To operationalize voluntariness, laws like ERISA and the ACA need updates. For instance, employers should be allowed (or encouraged) to offer an "opt-out bonus" equal to what they would have spent on insurance, without violating ACA employer mandate (perhaps the credit qualifies as an offer of coverage for mandate purposes). Medicare should allow beneficiaries to choose a credit instead of enrolling (similar to proposals for Medicare premium support). States should get flexibility to coordinate Medicaid with the credit (e.g., wraparound or let near-poor take the federal credit plus a smaller state supplement). A robust outreach would be needed to inform citizens of their options.
- **Regulatory Setup for Individual Market:** A thriving individual insurance market is crucial, since many will use the credit to buy private plans. This means maintaining protections like guaranteed issue (no denial for pre-existing conditions) and ideally fostering **competitive exchanges** or marketplaces where people can compare plans easily (building on the ACA exchanges, but now open to all ages/incomes using the credit). Insurers will need to adjust to a world with more high-deductible plans and potentially more creative benefit designs. Policymakers might consider risk adjustment mechanisms to prevent insurers from only chasing healthy enrollees. However, since people can self-select staying in old system vs new, adverse selection will be naturally managed (only those confident they can manage within the credit will opt in).
- **Fiscal Management and Indexing:** To keep the system sustainable, the credit growth should be indexed to a reasonable metric. The proposal uses $100 per year of age which is essentially a rough static index; policymakers might also index the base amounts over time to inflation (e.g., the $3,000 for 0–39 could be indexed to CPI-medical or general CPI after implementation). The key is to avoid unsustainable promises – unlike ACA subsidies which rise with premiums, this credit should not automatically balloon if healthcare inflation spikes. That discipline is what yields federal savings. Congress might incorporate a budgetary "guardrail" that if health costs start growing faster than expected, the credit formula is revisited rather than unchecked.
- **Education and Support Tools:** Moving to this model means consumers must make more decisions. The government and private sector should provide tools: decision support for choosing insurance, HSA investment education, price transparency tools for medical services, etc. This will help average people succeed in a consumer-driven system. In the long run, a more informed consumer base will drive innovation (for example, we may see

health care advisors or services akin to financial advisors, guiding families on how to optimize their health spending and saving).

- **Phase-In Strategies:** One could phase the reform by cohort. For instance, allow those under 50 to opt in first, while gradually introducing it to older groups once the system is proven (this avoids disrupting current seniors). Or start with a pilot in certain states or for federal employees as a demonstration. The transition must be managed so that risk pools in old and new systems remain stable. For example, if mostly healthy people leave an employer plan, that employer plan's premiums could rise; to address this, employers might transition fully after a tipping point. Careful monitoring and mid-course policy corrections (like reinsurance or risk-adjusted employer incentives) can mitigate transition issues.

In conclusion, the voluntary defined contribution health reform presents a win-win proposition: **Individuals win** by gaining choice, flexibility, and the opportunity to build wealth rather than pay premiums into a void. **Employers win** by shedding a significant cost burden and focusing on wages and productivity. **The economy wins** through enhanced efficiency, entrepreneurship, and investment. And **the federal budget wins** by converting an unsustainable liability into a controlled, predictable outlay – bending the cost curve and reducing long-term debt

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This blueprint maintains the fundamental promise of access to health funds for all (indeed, it could achieve near-universal coverage since everyone gets the credit to buy insurance, unlike the gaps that still persist today), but it does so in a way that treats citizens as **responsible owners** of their healthcare finances. It is a model that combines the best elements of personal freedom with a social safety net: the government ensures everyone has basic resources for care (fulfilling a social contract to support health), and individuals direct those resources in the way that best suits their families, with skin in the game to make prudent choices.

For policymakers at institutions like Heritage, which champions free-market and family-centric policies, this reform aligns perfectly with those values. It leverages market competition, individual liberty, and fiscal prudence, while also strengthening families and communities (through wealth and empowerment). The positive generational effects – families building inheritances instead of medical debt – could be transformative for American society.

Implementing such a sweeping reform will undoubtedly face political and logistical challenges. However, by emphasizing its **voluntary nature and tangible benefits** (bigger paychecks, personal health savings, and a say in one's healthcare), a coalition of public support can be built. We recommend starting the process through smaller pilot legislation (for instance, expanding HSAs and offering opt-out credits in a few settings) and clearly communicating outcomes. Over time, as confidence grows, the system can expand nationwide.

In a time of partisan divides, this proposal contains elements to appeal to both sides: the right honors the free-market, limited government approach with cost control, and the left can appreciate that it achieves universal participation in a healthcare support system (everyone gets a credit) and can be designed to protect the vulnerable (through voluntary retention of traditional coverage or state supplements). Thus, it could form the basis of a **grand bargain** on health reform.

The American healthcare system has long struggled to balance cost, access, and quality. This defined contribution blueprint realigns incentives to finally achieve that balance. It is **comprehensive, gradual, and empowering**. By maintaining the structure of the familiar (people can keep plans if they want) while offering a clearly superior alternative, it avoids the mistakes of past reforms that were too disruptive or coercive. Instead, it trusts Americans to make the right choice for themselves – and by extension, for the nation's healthcare future.

Policy Recommendation: Congress and the Administration should enact a phased-in voluntary defined contribution health plan, establishing universal age-based health tax credits and enlarged HSAs, while permitting individuals to remain in existing coverage if they choose. Accompanying measures should phase out the tax exclusion and modify Medicare/Medicaid to allow opt-outs. This reform should be coupled with robust consumer education and market transparency initiatives. Over the next decade, monitor and adjust the credit amounts and regulatory settings to ensure stability and effectiveness. By 2035, aim for the majority of working-age Americans and a substantial share of seniors to be enrolled in the new model, generating significant federal savings and setting up the next generation for greater prosperity and health security.

In crafting America's next healthcare chapter, **empowering the individual is the surest path to affordability and innovation**. This blueprint provides that path, with a defined contribution that is defined by **freedom, choice, and hope for a healthier economic future**.

Sources: This paper drew on analysis of health spending data from CMS and Peterson-KFF

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. These citations and the preceding analysis support the feasibility and desirability of the proposed reform. The evidence suggests that a voluntary, age-adjusted defined contribution system could cover Americans' needs while significantly improving economic outcomes for families and the nation.