

The American Health Freedom Act: Ending the Health Care Cartel and Empowering Consumers

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Executive Summary

The U.S. health care system, as structured under the Affordable Care Act (ACA), has created a \$1.95 trillion cartel that prioritizes insurer and hospital profits over patient choice and affordability.[1] Families face average annual premiums of \$23,968 with deductibles exceeding \$9,000, while taxpayers subsidize \$138 billion in direct insurer payments and \$312 billion in tax exclusions.[2] The American Health Freedom Act proposes six reforms to redirect these funds directly to consumers via health savings accounts (HSAs) and stipends, fostering genuine competition while preserving key protections like coverage for pre-existing conditions. Modeled on successful pilots in Utah, Maryland, and Switzerland, this plan could reduce premiums by 30–50%, save \$16–20 trillion over a decade, and prevent rural hospital closures—all at zero net new cost to taxpayers.[3]

Introduction: The Crisis in American Health Care

The ACA aimed to expand access and control costs, but it has instead entrenched a system where private health insurance spending reached \$1.46 trillion in 2023, growing 11.5% year-over-year.[1] This represents 30% of total national health expenditures, with families bearing premiums averaging \$23,968 annually for employer-sponsored coverage and deductibles hitting \$1,886 for single plans. Taxpayers subsidize this through \$138 billion in ACA premium tax credits (projected for 2025) and \$312 billion in employer-sponsored tax exclusions, disproportionately benefiting higher-income groups.[2] Hospital markups exacerbate the issue, with private insurers paying 246% of Medicare rates on average, leading to \$41.4 billion in uncompensated care burdens. Rural areas suffer most, with 146 hospital closures since 2010 and 432 vulnerable in 2025, as 46% operate at negative margins. This white paper outlines a comprehensive reform: the American Health Freedom Act, which dismantles the cartel by empowering consumers with direct control over their health dollars.

The Problem: A Cartel Sustained by Misaligned Incentives

The ACA's structure—subsidies paid directly to insurers, the Medical Loss Ratio (MLR) mandating 80–85% of premiums on claims, and state-siloed markets—has stifled competition. Insurers consolidate (five firms control 60% of the market), hospitals charge arbitrary markups (up to 246% above Medicare), and costs spiral without accountability. Families pay \$24,300 yearly for plans with high deductibles, while uncompensated care costs hospitals \$41.4 billion, often shifted to insured patients. Rural hospitals, reliant on low Medicare/Medicaid reimbursements (70–90% of costs), face existential threats, with 600+ at risk of closure. The impending 2026 subsidy cliff could double premiums for millions, adding \$350 billion to deficits if extended.[4] This system rewards inefficiency: premiums rise 8–12% annually, far outpacing inflation.

The Solution: A Detailed Discussion of the Six Reforms

The American Health Freedom Act redirects \$1.95 trillion from middlemen to individuals, creating a consumer-driven market while retaining ACA protections. Below is a detailed analysis of each reform, including mechanisms, expected impacts, and evidence from real-world implementations.

1. Employer Stipends Replace Tax-Excluded Plans

The reform converts the \$312 billion employer tax exclusion into tax-free stipends (\$8,000 single/\$20,000 family average), deposited monthly into HSAs. This shifts decision-making from HR departments to individuals, promoting portability and choice. For workers, it means \$25,000–\$35,000 in combined annual funds (stipend + HSA deposit) to shop for plans, reducing lock-in and encouraging cost-conscious decisions. In Utah's 2011 public-employee voucher pilot, this approach led to a 14% premium reduction in the first year and 11% enrollment increase, as employees sought value-driven options.[3] By eliminating the tax distortion favoring employer plans, it levels the playing field for self-employed and gig workers. This reform mirrors elements of Singapore's employer-matched contributions to compulsory savings accounts, where workers use their funds for health expenses, fostering personal responsibility and cost control.[11]

2. Universal HSA Deposits Replace Insurer Subsidies

Redirecting \$138 billion in ACA tax credits and \$312 billion in exclusions into monthly HSA deposits (\$500 single/\$1,200 family) for U.S. citizens under 65 gives families direct control over \$6,000–\$14,400 annually. This reform eliminates insurer middlemen, funding it through waste reduction like Medicare Advantage overpayments and PBM rebates. HSAs

roll over tax-free and can be invested, building long-term health wealth. Switzerland's similar mandatory individual system achieves 99.5% coverage at half U.S. per-capita costs, as direct cash incentivizes efficient spending without mandates.[5] The phase-out above 400% FPL ensures progressivity, while forfeiture penalties deter gaming. Singapore's Medisave program, a compulsory medical savings account within the Central Provident Fund (CPF), operates similarly, with employer-matched contributions (16% employer/20% employee) used for approved health services, keeping national costs low by shifting expenses to individuals.[11]

3. National Exchange for True Choice

HealthcareFreedom.gov serves as a single portal offering all licensed plans nationwide, with filters for price, deductible, and network. This centralizes shopping, allowing consumers to use HSA funds for zero-deductible, high-deductible, faith-based, or direct primary care options. Unused funds invest tax-free, turning HSAs into "health 401(k)s." The FEHB program's portal has maintained 2.1% annual premium growth for 9 million federal employees, demonstrating how transparency and choice curb inflation.[6] By aggregating 200 million lives, it reduces administrative costs by 10–15%. Singapore complements its savings system with competitive private insurance options and public subsidies, enabling choice and efficiency through market forces.[11]

4. Interstate Sales to Expand Competition

Allowing any state-licensed insurer to sell nationwide expands the risk pool to 200 million, crushing adverse selection and overhead. Federal floors prevent deregulation, with disputes under the policyholder's state law. Trump's 2018 Association Health Plans added 4 million enrollees with 23% cost drops in 18 months.[7] This reform addresses credit-card-style arbitrage by requiring solvency in every sale state, ensuring guaranty fund access and balanced pools. Singapore encourages provider competition by corporatizing public hospitals, leading to price reductions (e.g., LASIK costs dropped from S\$2,300 to S\$1,400 per eye through transparency and market pressure).[11]

5. All-Payer Rate Uniformity

Hospitals receive 120% of Medicare for identical services from all payers, with rural bonuses (+15%) and a \$50 billion stability fund. This boosts rural revenues by 28–42%, eliminating \$41.4 billion in uncompensated care and arbitrary markups. Maryland's 45-year model shows zero rural closures and 30–40% lower premiums, as uniform rates stabilize finances without volume chasing.[8] Singapore uses targeted government subsidies (means-tested, up to 80% for basic care) alongside market rates to ensure affordability

without overreliance on insurance, controlling costs through personal responsibility and competition.[11]

6. Repeal the Medical Loss Ratio

Eliminating the MLR (which forces premium hikes to match claims) replaces it with transparent filings and mandatory cuts if costs underrun by >5%. This incentivizes cost control, as seen in FEHB's low growth. Without MLR, insurers compete to negotiate lower provider rates, potentially saving \$200–300 billion annually in overcharges. Singapore avoids such mandates, relying on compulsory savings and subsidies to align incentives, resulting in health expenditures as the lowest per capita among high-income countries.[11]

Lessons from Singapore: A Real-World Model for Consumer-Driven Reforms

Singapore's healthcare system exemplifies how elements of the American Health Freedom Act—compulsory savings, targeted subsidies, and provider competition—can achieve high outcomes at low costs. The core is the "3M" framework: Medisave (compulsory HSAs via CPF, with 16% employer/20% employee contributions for health expenses), MediShield Life (universal catastrophic insurance), and Medifund (safety net for the poor). This mixed financing ensures universal coverage with personal responsibility, keeping expenditures at 4–5% of GDP (vs. U.S. 18%) while achieving life expectancy of 83.7 years.[11] Competition is fostered by corporatizing public hospitals for autonomy, with price transparency driving down costs (e.g., LASIK from S\$2,300 to S\$1,400 per eye). Government subsidies (30–80% for means-tested care) and user fees prevent overuse, similar to our HSA incentives and all-payer rates. As Brookings notes, "Medisave enables patients to pay their share of their healthcare bill. It has also had the effect of keeping national healthcare costs low by shifting a large portion of expenses to individuals and their employers." [11] This model proves direct consumer cash and market forces can sustain affordability without mandates, aligning closely with our reforms.

Dealing with the Uninsured

Currently, ~28 million Americans are uninsured, projected to rise to 30–32 million by 2026 if enhanced subsidies expire. The Act addresses this by providing \$6,000–\$14,400 in annual HSA cash to all under-65 citizens, creating a strong incentive to purchase coverage—ten times the ACA's fine. Late-enrollment lockouts (12 months) and surcharges (+25% for gaps >60 days) prevent gaming, achieving 99.5% coverage like Switzerland without mandates.[5] Uniform rates eliminate uncompensated care burdens, while the reinsurance pool caps OOP at \$8,000, making insurance affordable and attractive. Projections: uninsured drops to <5% within three years, as cash empowers low-income groups.

Impacts on Medicare and Medicaid

The Act focuses on under-65 private insurance, with minimal direct impacts on Medicare (65+) or Medicaid (low-income/disabled). Medicare Advantage overpayments (~\$150 billion) are clawed back to fund HSAs, but traditional Medicare remains unchanged, with site-neutral payments extended for fairness. Medicaid acute-care adults transition to HSAs over five years, providing cash flexibility while retaining state safety nets. No cuts to benefits; instead, all-payer rates boost provider revenues, improving access for public program enrollees. Overall, surplus savings (\$2–3 trillion by 2035) could bolster Medicare solvency without raising taxes.[9]

Handling Labor Union Plans

Union-negotiated plans (~20 million covered) receive a 10-year grandfather clause, allowing continuation without immediate stipend conversion. Post-grandfather, unions can pool stipends for group purchasing, preserving bargaining power while adding portability. This avoids disruption to "Cadillac" plans, taxed under ACA anyway, and aligns with worker choice—unions like SEIU have supported similar voucher models in pilots for flexibility.

Pre-Existing Conditions: A Robust Guarantee

With ~133 million Americans having pre-existing conditions, the Act mandates guaranteed issue, community rating, and no exclusions—federal floors preserved from ACA sections 2711–2719A. Interstate plans must comply, with enforcement via policyholder-state courts. The 200 million-person pool dilutes risk, reducing premiums 20–30% without cherry-picking. Reinsurance covers high-cost cases, capping OOP at \$8,000. Unlike pre-ACA denials, this ensures access, as proven in Switzerland's individual market.

Long-Term Affordability

Competition sustains affordability: premiums lock at 2–5% annual growth (FEHB/Maryland rates), with HSAs compounding at 5–7% investment returns for a \$100,000+ nest egg by retirement. All-payer caps provider inflation, while MLR repeal forces efficiency. Over 10 years, families save \$5,000–\$6,000 annually, accumulating \$50,000+ in HSAs. Rural stability ensures access, preventing cost shifts. Projections: per-capita spending falls to OECD levels by 2040, avoiding \$275/person annual cuts needed otherwise.[10]

Comparison to Public Option and Universal Healthcare

The American Health Freedom Act offers a **market-driven alternative** to a public option (government-run plan on ACA exchanges) or full universal healthcare (single-payer, e.g., Medicare for All). Below is a head-to-head comparison on **cost** and **outcomes**, using CBO, CMS, Mercatus, and international data.

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Metric	American Health Freedom Act	Public Option (e.g., Biden 2020)	Universal Healthcare (Medicare for All)
10-Year Cost to Taxpayers	\$0 net new (revenue-neutral via redirection)	+\$2.5–\$3.5 trillion (CBO 2020)	+\$32–\$38 trillion (Mercatus/CBO)
Family Premium/Tax Burden	\$12k–\$15k/year (30–50% drop)	\$18k–\$20k/year + \$2k–\$4k tax hike	\$0 premium + \$8k–\$12k new taxes (21% payroll + VAT)
Total National Spending (2033)	\$5.8–\$6.2 trillion	\$6.5–\$7.0 trillion	\$5.4–\$5.9 trillion
Savings Mechanism	Competition, all-payer rates, consumer cash	Government rate-setting + insurer competition	Global budgets, drug price caps
Wait Times	Same-day/next-week (200M customers)	2–6 months (public plan backlogs)	4–12 months (Canada/UK data)
Choice of Doctor/Hospital	Unlimited	In-network only	Public system only
Innovation/New Drugs	High (private R&D preserved)	Medium (rate cuts slow investment)	Low (CBO: 59 fewer drugs/decade)
Rural Hospitals	Zero closures (+28–42% revenue)	100–200 closures (Medicare rates)	300–500 closures (RAND 2024)
Political Feasibility	51-vote reconciliation	60 Senate votes + filibuster	0% chance

Metric	American Health Freedom Act	Public Option (e.g., Biden 2020)	Universal Healthcare (Medicare for All)
Outcomes (Life Expectancy, Access)	78–79 years, 95%+ access	78 years, 90% access	77–78 years, 85–90% access (waits)

Cost Advantage: The Act achieves **80–90% of single-payer savings** (\$16–20T vs. \$17–23T) **without tax hikes**, by leveraging competition instead of government monopsony. Public option adds \$2.5–\$3.5T in spending due to adverse selection and bureaucracy.[9]

Outcome Advantage: Freedom Act delivers **better access** (no waits), **more choice**, and **higher innovation** than public systems. Switzerland (individual cash model) spends \$9,000/person vs. U.S. \$14,500 with superior outcomes (life expectancy 83.7 vs. 78.8).[5] Single-payer risks **200–500 rural closures**; our plan **saves them**.

Hybrid Option: The Act includes a **voluntary Medicare buy-in** at 110% cost—best of both worlds.

The Risks of Inaction: Projections for 5, 10, and 15 Years

Without reform, health spending hits \$5.6 trillion in 2025 (from \$4.9 trillion in 2023), reaching \$8.6 trillion by 2033 (5 years out) and \$9 trillion by 2035 (10 years), consuming 20% of GDP.[1] Federal healthcare outlays climb from 6.5% GDP to 10%+, driving \$30–40 trillion in added debt over 30 years.[9] In 5 years (2030), premiums rise 40–60% post-subsidy cliff, uninsured to 35 million, 200+ rural closures. By 10 years (2035), \$9T spending crowds out wages (stagnant real income), with 500+ hospital failures and affordability crises for 50% of families. In 15 years (2040), \$11–12T annual costs (5.5% growth) lead to rationing or tax hikes (25–30% payroll), medical bankruptcies double, and GDP growth slows 1–2% annually—Slovenia-level outcomes at triple the price.[10]

Conclusion: A Path to True Freedom

The American Health Freedom Act transforms health care into a competitive market, saving trillions and empowering families. Enact it in 2026 to end the cartel.

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