



# A BETTER WAY

OUR VISION FOR A CONFIDENT AMERICA

Health Care

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## High-Quality Health Care for All

Americans deserve an accessible and affordable health care system that promotes quality care and peace of mind. It should empower patients and support innovation. Sadly, that is not the system we have today. Obamacare has limited choices for patients, driven up costs for consumers, and buried employers and health care providers under thousands of new regulations. It forced people into expensive plans they did not want and put the government in charge of one of the most personal decisions families will ever make.

House Republicans know there is a better way.

Republicans have put forward ideas ranging from complete alternatives to targeted, issue-specific proposals [Figure 1]. The plan presented here unites these efforts under one complete vision that successfully reforms America's health care system. It recognizes that health care today is a wholly integrated system, consisting of providers, insurers, researchers, entrepreneurs, and others working to deliver the best quality care. Our proposal embraces this reality but also recognizes that **people** must come first. A health care system is only as good as its service of the patients who rely on it.

The proposal is built on five principles:

1. **Repeal Obamacare.** The law that Democrats forced through Congress in 2010 was filled with special interest handouts, budget gimmicks, and tax increases. Nonpartisan analysts warned that the law's new mandates and regulations would lead to higher premiums and reduced access to care.<sup>1</sup> Budget experts cautioned that the law's cuts to entitlement programs were unsustainable, while health professionals worried about declining quality of care.<sup>2,3</sup> Now, six years later, it is clear these warnings have become reality, and the American public is bearing the consequences. This law cannot be fixed. Its knot of regulations, taxes, and mandates cannot be untangled. We need a clean start in order to pursue the patient-centered reforms the American people deserve.
2. **Provide all Americans with more choices, lower costs, and greater flexibility.** The nation's health care system is too bureaucratic and too expensive. It didn't work before Obamacare, and it most certainly does not work now. Insurance companies should be competing against each other to offer the most affordable, highest quality options for consumers. While Obamacare favors a one-size-fits all approach, we believe choice, portability, innovation, and transparency are essential elements of successful reform, and for too long they have been absent in health care.
3. **Protect our nation's most vulnerable.** Patients with pre-existing conditions, loved ones struggling with complex medical needs, and other vulnerable Americans should have access to high-quality and affordable coverage options. Obamacare's solution was to force millions of people onto Medicaid, a broken insurance program that has historically failed lower-income families. We reject this approach. Instead, we believe states and individuals should have better tools, resources, and flexibility to find solutions that fit their unique needs.
4. **Spur innovation in health care.** From new procedures to advanced, life-saving devices and therapies, the U.S. has always been at the forefront of medical discoveries. Unfortunately, we cannot say the same for our policies. Today, it costs \$2 billion and takes 14 years to get a new drug through the byzantine clearance process at the Food and Drug Administration.<sup>4</sup> Obamacare made the problem worse by levying a new tax on medical devices, driving out jobs, and slowing the development of new and innovative products that could help cure patients in need. Last year, the House passed the *21<sup>st</sup> Century Cures Act*, which would pave the way for new ideas and support advancements in cures and treatments. Our plan builds on that legislation and promotes U.S. leadership in this area.

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<sup>1</sup> [An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act](#), Congressional Budget Office, Nov. 30, 2009.

<sup>2</sup> Douglas Holtz-Eakin, [The Real Arithmetic of Health Care Reform](#), New York Times, March 20, 2010

<sup>3</sup> Jason Fodeman, [The New Health Law: Bad for Doctors, Awful for Patients](#), The Institute for Health Care Consumerism, April, 2011.

<sup>4</sup> [Tackling the Bottlenecks in the Drug Development Pipeline](#), Dr. Francis Collins, NIH Director's Blog, January 4, 2013.

5. **Protect and preserve Medicare.** Today, more than 50 million seniors and individuals with disabilities rely on Medicare for access to health care.<sup>5</sup> And millions more are counting on Medicare to provide health security when they reach retirement. Unfortunately, the program is unsustainable and will fail current and future Americans without significant reforms. The problem is driven by demographics, cost growth, and outdated payment systems that encourage overuse of health services. Despite this, Obamacare raided more than \$800 billion from the program and beneficiaries it serves and used the funds to finance the law's open-ended expansion of entitlements. Republicans fundamentally reject this idea. Medicare must be protected for today's seniors, and it must be strengthened for future generations. We can do this without undermining Medicare's promise to current beneficiaries by slowly phasing in improvements that will provide future generations with greater choices.

We know the [Report from the Health Care Reform Task Force](#) lowers costs and delivers quality, affordable health care choices because it is built on the same principles that have already delivered successful and enduring changes to our health care system. In the 21<sup>st</sup> century, Congress has enacted four major successful health reforms:

1. Health Savings Accounts (HSAs) and consumer-directed health care<sup>6</sup>
2. Medicare Advantage<sup>7</sup>
3. Medicare Part D prescription drug coverage<sup>8</sup>
4. Quality reporting and paying for value<sup>9</sup>

These ideas, which began as Republican proposals, now enjoy wide bipartisan support and are more popular than ever. Nearly 20 million Americans have an HSA which provides greater flexibility, portability, and autonomy to patients. 17 million seniors are enrolled in Medicare Advantage, and more than 39 million Medicare beneficiaries are enrolled in Medicare Part D<sup>10,11,12</sup> And there is a growing consensus that we should tie reimbursement to quality, which has led to some of the most robust value-based programs in health care today.

Each of these policies improved quality and lowered costs. They put patients in charge of their health decisions, increased transparency in price and quality, and promoted choice and competition. When these principles are put to work, Americans are rewarded with the kind of health care system they deserve.

Obamacare set America on a path that leads to a larger government having a greater role in how health care decisions are made. Today we are proposing a new approach. This *Report* is the beginning of the conversation, not the end. In contrast to Obamacare, our plan will serve as the foundation for multiple pieces of straightforward legislation, not a comprehensive, overly complex, and confusing 3,000 page bill. Successfully transitioning these ideas into action requires a step-by-step approach. There is still time to fix what is broken in health care without undermining what works. The [Report from the Health Care Reform Task Force](#) offers a roadmap to do just that.

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<sup>5</sup> [Total Number of Medicare Beneficiaries](#), The Henry J. Kaiser Family Foundation, March, 2016.

<sup>6</sup> [H.R.1 - Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 2003.](#)

<sup>7</sup> [Ibid](#)

<sup>8</sup> [Ibid](#)

<sup>9</sup> [Ibid](#)

<sup>10</sup> [2015 Census of Health Savings Account – High Deductible Health Plans](#), AHIP Center for Policy and Research, Nov. 2015.

<sup>11</sup> [Medicare Advantage/Part D Contract and Enrollment Data](#), Centers for Medicare and Medicaid Services, Feb. 23, 2016.

<sup>12</sup> [Ibid](#)

**Figure 1**

**House Republican Health Reform Proposals: 114<sup>th</sup> Congress**

In the 114<sup>th</sup> Congress alone, House Republicans have introduced more than 400 individual bills that would improve our nation's health care system. Below are just a few of those ideas:

- HR 954; Coverage Under the CO-OP Program – Rep. Adrian Smith*
- HR 4499; PROP Act of 2016 – Rep. Alexander Mooney*
- HR 2603; Saving Lives, Saving Costs Act – Rep. Andy Barr*
- HR 221; Obamacare Taxpayer Bailout Prevention Act – Rep. Andy Harris*
- HR 795; Medicare Payment Rate Disclosure Act – Rep. Bill Huizenga*
- HR 1636; Vaccine Safety Study Act – Rep. Bill Posey*
- HR 4058; Obamacare Full Disclosure Act – Rep. Bill Shuster*
- HR 815; Access to Professional Health Insurance Advisors Act – Rep. Billy Long*
- HR 596; Repeal the Patient Protection and Affordable Care Act – Rep. Bradley Byrne*
- HR 1624; Protecting Affordable Coverage for Employees Act – Rep. Brett Guthrie*
- HR 886; State Flexibility and Workforce Requirement Act – Rep. Bruce Westerman*
- HR 4805; Ensuring Patient Access to Healthcare Records Act – Rep. Cathy McMorris Rodgers*
- HR 5447; Small Business Health Care Relief Act – Rep. Charles Boustany*
- HR 5021; Better Accounting for Medicaid Costs Act – Rep. Chris Collins*
- HR 868; Veterans TRICARE Choice Act – Rep. Chris Stewart*
- HR 7; No Taxpayer Funding for Abortion – Rep. Chris Smith*
- HR 138; Access to Insurance for All Americans Act – Rep. Darrell Issa*
- HR 3301; Prohibit Federal Funding of Planned Parenthood Federation of America – Rep. David Jolly*
- HR 2653; American Health Care Reform Act – Rep. Phil Roe*
- HR 420; Obamacare Opt-Out Act – Rep. David Schweikert*
- HR 940; Health Care Conscience Rights Act – Rep. Diane Black*
- HR 5445; Health Care Security Act – Rep. Erik Paulsen*
- HR 6; 21st Century Cures Act – Rep. Fred Upton*
- HR 1570; Medicaid and CHIP Territory Transparency and Information Act – Rep. Gus Bilirakis*
- HR 289; Better Efficiency and Administrative Simplification Act – Rep. James Renacci*
- HR 626; Seniors' Rights to Know Act – Rep. Jeff Denham*
- HR 4506; Know Before You Go Act – Rep. Jeff Fortenberry*
- HR 2420; Reduce Administrative Burdens on Researchers – Rep. Joe Barton*
- HR 1664; Health Insurance Freedom Act – Rep. John Culberson*
- HR 4828; Conscience Protection Act – Rep. John Fleming*
- HR 1189; Preserving Employee Wellness Programs Act – Rep. John Kline*
- HR 5452; HSAs for Indian Health Service – Rep. John Moolenaar*
- HR 3444; Medicaid and CHIP Territory Fraud Prevention Act – Rep. Joseph Pitts*
- HR 2869; Local and Municipal Health Care Choice Act – Rep. Kenny Marchant*
- HR 1479; Repeal of the Obamacare Bay State Boondoogle Act – Rep. Kevin Brady*
- HR 3742; Access to Marketplace Insurance Act – Rep. Kevin Cramer*
- HR 5406; HEALTHH Act – Rep. Kristi Noem*
- HR 5122; Prohibition of Medicare Part B Drug Model – Rep. Larry Bucshon*

## **House Republican Health Reform Proposals: 114<sup>th</sup> Congress (continued)**

HR 724; Taxpayer Bailout Protection Act – Rep. Leonard Lance  
HR 769; Safeguarding Classrooms Hurt by Obamacare’s Obligatory Levies – Rep. Luke Messer  
HR 1270; Restoring Access to Medication Act – Rep. Lynn Jenkins  
HR 210; Student Worker Exemption Act – Rep. Mark Meadows  
HR 543; Health Care Choice Act – Rep. Marsha Blackburn  
HR 3590; Halt Tax Increases on Middle Class and Seniors Act – Rep. Martha McSally  
HR 2; Medicare Access and CHIP Reauthorization Act – Rep. Michael Burgess  
HR 519; Healthcare Tax Relief and Mandate Repeal Act – Rep. Michael Turner  
HR 2505; Medicare Advantage Coverage Transparency Act – Rep. Mike Kelly  
HR 1400; Insurance Rate Transparency Act – Rep. Morgan Griffith  
HR 4876; Medicare Prescription Drug Abuse Prevention Act – Rep. Patrick Meehan  
HR 5273; Helping Hospitals Improve Patient Care Act – Rep. Pat Tiberi  
HR 494; Competitive Health Insurance Reform Act – Rep. Paul Gosar  
HR 489; Taxpayer Conscience Protection Act – Rep. Pete Olson  
HR 5284; World’s Greatest Healthcare Plan Act – Rep. Pete Sessions  
HR 4853; SAFE Act – Rep. Peter Roskam  
HR 2756; Patient Freedom Act – Rep. Ralph Abraham  
HR 3352; State Health Care Options Act – Rep. Randy Hultgren  
HR 1348; Health Insurance Freedom Act – Rep. Renee Ellmers  
HR 4262; Transparency and Accountability of Failed Exchanges Act – Rep. Rick Allen  
HR 1446; Healthcare Consumer Privacy Act – Rep. Robert Hurt  
HR 2513; PACE Act – Rep. Sam Johnson  
HR 2841; FAST Generics Act – Rep. Steve Stivers  
HR 536; Provider Tax Administrative Simplification Act – Rep. Steve Womack  
HR 4362; State Health Flexibility Act – Rep. Todd Rokita  
HR 2300; Empowering Patients First Act – Rep. Tom Price  
HR 1178; Ensuring Equal Access to Treatments Act – Rep. Tom Reed  
HR 4771; HEALTH Act – Rep. Trent Franks  
HR 5324; Health Savings Account Expansion Act of 2016 – Rep. Dave Brat



## Obamacare Has Not Worked

President Obama's signature health care law has proven unaffordable, unworkable, and intrusive in Americans' everyday lives. Americans with job-based health care coverage—approximately 155 million people—are now facing higher premiums and higher deductibles.<sup>13</sup> President Obama promised that premiums would decline by \$2,500 per year; instead, average premiums in job-based coverage increased by \$3,775.<sup>14,15</sup> The average premiums for families enrolled in employer-sponsored coverage have increased more than \$17,000 annually since 2010, a growth of over 27 percent.<sup>16</sup> The non-partisan Congressional Budget Office (CBO) has said that premiums in the individual market “are projected to grow somewhat more quickly over the next few years because of factors related to the ACA.”<sup>17</sup> And an analysis by the Heritage Foundation found that three of Obamacare's most costly insurance regulations—age-rating restrictions, benefit mandates, and minimum actuarial value requirements—“collectively increased premiums for younger adults by 44 percent, and for pre-retirement-age adults by 7 percent, relative to the previously available least expensive plans.”<sup>18</sup>

At the same time, contrary to the President's promise that Americans could keep the plans they had and liked, according to the Associated Press, millions have lost coverage as insurers were forced to cancel policies that did not satisfy the law's requirements.<sup>19</sup> Consumers across the country found themselves with little choice but to enroll in plans with narrower networks, as insurers struggled to deal with the costs of Obamacare's mandates and regulations. A report by Modern Healthcare found that 70 percent of plans sold on the Obamacare exchanges in 2014 had narrow networks.<sup>20</sup> In addition, a recent Avalere study found that exchange networks have 34 percent fewer providers compared to commercial plans available outside the exchange.<sup>21</sup> On average, Obamacare plans have 42 percent fewer oncologists and 32 percent fewer primary-care physicians.<sup>22</sup> It comes as no surprise that, according to a recent Deloitte survey, only 30 percent of exchange enrollees were satisfied with their health coverage plan, significantly lower than other types of insurance, including job-based coverage, Medicaid, and Medicare.<sup>23</sup>

The law has had similar negative effects on employees, their employers, and the U.S. economy. Individuals are discouraged from work in part because the premium subsidies decrease as wages increase, effectively raising the marginal tax rate on Americans trying to earn a living.<sup>24</sup> In other words, earning more can make health coverage more expensive. This is especially true for the middle class, who have faced dramatic marginal tax increases. The tax increases in the law total more than \$1 trillion over the next decade, reducing economic growth, wages, and work.<sup>25</sup> This includes a tax on health insurers that is being passed along to consumers in the form of higher premiums, increased payroll taxes, taxes on investment, and taxes on medical devices.<sup>26</sup>

Another harmful feature of Obamacare coincides with troubling trends in the labor market. For example, more than 6.4 million Americans are now working part-time because they cannot find full-time work; that is over two million more than the amount seen before the recession.<sup>27,28</sup> And there is reason to believe Obamacare has stalled progress in reducing that figure.

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<sup>13</sup> [Health Insurance Coverage of the Total Population](#), The Henry J. Kaiser Family Foundation, March, 2015.

<sup>14</sup> J.B. Wogan, [No Cut in Premiums for Typical Family](#), Politifact, Aug. 31, 2012.

<sup>15</sup> [Premiums and Worker Contributions Among Workers Covered by Employer-Sponsored Coverage, 1999-2015](#), The Henry J. Kaiser Family Foundation, 2016.

<sup>16</sup> [Ibid](#)

<sup>17</sup> [Private Health Insurance Premiums and Federal Policy](#), Congressional Budget Office, Feb. 2016.

<sup>18</sup> Drew Gonshorowski, Edmund Haislmaier, [3 Ways ObamaCare's Insurance Regulations Could Cost You](#), The Daily Signal, March 28, 2016.

<sup>19</sup> [Policy notifications and current status, by state](#), The Associated Press, December 26, 2013.

<sup>20</sup> Bob Herman, [Network Squeeze: Controversies Continue Over Narrow Health Plans](#), Modern Healthcare, March 28, 2015.

<sup>21</sup> [Exchange Plans Include 34 Percent Fewer Providers than the Average for Commercial Plans](#), Avalere, July 15, 2015.

<sup>22</sup> [Ibid](#)

<sup>23</sup> [Public Health Insurance Exchanges: Opening the Door for a New Generation of Engaged Health Care Consumers](#), Deloitte, 2015.

<sup>24</sup> Edward Harris, Shannon Mok, [How CBO Estimates the Effects of the Affordable Care Act on the Labor Market](#), Congressional Budget Office, Dec. 2015.

<sup>25</sup> [Ibid](#)

<sup>26</sup> [ObamaCare: Trillion Dollar Tax Hike that Hurts Small Businesses](#), House Committee on Ways and Means, March 4, 2013.

<sup>27</sup> [The Employment Situation – May 2016](#), Bureau of Labor Statistics, U.S. Department of Labor, June 3, 2016.

<sup>28</sup> [The Employment Situation – October 2007](#), Bureau of Labor Statistics, U.S. Department of Labor, Nov. 2, 2007.

New data shows a decline in the average hours worked per week by lower-wage employees and many more employees working just below 30 hours per week. Roughly 2.6 million people are at risk of having their work hours cut.<sup>29</sup> Sixty-three percent of the people most at risk are female, and nearly sixty percent are 19 to 34 years old.<sup>30</sup>

Part of the reason this may be happening is that employers are also facing new costs in order to comply with the law. Obamacare requires employers with more than 50 full-time workers to offer health insurance that meets certain Washington standards. And if they don't, Obamacare penalizes them for each employee they fail to cover—up to \$3,000 per worker.<sup>31</sup> This new penalty, plus Obamacare's new definition of a 30-hour work-week, is having a profound impact on the financial well-being of workers. As former CBO Director Doug Holtz-Eakin testified before the Ways and Means Committee, if an employee's hours were cut below the 30-hour mark, "an employee earning the national average of \$24.31 an hour would see a reduction in wages of \$13,370 annually"<sup>32</sup>—something many Americans can't afford [Figure 2].

Health care providers, hospitals, and medical suppliers are also feeling the consequences of Obamacare. Rather than make needed structural reforms to protect and preserve Medicare, the law created a de facto rationing board. As a result, Medicare's own chief actuary has warned that, "it is likely that access to, and quality of, physicians services would deteriorate over time for beneficiaries."<sup>33</sup> Moreover, the law swelled the rolls of Medicaid—a program that currently fails to provide adequate access to care for enrollees—through an unprecedented expansion of eligibility. According to CBO, 11 million new individuals enrolled in Medicaid in 2015, and by 2025 there will be 14.5 million new people in the program.<sup>34</sup> Newly eligible beneficiaries will add pressure to already-strained state budgets beginning in 2016, when the federal funds to support the expansion begin to decrease and the health care law forces states to bear a greater share of the costs.

Obamacare simply does not work. The promises made to pass the law have been broken. In addition, the law is responsible for billions in taxpayer funds lost to fraud, waste, and abuse. Many of these programs were either duplicative of existing efforts or spent taxpayer dollars with no accountability [Figure 3]. The law has dramatically expanded the role the federal government plays in people's health care decisions and in the health care system at large. It cannot be amended or fixed through incremental changes. Obamacare must be repealed so that Congress can move forward with the kinds of reforms that will give Americans the care they deserve.

**Figure 2**

**More than Two Dozen New Taxes**

Obamacare imposed more than \$1 trillion in new taxes on health providers, taxpayers, and businesses. House Republicans would repeal all of these punitive taxes as part of their plan to fix America's health care system and replace Obamacare with patient-centered reforms. The most egregious of the tax increases include:

New 0.9 percent payroll tax on wages and self-employment income and new 3.8 percent tax on dividends, capital gains, and other investment income for taxpayers earning over \$200,000 (singles)/\$250,000 (married)	Increased penalty for nonqualified HSA distributions, limited the use of HSAs, FSAs, HRAs, and Archer MSAs to purchase over-the-counter medicines, and limited FSAs in cafeteria plans
"Cadillac tax" on high cost plans	Annual tax on health insurers and a new fee on insured and self-insured health plans
Individual mandate	Employer mandate
2.3 percent excise tax on medical device manufacturers/importers	Annual tax on drug manufacturers/importers
Increased 7.5 percent AGI floor on medical expense deduction to 10 percent	Eliminated deduction for expenses allocable to Medicare Part D subsidy

<sup>29</sup> Lanhee Chen, [Hearing on the Impact of the Affordable Care Act \(ACA\) Employer Mandate's Definition of Full-Time Employee on Jobs and Opportunities](#), Hoover Institution, Jan. 28, 2014.

<sup>30</sup> *Ibid*

<sup>31</sup> [Employer Responsibility Under the Affordable Care Act](#), The Henry J. Kaiser Family Foundation, Oct. 2, 2015.

<sup>32</sup> Douglas Holtz-Eakin, [Addressing the Growth Challenge](#), House Committee on Ways and Means Testimony, Feb. 2, 2016.

<sup>33</sup> [The 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#), Centers for Medicare/Medicaid Services, July 22, 2015.

<sup>34</sup> [Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 – 2026](#), Congressional Budget Office, March 2016.

**Figure 3**

### **Ignoring the Rule of Law: Obamacare Implementation and Administrative Overreach**

The implementation of Obamacare – an unpopular and unworkable law – has been riddled with delays, obstructions, and failures. Most critically, the Administration has shown an utter disregard for the plain language of the law in order to prop it up. Its illegal actions and overreach have made health care worse for consumers and taxpayers.

Some of the most egregious unauthorized executive actions are:

1. Paying cost-sharing subsidies to insurance companies without Congressional appropriation.<sup>1</sup>
2. Via a blog post, delaying the employer mandate beyond the statutorily mandated start date.<sup>2</sup>
3. Allowing insurance companies to extend non-compliant health plans without statutory authority.<sup>3</sup>
4. Repeatedly delaying employer reporting requirements.<sup>4</sup>
5. Failing to adequately verify eligibility for recipients of subsidies during the first year of coverage.<sup>5</sup>
6. Delaying and then creating multiple “exemptions” to the individual mandate as well as altering open enrollment periods not specified in statute.<sup>6,7</sup>
7. Failing to provide to the Treasury as much as \$3.5 billion in reinsurance fees.<sup>8</sup>
8. Exempting unions from paying into the reinsurance program.<sup>9</sup>
9. Making illegal payments to insurance companies through the risk corridor program.<sup>10</sup>
10. Failing to enforce abortion restrictions placed on insurance plans.<sup>11</sup>
11. Delaying statutory requirements for insurance companies to disclose the number of people enrolled, disenrollment, number of claims denied, costs to consumers for certain services, etc. – all efforts that would increase transparency of coverage.<sup>12</sup>
12. Providing waivers for the ban on annual limits.<sup>13</sup>
13. Exempting U.S. territories – after claiming they had no authority to do so – from six major ACA insurance requirements, including guaranteed issue, community rating, and the essential benefit mandates.<sup>14</sup>
14. Forcing mandatory models on Medicare providers through CMMI.<sup>15</sup>
15. Making unauthorized payments for Obamacare’s Basic Health Program.<sup>16</sup>
16. Missing four of five statutory deadlines between March 24, 2014 and March 23, 2015.<sup>17</sup>
17. Implementing a Nationwide Medicare Advantage (MA) “demonstration” to blunt Obamacare’s MA cuts.<sup>18</sup>

<sup>1</sup> [Letter to U.S. Department of Health and Human Services](#), Committee on Energy & Commerce and Committee on Ways & Means, February 3, 2015.

<sup>2</sup> [IRS Notice 2013-45](#) and [Treasury Department Blog Post](#), Internal Revenue Service and U.S. Department of the Treasury, July 2, 2013.

<sup>3</sup> [Letter to Insurance Commissioners](#), Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, November 14, 2013.

<sup>4</sup> [IRS Notice 2016-4](#), Internal Revenue Service, March 10, 2014.

<sup>5</sup> Seto J. Bagdoyan, [Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of Enrollment Controls for Health Care Coverage and Consumer Subsidies Provided Under the Act](#), Government Accountability Office, July 23, 2014.

<sup>6</sup> [Shared Responsibility Provision Question and Answer](#), Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, October 28, 2013.

<sup>7</sup> Amy Goldstein, [Obama Administration Will Allow More Time to Enroll in Health Care on Federal Marketplace](#), The Washington Post, March 25, 2014.

<sup>8</sup> Seth Chandler, [How the Obama Administration Raided The Treasury to Pay Off Insurers](#), Forbes, January 18, 2016.

<sup>9</sup> U.S. Department of Health and Human Services, [Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015](#), November 21, 2013.

<sup>10</sup> Government Accountability Office, [Risk Corridors Program](#), September 30, 2014.

<sup>11</sup> Government Accountability Office, [Health Insurance Exchanges: Coverage of Non-excepted Abortion Services by Qualified Health Plans](#), September 15, 2014.

<sup>12</sup> Robert Pear, [Insurers' Consumer Data Isn't Ready for Enrollees](#), New York Times, October 25, 2014.

<sup>13</sup> Reed Abelson, [Waivers Aim at Talk of Dropping Health Coverage](#), New York Times, October 6, 2015.

<sup>14</sup> Centers for Medicare and Medicaid Services, [Letter to Commissioner Francis](#), July 16, 2014.

<sup>15</sup> Centers for Medicare and Medicaid Services, [Medicare Part B Model](#), March 8, 2016.

<sup>16</sup> [Letter to U.S. Department of Health and Human Services](#), Committee on Energy & Commerce and Committee on Ways & Means, January 15, 2016.

<sup>17</sup> [Actions Taken by Federal Officials and Entities Through December 20, 2015, to Meet Certain Statutory Deadlines in the Affordable Care Act](#), Congressional Research Service, January 11, 2016.

<sup>18</sup> [Medicare Advantage Quality Care Bonus Payment Demonstration](#), Government Accountability Office, July 11, 2012.

## More Choices, Lower Costs, Greater Flexibility

In a nation of over 323 million people, each with different needs and circumstances, it makes no sense for one federal agency to dictate the contents of every American's health insurance plan. And it makes even less sense to impose a tax penalty on any American who chooses not to purchase that plan.

Americans deserve a competitive insurance marketplace that provides quality care at an affordable cost. But, this does not mean returning to the pre-Obamacare status quo. Our health care system has been broken for decades because people lack the most basic tools they need to make decisions that are right for them. Red tape hides information on prices and quality, bureaucrats in Washington put themselves between doctors and their patients, and choice and competition take a back seat to federal mandates and coercive taxes.

It's imperative to move in an entirely new direction that reflects a 21<sup>st</sup> century approach to health care.

A modern-day health care model should trust that patients—with their health care provider— will make better decisions about their health care needs than a federal administrator. And loving parents will do a far better job of protecting the health of their children than a distant bureaucrat.

In other words, it is not just a nice idea to allow people to shop for the plan that best fits their needs—it is sound health policy. Putting individuals in charge will lead to better health outcomes at lower cost.

States have been in the business of regulating health insurance for decades. They should be empowered to make the right tradeoffs between consumer protections and individual choice, not regulators in Washington. The federal role should be minimal and set a few broadly shared goals, while state governments determine how best to implement those goals in their own markets.

For this type of system to work, support for the purchase of health insurance must be portable. Today, Americans must navigate a complicated system of subsidies and tax rules that create confusion, increase costs, and discourage personal choice. Millions of families are left to shoulder the entire cost of care on their own while others simply go without because they cannot afford the options available to them. A better solution would be to focus on increased equity that allows people to purchase the health insurance of their choosing. We can offer simple financial assistance by reforming our broken tax code and addressing the inequities that are truly driving health care costs. Improving the flexibility of health savings accounts and other consumer-oriented health care options will further enhance individual choice, without compromising quality of care or driving up the cost of coverage.

Our plan advances a series of proposals that not only protects the health insurance Americans receive through their job, but also moves toward a fairer system that ensures access to coverage for all Americans. It allows for more choices, not top-down mandates, so that Americans can pick the benefits that work best for them.



## Recommendations

- ✓ **Expanding Consumer-Directed Health Care Options**
- ✓ **Expanding Opportunities for Pooling**
- ✓ **Making Support for Coverage Portable**
- ✓ **Preserving Employee Wellness Programs**
- ✓ **Preserving Employer-Sponsored Insurance**
- ✓ **Protecting Employers' Flexibility to Self-Insure**
- ✓ **Purchasing Across State Lines**
- ✓ **Medical Liability Reform**

## Policies

### ✓ **Expanding Choice through Consumer-Directed Health Care**

Unleashing the power of choice and competition is the best way to lower health care costs and improve quality. One way to immediately empower Americans and put them in the driver's seat of their health care decisions is to expand consumer-driven health care. Consumer-driven health care allows individuals and families to control their utilization of health care by providing incentives to shop around. This ultimately lowers costs and increases quality.

While Obamacare tried to sideline consumer-directed health care by placing substantial fines on certain accounts and limiting the use of others, Republicans have long supported expansions to these popular arrangements, especially HSAs. HSAs are tax-advantaged savings accounts, tied to a high-deductible health plan (HDHP), which can be used to pay for certain medical expenses. This insurance arrangement— in which a person is protected against catastrophic expenses, can pay out-of-pocket costs using tax-free dollars, and in turn takes responsibility for day-to-day health care expenses— is an excellent option for consumers. HSAs tied to HDHPs are popular tools that lower costs and empower individuals and families. This type of coverage also helps patients understand the true cost of care, allows them to decide how much to spend, and provides them with the freedom to seek treatment at a place of their choosing.

For these reasons, our plan eliminates the roadblocks put in place by Obamacare and institutes several commonsense expansions to HSAs. For instance, our plan would do the following:

- Allow spouses to make catch-up contributions to the same HSA account;
- Allow qualified medical expenses incurred before HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established within 60 days;
- Set the maximum contribution to an HSA at the maximum combined and allowed annual deductible and out-of-pocket expense limits; and
- Expand accessibility for HSAs to certain groups, like those who get services through the Indian Health Service and TRICARE.

Our plan also creates space for innovative purchasing platforms, like private exchanges, to expand. Our plan encourages the use of direct or "defined contribution" methods, such as health reimbursement accounts (HRAs), which give individuals more freedom over their health care choices. Before the President's health care law tried to eliminate HRAs, some employers reimbursed some health expenses of their employees, including their premiums. In certain cases, employers provided HRAs, even if funding a group health plan was beyond their business resources.<sup>35</sup> These employer payment arrangements allowed employees to purchase coverage in the individual market, serving as an example of true portability: If the employee lost her job, then she could still keep the health insurance plan she liked. Our plan encourages the expansion of this arrangement, which once again empowers individuals to choose the insurance plan that best fits their needs.

<sup>35</sup> Grace Marie-Turner, [Small Businesses Threatened With \\$36,500 IRS Fines for Helping Employees with Health Costs](#), Forbes, June 30, 2015.

### ✓ **Making Support for Coverage Portable**

More than 150 million Americans have a plan sponsored by their employer. The system generally works well for them. Our plan strongly supports employer-based care and recognizes the certainty and stability job-based health insurance offers. But millions of Americans don't have this option – leaving many to purchase coverage with almost no financial support. They face a system that offers little in the way of choice, affordability, or flexibility when it comes to the purchase of health insurance. Our plan finally brings relief to these Americans.

Unlike Obamacare, our proposal is like a health care “backpack” that provides every American access to financial support for an insurance plan chosen by the individual and can be taken with them job-to-job, home to start a small business or raise a family, and even into retirement years. For those who do not have access to job-based coverage, Medicare, or Medicaid, our plan provides a universal advanceable, refundable tax credit for individuals and families, many of whom found themselves left behind under Obamacare. This portable payment – available at the beginning of every month – would be adjusted for age, ensuring older Americans receive more support, and would grow over time. Americans could spend this money to help offset the cost of purchasing a plan of their choice, rather than the current offering of expensive, one-size-fits-all, Washington-approved products. Given the increased flexibility in the insurance market, the new fixed credit would be large enough to purchase the typical pre-Obamacare health insurance plan – a level of support that better reflects the actual cost of coverage once states have the power to regulate plans at a more local level, rather than face costly federal mandates and regulations imposed by the President's health care law.

If a recipient of this assistance selected a health insurance plan that is less expensive than the value of the credit, the difference would be deposited into an HSA-like account and could be used toward other health care expenses, like over-the-counter medicines or dental and vision care. This added benefit would provide a solid source of funding for out-of-pocket costs. It would also allow families to begin saving for future medical expenses, while encouraging efficient decision making. As under current law, individuals who are in this country unlawfully would be ineligible for this new portable payment. Further, this new payment would not be allowed to pay for abortion coverage or services.

In contrast to the expensive debacle of HealthCare.gov, administration of the tax credits under our plan would be more flexible and available for shoppers through multiple portals, including private exchanges. Robust verification methods would be put in place to protect taxpayer dollars and quickly resolve any inconsistencies that occur.

The structure of this monthly financial assistance would be a departure from Obamacare in several critical ways. First, as a result of Obamacare's poor design and incentives, many Americans— who do not have an offer of health insurance through their employer— have fallen into a coverage gap between their state's Medicaid eligibility and the eligibility criteria for the Obamacare subsidies. Likewise, many middle class families find themselves with little or no assistance to purchase increasingly expensive health insurance. Our plan would provide assistance to those individuals and families. It would also ease fears of “job-lock” for more Americans, a situation where employees remain in jobs they may not like for fear of losing their tax-preferred job-based health care.

Second, Obamacare penalizes work. The law's employer mandate and definition of a “full-time” employee play a significant role in reduced hours, wages, and jobs. Even more critically, Obamacare's subsidies themselves are riddled with cliffs and phase-outs, and the law includes a direct tax on work. Taken as a whole, CBO found that the law's policies discourage work in such a way that it will be as if 2 million full-time jobs vanish from the economy by 2025.<sup>36</sup> Our plan would repeal those taxes and work disincentives and implement a flat, simple form of assistance that would grow the economy and ensure work pays.

Third, Obamacare's credits are tied to health care premiums, which means that as premiums increase in size, federal costs increase. That sends the wrong signals to insurers. Instead of a system that chases ever increasing health care costs with ever increasing subsidies, our plan provides a fixed amount grown over time that can be used in more places and on more choices. Taken together, these structural changes will bend the health care cost curve.

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<sup>36</sup> Edward Harris, Shannon Mok, [How CBO Estimates the Effects of the Affordable Care Act on the Labor Market](#), Congressional Budget Office, Dec. 2015.

## ✓ **Preserving Employer Sponsored Health Insurance**

Many Americans now receive employer-sponsored insurance (ESI) on a pre-tax basis. This tax preference allows individuals to “exclude” from their gross income the value of their job-based insurance. That means, unlike other forms of compensation—like wages—an individual doesn’t pay income and payroll taxes on the costs of a health care plan they get through their job. This amount, unlike other benefits—such as retirement savings accounts—is unlimited and uncapped, so the federal subsidy is endless.

The non-partisan CBO projects this job-based subsidy will lower federal revenues by \$266 billion in fiscal year 2016 alone and \$3.6 trillion over the next decade.<sup>37</sup> This benefit is so massive that, in terms of federal support, it would be the third largest health expenditure, after Medicare and Medicaid.

Economists on both sides of the aisle have recognized the effects of the employer exclusion. CBO has estimated that the ESI exclusion increases average premiums for employer-based coverage 10 to 15 percent above what it would have been without the benefit because “the open-ended nature of the subsidy gives employers and employees an incentive to select more extensive coverage than they otherwise would.”<sup>38</sup>

The exclusion also holds down wages as workers substitute tax-free benefits for taxable income. As a result, workers receive more of their compensation in generous health benefits instead of take-home pay. Thus, the ESI exclusion has contributed to the lack of growth in take-home pay that has frustrated many American families. The benefit is also regressive because it becomes proportionately larger – and more valuable – for the wealthiest Americans. In essence, it excludes dollars from taxable income, so those who pay the highest rates – the wealthiest Americans – receive the biggest benefit.

Bringing more parity to the group and individual health markets does not have to disrupt the way Americans currently receive their coverage. To help lower the cost of coverage, our plan proposes to cap the exclusion at a level that would ensure job-based coverage continues unchanged for the vast majority of health insurance plans. Only the most generous plans would see a difference and most Americans’ plans would not be affected. In fact, it’s likely that most health plans would change their design to avoid hitting the threshold by shifting compensation away from health care and toward take-home pay. Americans would have more money in their pockets and face lower premiums as a result of this policy.

This reform is a fundamental departure from Obamacare’s “Cadillac tax.” Obamacare mandates that individuals and employers only purchase Washington-mandated health insurance, which limits plan flexibility and coverage options. The law simultaneously mandates a vast array of benefits and insurance regulations that drive up the cost of coverage. Then, it turns around and taxes people for these high-cost plans. The Cadillac tax’s poor design layers yet another complex tax into an already confusing tax code, provides for special interest carve-outs, and has an aggressive penalty rate.

The tax itself is a 40 percent penalty, regardless of income, for each dollar in benefits above Obamacare’s thresholds, which means higher income workers bear the smallest burdens. In contrast, a cap would provide relief for lower income workers relative to current law. Moreover, the Cadillac tax fails to adjust for the cost of providing health insurance driven by differences such as cost of living. Our plan adjusts the cap so someone is not unfairly penalized if they live in a place where health care costs are higher simply because their cost of living is higher. Thus, our plan provides relief from the Cadillac tax for lower income workers and those who live in areas with higher labor costs.

Finally, rather than encourage the use of tools that lower costs and encourage better utilization, the Cadillac tax penalizes employee contributions to HSAs. Our plan recognizes that it is good policy to encourage use of HSAs. As a result, our plan omits employee contributions made on a pre-tax basis to an HSA from counting toward to cost of coverage for purposes of the cap.

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<sup>37</sup> [Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 – 2026](#), Congressional Budget Office, March 2016.

<sup>38</sup> [Private Health Insurance Premiums and Federal Policy](#), Congressional Budget Office, Feb. 2016.

✓ **Purchasing Coverage across State Lines**

Under our plan, consumers would no longer be limited to coverage options available only in their state. Current law obstructs people from purchasing a plan licensed in another state. Our plan would fix this problem, increasing competition among plans and freeing Americans to purchase plans licensed in other states.

Our plan would also make it easier for states to enter into interstate compacts for pooling, which would ease the current administration's chokehold on health care options by increasing health competition. This would bring balance to the market by giving consumers the choice to purchase across state lines and returning authority to states to regulate health plans as they have in the past.

✓ **Expanding Opportunities for Pooling**

Small businesses across the country repeatedly say the single largest obstacle to offering workers health insurance is cost—both for them as employers and for their employees. A 2015 survey of small employers by the National Federation of Independent Businesses found that “[o]f the 60 percent of small employers who do not offer health insurance coverage, 52 percent say cost is the reason they do not. And unfortunately, the cost barrier for those not offering continues to grow as average yearly premium increases outpace wages and inflation.”<sup>39</sup> Contrary to promises made before it was passed, the President's health care law did nothing to drive down the cost of health care coverage. Instead it imposed more requirements on small-group market coverage—requirements that have only made it more expensive for small businesses to offer health insurance.

Instead, Republicans have a different vision to improve access and drive down costs. This plan allows small businesses to band together to offer small business health plans, also known as association health plans (AHPs). Small businesses and voluntary organizations—such as alumni organizations, trade associations, and other groups—should have the ability to pool together and offer health care coverage at lower prices through improved bargaining power at the negotiating table with insurers just as corporations and labor unions do. By increasing the negotiating power of small businesses with health care insurers, AHPs would free employers from costly state-mandated benefit packages and lower their overhead costs.

These new pools would be prohibited from “cherry picking” only healthy participants because sick or high-risk patients cannot be denied coverage. They would further be prohibited from charging higher rates for sicker people on the plan, except to the extent already allowed under the relevant state rating law.

Like small businesses, people buying health care coverage on their own are also unable to take advantage of pooling options. Instead, Americans across the country should be able to come together for the sole purpose of purchasing health care coverage through individual health pools (IHPs). IHPs would allow people to join together in order to garner the same purchasing power as employers and negotiate lower rates with insurance companies in the individual market. This pooling mechanism would operate similarly to AHPs in many respects – improve bargaining power, unbound by benefit mandates, reduce overhead costs, provide protections for sick and high-risk patients – to improve access and reduce costs for individuals and families.

✓ **Preserving Employee Wellness Programs**

Our plan supports employers who want to reward their workers for healthy behaviors through lower health insurance premiums based upon participation in prevention and wellness programs. To encourage healthy lifestyle behaviors and lower costs, companies that sponsor a weight loss or smoking-cessation program should be able to continue to offer participating employees health care coverage at lower cost [Figure 4].

Sadly, the Administration continues to stand in the way of these commonsense programs. Legal challenges<sup>40</sup> and burdensome regulations have undermined employers' ability to offer wellness programs, leaving them in a perpetual state of uncertainty.

<sup>39</sup> [Small Business's Introduction to the Affordable Care Act, Part III](#), NFIB Research Foundation, Nov. 2015.

<sup>40</sup> See, e.g. *EEOC v Honeywell*, 2014 WL 5795481 (D. Minn. Nov 6 2014).



Our plan ensures employers may offer wellness programs that are tied to a financial reward or surcharge so long as those programs do not exceed the limits under current law. It also clarifies that offers of financial incentives do not violate the *Americans with Disabilities Act of 1990* (ADA). Our plan also says voluntary collection of medical information from an employee's family member as part of a wellness program cannot violate the *Genetic Information Nondiscrimination Act of 2008* (GINA). Our proposal would provide much-needed certainty, protect workplace wellness programs from costly litigation, and ensure employers can continue to make crucial benefit decisions that have a large impact on their daily operations and health care resources.

**Figure 4**

#### **Wellness Programs: Under Attack from EEOC**

Wellness programs typically focus on health promotion and disease prevention, and include offerings such as cycle-to-work programs, workplace fitness challenges, or on-site nutrition coaches. To encourage participation in these wellness programs, an employer or insurer may offer incentives like insurance premium discounts, cash rewards, or free health club memberships. Research shows that employers who offer incentives increase participation rates. When incentives reduce health plan premiums or deductibles, participation rates in wellness programs increase even further, to as much as 90 percent.

Both Republicans and Democrats recognize the value of these programs. Therefore, Congress facilitated wellness programs provided they comply with certain nondiscrimination requirements under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). To implement these provisions, a regulation in June 2013 set the maximum reward for voluntary employee participation in wellness programs. Under that regulation, employees may be rewarded up to 50 percent of the cost of health coverage for smoking-cessation programs and 30 percent for other programs.

Unfortunately, the Equal Employment Opportunity Commission (EEOC), an independent federal agency responsible for enforcing federal nondiscrimination laws, has attacked wellness programs. EEOC has pursued litigation and regulations premised on the false belief that employees are forced to participate in such programs, thereby violating the *Americans with Disabilities Act of 1990* (ADA) and the *Genetic Information Nondiscrimination Act of 2008* (GINA).

In litigation, EEOC has argued wellness programs may be involuntary when employers offer substantial financial inducements to participating employees. Further, EEOC has claimed employers' collection of medical information from an employee's family member participating in a wellness program may be unlawful, even though it is permissible under HIPAA.

Last month, the EEOC issued new regulations threatening the expansion of wellness programs, even if employers otherwise comply with all applicable health laws that already contain nondiscrimination protections. Under the new rules, the EEOC states that an employer's compliance with ADA and GINA are distinct from those requirements already settled on in the health care law and regulations. As a result, the EEOC has created great uncertainty for employers trying to implement these programs. These new rules will discourage employers from establishing these plans, resulting in harm to employees' health – and their pocketbooks.

### ✓ **Protecting Employers' Flexibility for Self-Insurance**

Self-insured health plans play an important role in our nation's health care system. Many companies provide health insurance directly to their employees instead of contracting with a third-party insurer. An employer who self-insures (also known as "self-funding") assumes the financial risk of employee health expenses by paying health care providers directly or reimbursing employees as claims arise, instead of paying a fixed premium to an insurance company. Thus, self-insured employers are able to structure their plans to meet the unique needs of their employees.

Employers who self-insure often purchase stop-loss insurance to cover large medical claims and protect against the financial danger such claims often pose. Stop-loss insurance is a financial risk-management product that limits liability for very large claims or an unexpected level of claims and expenses. Self-insurance, in combination with stop-loss coverage, provides employers with the flexibility to customize health plans to their workforce and allows for retention of savings in years with low claims.

Rather than encourage employers to use these tools for the benefit of their employees, the Administration has tried to prevent employers from using self-insurance and stop-loss coverage in an attempt to boost enrollment in Obamacare's Small Business Health Options Program (SHOP) Exchanges. Many are concerned that the Department of Labor and the Department of Health and Human Services will attempt to redefine "group health insurance coverage" to include stop-loss insurance, thereby opening the door for regulation at the federal level.<sup>41</sup> Such regulation would limit the purchase of this financial risk-mitigation tool, effectively prohibiting employers from being able to self-insure.

Self-insured health plans should not be limited merely to extend the reach of the health care law's unpopular benefit mandates. Under our plan, employers would be able to freely choose insurance options, including self-insurance and stop-loss protections, by preserving the current definition of stop-loss insurance and maintaining its distinct difference from "group health insurance." Self-insurance provides employers with flexibility to adapt their health care needs to their unique workforce, while also providing long-term financial savings. Workers and employers need more affordable health care options, not fewer. We must continue to allow self-insured employers to have control over their health care dollars—to boost reserves for added protection against years of high claims and also to use the savings for growing their businesses and creating more jobs.

### ✓ **Medical Liability Reform**

The nation's medical liability system is broken, and it has imperiled patient access and imposed tremendous costs on our nation. The current system has forced doctors out of practicing in certain specialties; it has caused trauma centers to close; and it has forced pregnant women to drive hours to find an obstetrician.<sup>42</sup> The current system also has imposed a tremendous burden in unnecessary costs on our national health care system and federal government. Estimates are that the failure to enact meaningful medical liability reform costs our nation's health care system as much as \$300 billion each year.<sup>43</sup>

In states without liability reform, the system does not serve anyone except trial lawyers. Injured patients are not compensated in a timely or equitable way. They are forced to wade through several years of litigation and receive, on average, only 46 cents of every dollar awarded while the remaining 54 cents goes to their lawyers and other administrative fees.<sup>44</sup>

President Obama has repeatedly promised to address the issue of medical liability reform but has failed to do so. The time for experiments is over. California and Texas, as well as numerous other states, already have taken the difficult steps to enact comprehensive liability reforms, and they have shown that such reforms result in an increase in doctors, increased access to specialists, and reduction in medical liability insurance premiums.<sup>45</sup>

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<sup>41</sup> [Request for Information Regarding Stop Loss Insurance](#), Federal Register 77, at 25788-25790, May 1, 2012.

<sup>42</sup> [Medical Malpractice: Implications of Rising Premiums on Access to Health Care](#), United States General Accounting Office, Aug. 2003.

<sup>43</sup> [The Factors Fueling Rising Healthcare Costs 2006](#), PriceWaterhouseCoopers, Jan. 2006.

<sup>44</sup> [U.S. Tort Costs: 2003 Update](#), Tillinghast-Towers Perrin, 2003.

<sup>45</sup> [State Enactments of Selected Healthcare Liability Reforms](#), PIAA, May 17, 2016.

From 1976 through 2012, California's medical liability insurance premiums increased by 241 percent compared to a total increase of 679 percent for the other 49 states.<sup>46</sup> From 2003 through 2015, the Texas Medical Board saw an increase of roughly 109 percent in their new physician licensure applications.<sup>47</sup> While other states were losing obstetricians, Texas actually gained obstetricians: the number of obstetricians in Texas increased by 429 between 2003 and 2015 to a total of 2,732.<sup>48</sup>

Medical liability also has an effect on the general economy. By contributing to rising health care costs, frivolous lawsuits make it even more difficult for businesses to remain profitable and for employers to create jobs. Medical liability reform is not just an issue for states. The burdens imposed by the current medical liability system – such as additional costs and limited access to care – affect Medicare and Medicaid beneficiaries, the national health care system as a whole, and the general economy.

We know that comprehensive medical liability reform that includes caps on non-economic damages will improve patients' access to quality care while reducing the overall cost of health care in America. Our plan will include liability reform that includes caps on non-economic damage awards, ensuring plaintiffs can recover full economic damages and that patients will not have their damages taken away by excessive lawyer contingency fees.

We will also encourage states to continue to be laboratories of innovation to find the best means by which to reduce frivolous lawsuits and the practice of defensive medicine. We will work with the states to pursue a wide variety of options such as loser-pays, proportional liability, the collateral source rule, consideration of the statute of limitation, safe harbor provisions, health courts, and independent pre-discovery medical review panels. We will also look at ways to strengthen federal health programs by pursuing laws that allow safe harbors and higher standards of evidence for medical professionals following clinical practice guidelines developed by national and state professional medical societies.

#### ✓ **Addressing Competition in Insurance Markets**

Some have raised concerns regarding the possible link between the limited anti-trust exemption under McCarran-Ferguson and lack of competition in insurance markets. Legislation has been introduced to repeal this limited exemption.

It is important to note that the CBO has previously reviewed legislation moving away from these McCarran-Ferguson carveouts and concluded that, "...enacting the legislation would have no significant effect on the premiums that private insurers would charge for health insurance." CBO also noted that, "To the extent that insurers would become subject to additional litigation, their costs and thus their premiums might increase."<sup>49</sup>

For this reason, we recommend charging the GAO to study the advantages and disadvantages of removing this limited McCarran-Ferguson anti-trust exemption. Among other items, the study should examine potential consumer impact, market consolidation, and effects on health insurance premiums. This study should also review state anti-trust regulation regarding health insurance since such regulation is not preempted by McCarran-Ferguson. Past CBO analyses and third-party actuarial estimates should also be consulted when studying this idea.

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<sup>46</sup> [Report on Profitability by Line by State \(1976-2012\)](#), National Association of Insurance Commissioners, summarized by PIAA.

<sup>47</sup> [New Physician Applications Received \(1999-2015\)](#), Texas Alliance for Patient Access, 2015.

<sup>48</sup> [Change in Percentage of High Risk Specialists](#), Texas Alliance for Patient Access, 2015.

<sup>49</sup> [H.R. 3596, Health Insurance Industry Antitrust Enforcement Act of 2009 Cost Estimate](#), Congressional Budget Office, Oct. 23, 2009.

## Protecting and Strengthening Coverage Options for All Americans

Commonsense protections must be in place to ensure Americans are treated fairly by insurance companies. At the same time, any reform plan must also recognize that too many regulations at too many levels of government can actually put the insurance companies back in charge.

### Recommendations

- ✓ **Pre-existing Condition Protections**
- ✓ **Practical Reforms**
- ✓ **Coverage Protections**
- ✓ **Continuous Coverage Protections**
- ✓ **Fair Premiums**
- ✓ **State Innovation Grants**
- ✓ **High-Risk Pools**
- ✓ **Open Enrollment Period**
- ✓ **Protecting Life and Conscious Rights**

Fairness is the cornerstone of putting Americans back in control of their health coverage decisions. For consumers, there are useful boundaries that will help guard families and individuals from being turned away from health care, regardless of how healthy or sick they may be. Republicans support important market reforms that encourage coverage innovation over costly mandates. Our strong belief in individual liberty extends to health care, which is why we recognize and incentivize good behavior instead of coercing patients into government-mandated decisions. And perhaps most importantly, in stark contrast to current law, our plan gives states the flexibility to pursue their own solutions if they find a better way to provide health care for their unique populations.

### Policies

#### ✓ **Protections for Patients**

- *Pre-existing Condition Protections*  
No American should ever be denied coverage or face a coverage exclusion on the basis of a pre-existing condition. Our plan ensures every American, healthy or sick, will have the comfort of knowing they can never be denied a plan from a health insurer.
- *Practical Reforms*  
Our plan builds on the reforms previously proposed by Republicans. For example, we would allow dependents up to age 26 to stay on their parents' plan, helping younger Americans receive health coverage and stabilizing the market. We also support changes that end the practice of imposing lifetime limits on the coverage provided to individuals.
- *Coverage Protections*  
Insurers should never be able to unfairly cancel coverage and drop Americans suddenly from the protection of a health insurance plan. This is why we propose that rescissions should never be allowed again, especially because someone gets sick. Under our proposal, insurance companies would not be allowed to turn away patients when they renew their plan simply because they may be sick.
- *Continuous Coverage Protections*  
Our plan also proposes a new patient protection for those Americans who maintain continuous coverage. Already in place for the employer market, this protection would apply to those in the individual market as well. This is how it works: If an individual experiences a qualifying life event, he or she would not be charged more than standard rates – even if he or she is dealing with a serious medical issue.

This new safeguard applies to everyone who remains enrolled in a health insurance plan, whether the individual is switching from employer-based health care to the individual market, or within the individual market.



This provision is modeled after a 1996 law – the Health Insurance Portability and Accountability Act, commonly known as HIPAA – that offers pre-existing condition protections when patients move from one job to another.<sup>50</sup> In other words, without this protection even those individuals who maintained continuous coverage in the group market were not rewarded and were rated by insurers each time they enrolled in a new plan. This often resulted in an increase in premium costs for individuals and families. Extending these protections to the individual market is a simple but important reform that will encourage Americans to enroll in coverage and stay enrolled.

- *Fair Premiums*

Another way to strengthen the health care market is to fix the age-rating ratio, which is used to adjust premium amounts according to an individual's age. One way to do this is by limiting the cost of an older individual's plan to no more than five times what a younger person pays in premiums. Most states were using this five-to-one ratio before 2010. However, Obamacare now mandates a three-to-one ratio — an unrealistic regulation — that is leading to insurance pools with older, less healthy individuals, while driving younger and healthier Americans from the insurance market. The ill-advised three-to-one policy is leading to artificially higher premiums for millions of Americans, especially younger and healthier patients. Recent studies confirm that many exchange enrollees have higher rates of certain diseases, use more medical services across all sites of care, and have higher medical costs associated with care.<sup>51</sup>

Under our plan, the default age-rating ratio would be set at five-to-one, but states would have the ability to narrow or expand. After all, states understand what their residents want and need better than Washington. Making health insurance more affordable for young people can entice them to buy—and keep—health insurance without punitive mandates.

- *State Innovation Grants*

States have long been America's innovation hubs. One key to long-term market stability is giving states the flexibility to craft premium-reduction programs that support wellness and offer innovative plan designs. First proposed in 2009 as part of the Republican response to the President's health care law, our plan provides at least \$25 billion for State Innovation Grants.<sup>52</sup> These grants reward states for developing effective reforms that make health care more affordable and accessible. To participate, states must achieve a certain target for the reduction of individual premiums, small group premiums and the number of uninsured in the state. A state would be rewarded — on a sliding scale — based on how well they performed. This data-based concept has been found in the past to lower costs.<sup>53</sup>

- *High-Risk Pools*

Another Republican solution to help states increase the number of patients with health coverage is through robust high-risk pools. High-risk pools give financial support for those who find themselves priced out of coverage, helping ensure all Americans have access to affordable health care.

Our plan provides at least \$25 billion in dedicated federal funding for these programs. As partners with the federal government, states would help maintain the actuarial solvency of these programs as outlined by their state insurance commissioner or non-government, third-party groups like the National Association of Insurance Commissioners (NAIC). Premiums for those participating in the high-risk pool would be capped, and wait lists would be prohibited.

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<sup>50</sup> [H.R. 3103, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191](#), 1996.

<sup>51</sup> [Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014-2015](#), Blue Cross Blue Shield, March 2016.

<sup>52</sup> Greg Hitt, [GOP Set to Propose its Own Health Bill](#), The Wall Street Journal, Nov. 2, 2009.

<sup>53</sup> [Congressional Budget Office Analysis of the Affordable Health Care for America Act](#), Congressional Budget Office, Nov. 4, 2009.

High-risk pools coupled with innovation grants – in harmony with the practical insurance guardrails listed above – can help states lower the cost of health care for some of their most vulnerable patients. In fact, in a previous analysis, CBO found proposals similar to those discussed above would reduce premiums.<sup>54</sup>

- *Open Enrollment*

Under current law, many patients are still struggling to get and keep health coverage. Our plan provides a one-time open enrollment period for individuals to join the health care market if they are uninsured, regardless of how sick or healthy they are. This fairness tool would give uninsured patients the same plan options as individuals who have previously entered the health care market. If someone chooses not to enroll during this one-time open enrollment period, the individual can get coverage at another time. However, making the decision to forego coverage during this one-time open enrollment period will result in the forfeiture of continuous coverage protections and lead to higher health insurance coverage costs for that individual for a period in the future.

- ✓ ***Protecting Life and Conscience Rights***

- *Conscience Protections*

Like patients, health care providers also need protections from unfair coercion and discrimination. Our plan incorporates bipartisan protections to give doctors, nurses, hospitals, and all other providers the freedom to exercise their conscience. Right now, Congress passes an annual conscience safeguard known as the Weldon Amendment, which bars federal funds from going to states that discriminate against individuals or entities who exercise their conscience.

Yet, California now requires all health insurance plans to cover abortion services—threatening the conscience rights of churches, religious charities, employers, and individuals.

HHS has opened an investigation into California's action within the Office of Civil Rights. When pressed about the slow pace of the investigation, which has remained unresolved since December 2014, even HHS Secretary Sylvia Burwell testified that she is unsatisfied.<sup>55</sup>

Our plan will permanently enact and expand the Weldon Amendment. And rather than force individuals to wait for a slow bureaucracy to assist in protecting their conscience rights, we believe Americans should have a private right of action to seek relief in court.

- *Ensuring Taxpayer Dollars Are Not Used to End Life*

The Hyde Amendment was a bipartisan initiative to ensure federal taxpayer dollars are not used to pay for abortion or abortion coverage. This commonsense protection has been enshrined in law for decades and continues to be supported by both Republicans and Democrats.

Despite promises that this protection for taxpayers would be upheld, Obamacare broke this bipartisan agreement by permitting federal dollars to flow toward plans that provide abortion coverage. The GAO confirmed that plans that cover abortion are receiving federal taxpayer dollars under Obamacare—corroborating claims that the Hyde amendment would apply to Obamacare did not come to fruition.<sup>56</sup>

Our plan would protect federal taxpayer dollars from being used for abortion or abortion services and ensure the Hyde Amendment is actually applied.

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<sup>54</sup> [Congressional Budget Office Analysis of the Affordable Health Care for America Act](#), Congressional Budget Office, Nov. 4, 2009.

<sup>55</sup> [The Fiscal Year 2017 HHS Budget](#), U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Feb. 24, 2016.

<sup>56</sup> [Health Insurance Exchanges: Coverage of Non-excepted Abortion Services by Qualified Health Plans](#), U.S. Government Accountability Office, Sep. 15, 2014.

## Medicaid Reform: Empowering States and Increasing Flexibility

The Medicaid program today is a critical lifeline for some of our nation's most vulnerable patients, as the program provides health care for children, pregnant mothers, the elderly, the blind, and the disabled. Medicaid currently covers nearly 72 million Americans—more than Medicare — and up to 98 million may be covered at any one point in a given year.<sup>57</sup>

Due in large part to the program's massive expansion under Obamacare, the federal government currently spends more general tax revenue on Medicaid than it does on Medicare. During fiscal year 2016, federal and state Medicaid outlays are expected to be approximately \$545 billion.<sup>58</sup> Today, Medicaid accounts for more than 15 percent of all health care spending in the United States and plays an increasingly large role in our nation's health care system.<sup>59</sup> Representing roughly one in every four dollars in a state's average budget, Medicaid accounts for nearly half of national spending on long-term services and supports and roughly a quarter of all mental health and substance abuse treatment spending.

The federal government's share of most Medicaid expenditures is determined by the federal medical assistance percentage (FMAP) rate. Section 1905(b) of the Social Security Act specifies the statutory formula for calculating FMAP rates. The foundation of the current Medicaid FMAP formula dates back to the creation of the program nearly 50 years ago. When Medicaid was created in 1965, Congress set the federal government's total nationwide share at 55 percent and set a maximum federal matching rate of 83 percent.

### **Inconsistent Quality and High Fraud**

GAO designated Medicaid as a program at high risk of fraud more than a decade ago due to "its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight."<sup>60</sup> While the joint federal-state administration leads to significant variability nation-wide, Medicaid is a program facing significant program integrity challenges. The federal error rate for Medicaid payments is high—and rising.

Many state Medicaid programs suffer from significant waste, fraud, and abuse, due to failures in state and federal oversight. For example, a recent GAO report found thousands of beneficiaries had payments made on their behalf concurrently by two or more state Medicaid programs, while hundreds of deceased beneficiaries received millions of dollars in Medicaid benefits after the beneficiary's death.<sup>61</sup>

Unfortunately, such lapses can also hurt patient safety. GAO found dozens of providers who were excluded from federal health-care programs, including Medicaid, for a variety of reasons—such as patient abuse or neglect, fraud, theft, bribery, or tax evasion—but were still being paid by the program.<sup>62</sup> The inspector general's office at HHS has found repeated cases of fraud, abuse, or neglect in Medicaid personal care services—services owed to some of the nation's most vulnerable patients.<sup>63</sup>

Timely access to care should be a top priority for lawmakers because of Medicaid patients' needs. As the federal government has imposed more red tape and states have cut payments to health care providers, low-income patients have less and less access to quality care. The result is nationally, only a portion of primary health care providers accept Medicaid beneficiaries—often with even fewer specialists accepting such patients.<sup>64</sup> The Medicaid and CHIP Payment and Access Commission (MACPAC) has reported that Medicaid patients disproportionately live in medically underserved communities – neighborhoods and localities that already suffer from shortages of primary care providers. According to MACPAC, in 2009, only 65 percent of physicians in such communities were accepting new Medicaid patients. GAO has also found Medicaid beneficiaries face particular challenges in accessing certain types of care.<sup>65</sup>

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<sup>57</sup> [Detail of Spending and Enrollment for Medicaid for CBO's March 2016 Baseline](#), Congressional Budget Office, March, 2016.

<sup>58</sup> [The Budget and Economic Outlook: 2016 to 2026](#), Congressional Budget Office, Jan. 2016.

and for the State share see: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf>

<sup>59</sup> [National Health Expenditures by Type and Payer, 2012](#), Medicaid and CHIP Payment and Access Commission, March, 2014.

<sup>60</sup> [High Risk Series: An Update](#), U.S. Government Accountability Office, Feb. 2015.

<sup>61</sup> Seto Bagdoyan, [Testimony Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives, Regarding Medicaid: CMS Could Take Additional Actions to Help Improve Provider and Beneficiary Fraud Control](#), U.S. Government Accountability Office, June 2, 2015.

<sup>62</sup> [Ibid](#)

<sup>63</sup> [Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement](#), U.S. Department of Health and Human Services, Nov. 2012.

<sup>64</sup> Phil Galewitz, [Study: Nearly a Third of Doctors Won't See New Medicaid Patients](#), Kaiser Health News, Aug. 6, 2012.

<sup>65</sup> [Medicaid: Key Issues Facing the Program](#), U.S. Government Accountability Office, July 2015.

Before Obamacare's massive expansion of Medicaid, a nationwide survey found that roughly one in three physicians was unwilling to accept new Medicaid patients.<sup>66</sup> In some states, like New Jersey, the survey found nearly two-thirds of physicians would not accept patients with Medicaid. As an article highlighting the survey results underscores, the problem can only be expected to worsen since the survey was "pre-ACA expansion and prior to any reimbursement fee changes."<sup>67</sup> Perhaps it is little surprise then that one recent analysis by the Commonwealth Fund noted that nearly half of those with Medicaid under the ACA detected no improvement in their access to health care.<sup>68</sup> This may explain why some research has suggested that Medicaid beneficiaries have not experienced notably better health outcomes than individuals without any health coverage—raising more questions about the quality and timeliness of access for Medicaid patients.

Even supporters of Obamacare's Medicaid expansion are forced to admit this is a problem. As one ardent champion for the law noted, "historically, Medicaid has faced a major challenge — a relatively low rate of physician participation."<sup>69</sup> As this analyst noted, the "pronounced and growing shortage of primary care professionals" means that "depressed Medicaid participation among available physicians is a major cause for concern."<sup>70</sup> This is one factor in understanding why the rate of visits to emergency departments in hospitals was still roughly twice as high for Medicaid patients in both 2013 and 2014 as it was for those with private insurance, or no insurance at all.<sup>71</sup> As the Centers for Disease Control and Prevention (CDC) explained, "ER use overall has not changed significantly after the first full year of ACA implementation." Given the growing role of Medicaid in our health system, it will be critical in the future to continue to evaluate the quality of care and access to care that vulnerable Medicaid patients receive.

### ***Obamacare's Uneven Treatment of Low-Income Americans***

Obamacare made a number of modifications to Medicaid that, taken together, represent the most significant expansion and changes to the program since its creation in 1965. Most notably, the law extended categorical Medicaid eligibility to non-disabled, working-age adults above the poverty level. Historically, Medicaid eligibility was largely limited to low-income children, pregnant women, parents of dependent children, elderly individuals, and individuals with disabilities.

However, Obamacare included a Medicaid expansion, which (after the Supreme Court's ruling in *NFIB vs. Sebelius*) allowed states to expand Medicaid eligibility to people under the age of 65 with income up to 138 percent of the federal poverty level (FPL).<sup>72</sup> The law also provided enhanced federal funding for coverage of this new expansion population, with the federal government covering 100 percent of the costs through 2016. The FMAP gradually diminishes to 90 percent by 2020.

This enhanced match policy creates a gross inequity under federal law. Under Obamacare, the federal government covers a higher percentage of the cost of care for able-bodied adults above poverty compared to the disabled, elderly, or children below poverty. This is particularly troubling since it creates an incentive for states that face pressure to make cuts to their programs as a result of Obamacare to cut benefits and services for the traditional Medicaid population. This policy flaw within Obamacare is all the more alarming in a program that was intended to focus on low-income individuals and families.

### ***The Medicaid Status Quo is Unfair to Taxpayers***

Today, the FMAP formula compares each state's per capita income relative to U.S. per capita income, and it provides higher reimbursement to states with lower per capita incomes and lower reimbursement to states with higher per capita incomes. Per capita income is used as a proxy for both state resources and the population in need of Medicaid services.

Federal statute outlines what percentage of each state dollar the federal government will match, setting a statutory maximum of 83 percent and a statutory minimum of 50 percent. Since states finance no more than half of the total cost of their Medicaid programs, states have mixed incentives with regard to overseeing the financial growth of the program. This

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<sup>66</sup> Sandra Decker, [In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help](#), Health Affairs, Aug. 2012.

<sup>67</sup> Elizabeth Renter, [You've Got Medicaid - Why Can't You See the Doctor?](#) U.S. News and World Report, May 26, 2015.

<sup>68</sup> Sara R. Collins, Munira Gunja, Michelle Doty, Sophie Beutel, [Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction](#), The Commonwealth Fund, May 25, 2016.

<sup>69</sup> Sara Rosenbaum, [Medicaid Payment and Access to Care](#), The New England Journal of Medicine, Dec. 18, 2014.

<sup>70</sup> [Ibid](#)

<sup>71</sup> Renee Gindi, Lindsey Black, Robin Cohen, [Reasons for Emergency Room Use Among U.S. Adults Aged 18–64](#), National Health Statistics Reports, Feb. 18, 2016.

<sup>72</sup> [National Federation of Independent Business ET AL. V. Sebelius, Secretary of Health and Human Services, ET AL.](#), Supreme Court of the United States, June 28, 2012.



dynamic is particularly exacerbated due to a number of funding sources states have used, including some financing mechanisms designed to maximize the amount of federal Medicaid funds coming to the state.

Medicaid's open-ended funding structure sets up the wrong set of incentives. Expanding Medicaid coverage during boom years is tempting for states because they pay half, or less than half, of the cost of the program. Conversely, there is little incentive for states to restrain Medicaid's growth, because state governments only retain 50 cents or less for every dollar worth of coverage or benefits they rescind.

Instead of a structure that drives innovation and increases quality for the most vulnerable, the status quo is full of incentives for state politicians and bureaucrats to maximize the share of Medicaid funded by federal taxpayers. In order to drive innovation that benefits patients and lowers costs, reforms are needed to financially align payments to states.

For Medicaid to be strengthened and sustained as a vital safety net to provide needed care for our nation's most vulnerable patients for coming decades, Congress will undoubtedly be forced to enact additional reforms to the program in the years ahead. As GAO has noted, "the effects of unprecedented changes recently made to the Medicaid program will continue to emerge in the coming years and are likely to exacerbate the challenges and shortcomings that already exist in federal oversight and management of the program."<sup>73</sup>

Put simply, the status quo of today's Medicaid program is unsustainable. According to CBO, the federal share of Medicaid outlays are expected roughly to double over the coming decade, increasing from \$350 billion in 2015, to more than \$624 billion in 2026. Based on current trends, by 2025, each year Medicaid will cost federal and state taxpayers nearly \$1 trillion and will cover more than 109 million Americans at some point that year.<sup>74</sup>

### ***Bringing Medicaid into the 21st Century***

For too long, states have been treated like junior partners in the oversight and management of the Medicaid program – forced to go through long and cumbersome waiver processes just to make modest changes to their program. Regrettably, in recent years the federal-state balance has shifted since the passage of the Affordable Care Act, redefining federalism – where programs that should be administered locally are being overseen by political appointees and career bureaucrats in Washington issuing new rules and regulations.

But governors and state legislatures are closer to patients in their states and know better than Washington bureaucrats where there are unmet needs and opportunities to cut down on waste, fraud, and abuse. All states should have more flexibility to adapt their Medicaid programs, to better design benefit packages in a way that better meets the needs of their state populations, promotes personal responsibility and healthy behaviors, and encourages a more holistic approach to care.

There are many ways Congress can improve incentives, enhance accountability, and implement fiscal discipline in the Medicaid program. For decades, conservatives have supported the idea of reforming Medicaid by capping federal funding and turning control of the program over to states. The aim of such reforms is to reduce federal funding over the long term, while preserving a safety net for needy, low-income Americans. An additional valuable aim of this effort has been to advance federalism by reducing the federal government's role and giving states and governors more freedom and flexibility in managing their Medicaid programs and helping people in their states.

House Republicans agree on returning control back to states and reducing the role of Washington bureaucrats in Medicaid. We have looked at different approaches to Medicaid reform. President Reagan proposed block grants in 1981, and they were subsequently proposed by President George W. Bush and Congressional Republicans. Another way to achieve the same goal of cutting federal spending, advancing federalism, and empowering states with flexibility is to reform Medicaid through a per capita allotment approach. This approach has been supported by a wide range of conservatives, including conservative stalwarts such as former Senators Phil Gramm (R-TX) and Jesse Helms (R-NC).<sup>75</sup>

Our plan maximizes state flexibility by providing states a choice of either a per capita allotment, or a block grant. Depending on their unique set of circumstances, states could choose the block grant option, or otherwise default into a per capita allotment approach.

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<sup>73</sup> [Medicaid: High Risk Series, an Update](#), U.S. Government Accountability Office, February 2015.

<sup>74</sup> CBO's March 2016 baseline and National Health Expenditure 2015 data.

<sup>75</sup> [Making Medicaid Work: Protect the Vulnerable, Offer Individualized Care, and Reduce Costs](#), U.S. Congress, May 1, 2013.

## **Reforming Medicaid with a Per Capita Allotment**

A per capita allotment reform achieves three inter-related aims: reforming Medicaid's financing, restoring Medicaid's focus on the most vulnerable, and restoring federalism by empowering states with new freedoms and flexibilities to run their Medicaid programs. Reforming Medicaid's financing with a per capita allotment reform certainly will reduce federal spending, but just as importantly, this Medicaid financing reform helps modernize the program by improving the incentives for States, plans, and providers to better manage dollars as they help provide care to vulnerable patients. By enhancing the incentives for states to better manage limited dollars and giving states more tools and authority over their program, state resources are freed up to work on quality outcomes across the continuum of care.

Back in 1995, then-President Bill Clinton called for reforming Medicaid with a per capita allotment. But today's Medicaid program is *three times larger* by enrollment and annual spending than it was when President Clinton first proposed per capita allotments. CBO has noted that Medicaid spending will continue to grow at a rate faster than the economy. So, at a time when roughly two-thirds of beneficiaries in the program receive their Medicaid benefits through a managed care arrangement, transitioning federal financing to what is effectively a per-member-per-month amount is a reasonable and responsible way to help further spur innovation and align incentives to care well for patients.

Transitioning Medicaid's financing to a per capita allotment has been supported by Republicans in Congress and Republican presidential candidates. For example, House Committee on Energy and Commerce Chairman Fred Upton and Senate Finance Committee Chairman Orrin Hatch – both leaders of the congressional committees charged with overseeing the Medicaid program – have proposed per capita allotment reforms. A form of a per capita allotment policy was also supported by several Republican presidential candidates in 2015—including Senator Marco Rubio, Governor Scott Walker, former Governor Jeb Bush, and Governor Chris Christie.

Putting the Medicaid program on a sustainable budget with per capita allotments will establish transparent funding streams for states to meet the individual health care needs of distinct Medicaid population categories. Here's how it would work:

In 2019, a total federal Medicaid allotment would be available for each state to draw down based on its federal matching rate. The amount of the federal allotment would be the product of the state's per capita allotment for the four major beneficiary categories—aged, blind and disabled, children, and adults—and the number of enrollees in each of those four categories. The per capita allotment for each beneficiary category would be determined by each state's average medical assistance and non-benefit expenditures per full-year-equivalent enrollee during the base year (2016), adjusted for inflation.

The fixed allotment, which would grow, at a rate slower than current law, protects federal taxpayers by reducing the perverse incentive for state politicians to spend more money just to acquire more federal funding. Recognizing the complexity of Medicaid financing, certain payment categories would be excluded from the allotment and would be calculated through a separate funding stream, such as federal payments to states for disproportionate share hospitals, Graduate Medical Education payments, and other appropriate exclusions.

One advantage of a per capita allotment approach is it would provide certainty for state budgets. The per capita allotments made to the states would be made for all enrollees in the program, including anyone who might not have been expected to sign up. In times of slow economic growth or during a recession, this certainty will afford each state the opportunity to provide coverage to those who meet the eligibility requirements, without breaking the state budget. Conversely, during times of prosperity, federal taxpayers would also be protected by not overpaying states, based on artificially determined enrollment thresholds.

This reform would promote good behavior and innovation. The amount states would receive from the federal government for each person enrolled would be capped according to the appropriate category, regardless of how much the state spent on each enrollee. This incentive would help encourage efficiencies and accountability with taxpayer funds.

One of the worst facets of Obamacare has been the disruption and damage to choices caused by the law. So this proposal provides a transition period before per capita allotments are applied in 2019.

For states that have not expanded Medicaid under Obamacare as of January 1, 2016, under this per capita allotment approach they would not be able to do so. States that already expanded Medicaid would be given new authorities to better manage the health care, and better control the costs, of the expansion population.

In 2019, states that have already expanded Medicaid under Obamacare would receive the same amount of dollars they receive today under the plan. However, the state would also have flexibility to shift dollars from less needy populations to target more funding to help those who need it the most. To prioritize the most vulnerable in Medicaid, starting in 2019, the enhanced FMAP for the expansion adult population in Medicaid would be slowly phased down each year until it reached a state's normal FMAP level. The aim of this policy is to provide a predictable path for states, while transitioning many of the able-bodied adults from Medicaid into commercial coverage with the tax credit or employment-based coverage. This policy also rebalances federal spending to ensure able-bodied adults above poverty are not prioritized over the most vulnerable beneficiaries.

To minimize disruption, the Children's Health Insurance Program (CHIP) would be continued at its historic rate of federal support. By statute, the E-FMAP for CHIP traditionally ranged from 65 percent to 85 percent. However, Obamacare upended the federal-state partnership for CHIP by including a provision to increase the E-FMAP rate by 23 percentage points (not to exceed 100 percent) starting in fiscal year 2016 and going through fiscal year 2019. As a result, in fiscal year 2016, the CHIP programs in 12 states are 100 percent federally financed. Yet Democrats and Republicans in Congress—and governors of both parties—hailed CHIP as a success at the original match rate.<sup>76</sup> Thus, this proposal returns the joint federal-state financing arrangement to the program and continues the program. The proposal also adopts common-sense reforms Republicans have supported previously. These reforms prevent crowd-out of other private coverage and refocus CHIP resources to better serve eligible children in working families, rather than oversubsidizing high-income families.

States have asked for flexibility to better manage their states' needs for years, and this per capita allotment proposal would ensure that reality by creating new statutory flexibilities. First, this proposal would allow states to adopt a requirement that able-bodied adults be seeking a job, employed, or participating in an education, training, or approved community program. Today, Obamacare's Medicaid expansion discourages work. CBO noted that enrolling in Medicaid reduces a person's "incentive to work," and "creates a tax on additional earnings."<sup>77</sup> But work—especially full-time work—has been correlated with gains in an individual's health and self-confidence. This policy would allow states to use Medicaid dollars to provide a defined contribution in the way of premium assistance or a limited benefit to work-capable adults who are working or preparing for work.

For most non-disabled adults, states would be allowed to set reasonable, enforceable premiums. The goal of this policy is to engage consumers in their own health care decision-making, help them take responsibility for their health care costs, and prepare them for transitioning to private or employer-sponsored health insurance. States could also require non-disabled adults to use premium assistance if it was cost-effective, without all of the existing requirements for the provision of wrap-around services. States could also use Medicaid dollars to help offset cost-sharing in an employer plan for an eligible adult and could implement programs to incentivize wellness and healthy behavior.

For populations and benefits that are today optional for states to cover, states would get broad new flexibilities such as the ability to charge reasonable enforceable premiums or offer a limited benefit package. States could also use waiting lists and enrollment caps for non-mandatory populations to help prevent crowd-out of private coverage. For the expansion population, states would also be allowed to reduce income eligibility thresholds below the current 138 percent FPL threshold, or phase out expansion by freezing enrollment but continuing to cover current enrollees.

This proposal also modernizes the waiver process. To protect taxpayers and prioritize dollars for the most vulnerable, this proposal would require Medicaid demonstration waivers to be budget-neutral to the federal government. It would also limit the ability of the Secretary of HHS to provide federal dollars for state programs on "costs not otherwise matchable"—unless such state programs specifically focus on serving health care needs of Medicaid patients or uninsured individuals below a specific income threshold.

Since many states have one or more waivers for managed care, this proposal would grandfather successful waivers for managed care if they have already been renewed twice. The proposal would also grandfather provisions of waivers that meet "fast track" parameters, so that states could fold such waivers in their state plan and would no longer be required to

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<sup>76</sup> Spending estimates based on projections of National Health Expenditure data from CMS, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>. Medicaid spending for 2024 and 2025 was further estimated assuming an annual rate of growth of 6.5 percent. Enrollment projection from CBO's Medicaid baseline.

<sup>77</sup> Edward Harris, Shannon Mok, [How CBO Estimates the Effects of the Affordable Care Act on the Labor Market](#), Congressional Budget Office, Dec. 2015.

seek renewals of such waivers. Moving forward, the proposal would do away with the requirement in current law that states obtain a waiver for enrolling some populations in managed care. This proposal would also adopt a waiver clock to track progress and deliver decision to states within a reasonably abbreviated timeframe.

Taken together, these new flexibilities and reforms to the waiver process would protect taxpayers and free up enormous administrative and state financial resources to better manage and oversee their Medicaid programs. By giving states broad new authorities and creating certainty, scarce resources and managerial oversight can be better directed toward needed areas. States would be required to report on their achievements related to measures on access to care, patient outcomes, patient experience, and health care costs. These reforms would modernize the outdated maze of confusing, burdensome, and costly rules with clear reporting standards to ensure transparency and accountability on key metrics related to cost, quality, access, and outcomes for Medicaid patients.

Finally, to correct an overreach by the Obama administration, this proposal clarifies states' flexibility under current law to establish criteria regarding the participation in its Medicaid program of entities or persons who perform, or participate in the performance of, elective abortions. This does not repeal existing Medicaid access standards but merely gives states flexibility to design their Medicaid programs in a manner they choose. State leaders care about ensuring their state's Medicaid program strongly serves the people who depend on the program.

### **Reforming Medicaid with a Block Grant**

A second approach to reforming our broken Medicaid system is to give states more control over Medicaid using block grants. Under the new Medicaid financing block grant option for states, a state that opts out of the per capita allotment could automatically receive a block grant of federal funds to finance their Medicaid program. Under this approach, funding would be determined using a base year in a manner that would assume states transition individuals currently enrolled in Obamacare's Medicaid expansion into other sources of coverage. With this option, states would receive maximum flexibility for the management of eligibility and benefits for non-disabled, non-elderly adults and children. This would remove the need for states to spend years working with HHS to receive waivers for programs, allowing states that successfully instituted waiver programs to keep or modify them as needed without further approval from HHS. The designation of how such funds are spent for these populations would rest solely with the state. States would be required to provide required services to the most vulnerable elderly and disabled individuals who are described as mandatory populations under current law.

Through this arrangement, both the federal government and the states would have budgetary certainty, which would create strong incentives for the states to manage the federal funding wisely. Any program spending that exceeded the federal amount provided to the state would have to be financed by the state. Conversely, the funding provided to states would not be reduced if they found innovative ways to reduce Medicaid costs. Any savings that a state was able to achieve would remain within that state.

This approach allows states to design programs to best meet the unique needs of their citizens. States could improve the quality of care and access to vital services. They could also implement safeguards to reduce waste, fraud, and abuse by requiring able-bodied individuals to seek a job, be employed, or participate in a training or educational program. States could also implement stringent residency requirements so that those individuals here illegally would not receive benefits. As state reforms reduce dependence on government assistance, the people helped would enter the workforce, have insurance, and be able to lift themselves up the economic ladder.

### **Promoting Innovation in Health Care**

Disease management is a monumental driver of cost in our health care system, not to mention the personal toll it takes on patients and their families. For example, although more than 5 million Americans are currently living with Alzheimer's disease and despite the fact that the economic burden of the disease may ultimately exceed \$1 trillion per year without effective therapies, we still lack a basic understanding of the disease's underlying causes.<sup>78</sup> Unfortunately, there are 10,000 known diseases, 7,000 of which are considered rare, and we only have treatments for 500 of them.<sup>79</sup>

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<sup>78</sup> [2016 Alzheimer's Disease Facts and Figures](#), Alzheimer's Association, 2016.

<sup>79</sup> [Rep. Lee Zeldin on the #Path2Cures in Long Island](#), The Energy and Commerce Committee of the House, Apr. 21, 2016.



In 2014, the Energy and Commerce Committee launched the bipartisan 21<sup>st</sup> Century Cures initiative to determine how Congress could play a role in addressing this multifaceted dilemma.<sup>80</sup> Members sought input and ideas from patients, researchers, and innovators from across the country about how we could collaboratively harness our nation's entrepreneurial spirit, human capital, and scientific expertise to accelerate the discovery, development, and delivery of better, safer treatments and cures to patients. Doing so will not only help patients, but will lower our nation's health care costs and solidify our status as the biomedical innovation capital of the world.

The *21<sup>st</sup> Century Cures Act*, which passed the House earlier this year, is a comprehensive strategy that incorporates a wide range of policies championed by Republican members. The Act includes reforms to accelerate the discovery, development, and delivery of new treatments and cures. These ideas include:

- Increasing research collaboration by breaking down regulatory barriers to sharing and analyzing health data—all while protecting patient privacy.
- Incorporating the patient perspective into the drug development regulatory review process by instituting a formal process to have the FDA use patient experience data when making risk-benefit decisions about new treatments and cures.
- Measuring success and identifying diseases through personalized medicine and developing new drug development tools like biomarkers to better understand how treatments affect different patients with individualized needs.
- Modernizing clinical trials by advancing the use of modern statistical tools, strengthening patient registries, fostering adaptive trial design, and removing unnecessary or duplicative paperwork.
- Removing regulatory uncertainty for new technology like medical apps.
- Providing new incentives for repurposing drugs for patients with rare diseases.

We must build on these efforts. The House has led the way in increasing investment in basic research at the National Institutes of Health (NIH) through the annual appropriations process. Our plan would provide NIH with a robust, steady level of discretionary funding while increasing accountability and supporting young, emerging scientists working on cutting-edge research. To make sure taxpayers are getting the most out of their investment, we would foster collaboration and, while protecting patient privacy, remove the silos from research conducted at various health care settings across the United States.

Translating research into therapies is an incredibly risky, cumbersome, and expensive process. According to NIH Director Francis Collins, it now takes around 14 years and \$2 billion or more to develop a new drug and “more than 95 percent of drugs fail during development.”<sup>81</sup> We must improve how new treatments are developed, tested, and ultimately approved by the FDA. Our plan would streamline clinical trials and modernize data collection activities by cutting through red tape, using drug development tools like biomarkers and patient-reported outcomes, and harnessing the wealth of information in electronic health records and other troves of real-world data.

While we may lack a basic understanding of what causes certain diseases, scientists have discovered specific genetic mutations that therapies can target and halt in their tracks. Our plan would unleash the promise of “precision medicine” by facilitating the development of innovative, accurate, and clinically meaningful diagnostic tests and drugs that treat patients based on their genetic makeup. In order to do so, we must make sure that our regulatory system keeps pace with the state of science. Our plan would not only enable FDA to attract and retain the best and brightest scientists and biostatisticians, but also it would modernize our drug and medical device regulations to account for these recent advancements.

In sum, our plan would unleash the power of innovation to solve these pressing medical and fiscal challenges. It would not stifle it with job-killing taxes, punitive policies, and outdated regulations.

o *Electronic Health Records and Meaningful Use Reform*

Our plan seeks to advance the use of electronic health records by spurring innovation and breaking down unnecessary legal and regulatory barriers.

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<sup>80</sup> [21<sup>st</sup> Century Cures: A Call to Action](#), The Energy and Commerce Committee of the House, May 1, 2014.

<sup>81</sup> [Tackling the Bottlenecks in the Drug Development Pipeline](#), Dr. Francis Collins, NIH Director's Blog, January 4, 2013.

Our proposal makes the necessary adjustments to the meaningful use program to allow for partnerships between technology and health care to be the driving force towards interoperability and exchange of information. These changes, coupled with putting the collection of health data in the appropriate hands and then putting the data itself back into the hands of patients, will bring meaningful use into the 21<sup>st</sup> century and help reach interoperability at a faster pace than the arcane policies of today.

## Protecting and Preserving Medicare

Medicare currently serves more than 57 million beneficiaries and by many measures has served seniors successfully since the 1960s by providing access to health care for millions and contributing to longer life expectancies.<sup>82</sup> Despite these successes, the program faces notable challenges, including a complex financial structure and projected spending growth that make the program unsustainable for the long term. For example, over the past five decades, Medicare has expanded to include four parts each with a different funding mechanism--Part A, coverage for hospital services; Part B, or supplementary medical insurance; Part C, or Medicare Advantage that offers beneficiaries private plan options that cover services provided under Part A, Part B, and often Part D benefits; and Part D, optional prescription drug coverage. Further, CBO projects spending for the program to more than double by 2026, reaching \$1.3 trillion that year due to several factors such as the aging of the population and rising health care costs.<sup>83</sup>

Obamacare's plan for Medicare was to raid and ration. Its more than \$800 billion raid of the program has been called "unsustainable," and Medicare's own chief actuary warned that "access to, and quality of, physicians' services would deteriorate over time for beneficiaries."<sup>84</sup> Additionally, the law empowered an unelected, unaccountable board of bureaucrats and gave them the power to effectively ration the program. The current Medicare spending trajectory continues to be unsustainable and has led the CBO to estimate that the Part A Hospital Insurance (HI) Trust Fund will be insolvent in 2026, four years earlier than previously projected.

Our plan rejects this strategy and instead takes a three-step approach to saving and strengthening this important health care program. First, it repeals the most damaging Medicare provisions contained in Obamacare. Second, our plan improves the program's fiscal health by adopting bipartisan reforms that make Medicare more responsive to patients' needs, while at the same time updating the payment systems that are outdated and inefficient. Lastly, our plan proposes to put Medicare on a sustainable path to ensure it can care for future generations. If we act now, this can mean that traditional Medicare will continue for those currently on the program or near Medicare eligibility. It builds in a transition period such that workers in their 40s and 50s today—for whom Medicare enrollment and use is in the distant future— will have a health care program that looks more like what they are accustomed to using today.

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<sup>82</sup> [Congressional Budget Office's March 2016 Medicare Baseline](#), Congressional Budget Office, March 24, 2016.

<sup>83</sup> [Updated Budget Predictions: 2016 to 2026](#), Congressional Budget Office, March 2016.

<sup>84</sup> [The 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#), Center for Medicare and Medicaid Services, July 22, 2015.

## Recommendations

### IMMEDIATE RELIEF FROM OBAMACARE

- ✓ Strengthen MA
- ✓ Repeal IPAB
- ✓ Repeal CMMI
- ✓ Repeal Ban on Physician-Owned Hospitals
- ✓ Repeal of the Bay State Boondoggle

### STRUCTURAL REFORMS

- ✓ MA VBID
- ✓ Medigap Reform
- ✓ Combining Medicare Parts A & B
- ✓ Protecting the Patient-Doctor Relationship
- ✓ Uncompensated Care Reform
- ✓ MA & FFS Medicare Performance Parity

### PRESERVING MEDICARE FOR FUTURE GENERATIONS

- ✓ Premium Support

## Policies

### ✓ ***Immediate Relief from Obamacare's Raid on Medicare Harming Seniors' Choice, Access, and the Doctor-Patient Relationship***

#### ○ *Strengthen Medicare Advantage*

Medicare Advantage (MA) was established in 2003 as a program to allow seniors to receive their benefits from a private, Medicare-approved health plan. It's a voluntary program that many seniors have chosen to move to from Medicare's traditional fee-for-service program. Today, over 17 million seniors— nearly 32 percent of Medicare beneficiaries today— participate in MA, and that number is projected to grow.<sup>85</sup> CBO estimates that MA enrollment will increase by one percent per year over the next ten years—meaning 44 percent of Medicare beneficiaries will be in MA by 2026.<sup>86</sup> Moreover, seniors overwhelmingly approve of the quality and service they receive from MA plans.<sup>87</sup> In fact, a substantial number of seniors actually switch in their second year of Medicare eligibility from the traditional fee-for-service Medicare benefit into MA.<sup>88</sup>

The program's success is rooted in the twin pillars of choice and competition. Plans are free to innovate in order to provide the services and benefits that best meet their patients' needs. For example, unlike traditional fee-for-service Medicare, MA plans are statutorily required to have financial protections in place for seniors, specifically a mandatory maximum out-of-pocket limit to protect beneficiaries from high health care costs. These limits provide valued financial safeguards for seniors that choose managed care under Medicare Advantage. It also makes the MA benefit design a modern one that looks more like the managed care-type plans many baby boomers had — and liked— prior to becoming Medicare eligible.

Despite MA's popularity and bipartisan appeal, Obamacare cut the program by \$150 billion when it was signed into law in 2010. The law's cuts have reduced MA's ability to meet the needs of patients and those effects are compounding over time. Our plan would make immediate reinvestments to MA:

#### Repeal the Benchmark Caps

MA plans are paid relative to a "benchmark," which is currently set by fee-for-service. Obamacare capped this benchmark to never exceed payments prior to the law. Obamacare provides quality bonuses for providing higher-value, coordinated care on a year by year basis, but places this arbitrary cap on quality incentives for those already providing these high levels of quality care.. Obamacare has in effect eliminated any incentive for plans to offer competitive products to seniors beyond these statutory maximums. One of

<sup>85</sup> [Congressional Budget Office's March 2016 Medicare Baseline](#), Congressional Budget Office, March 24, 2016.

<sup>86</sup> [Ibid](#)

<sup>87</sup> Meghan McCarthy, [Seniors Love Their Medicare \(Advantage\)](#), Morning Consult, March 30, 2015.

<sup>88</sup> [Chapter 13, The Medicare Advantage Program: Status Report](#), The Medicare Payment Advisory Commission, March, 2015.

the goals for health care reform should be to reward value. Reimbursing a plan that achieves a 3-star rating at the same amount as one that achieves a 5-star rating undermines this objective.

#### Limit the Administration's Ability to Arbitrarily Cut Medicare Advantage

The MA program requires participating physicians to provide as detailed a diagnosis of the patient as possible to help coordinate treatment. This is called “coding,” and it is one factor that affects how Medicare pays for MA services. Obamacare established minimum negative payment adjustments, or a “floor,” to coding, allowing for larger negative adjustments by CMS. This onerous policy - with the potential for perverse incentives in Medicare - has not been shown to do anything to enhance quality, increase efficiency, or produce savings. Our plan would instead freeze the administration's ability to negatively adjust MA payments based on accurate coding, delivering stability to the ever popular and growing program.

#### Open Enrollment Period

Before Obamacare, seniors were able to switch into a new MA plan during the first three months of the next year for certain specific reasons, such as discovering their doctor was no longer participating in their plan's network. Obamacare repealed this flexibility, locking seniors into the first choice regardless of sudden, unexpected changes that might occur. Our plan would restore this flexibility for seniors enrolled in MA.

- *Repeal of the Independent Payment Advisory Board*

Obamacare established a 15-member board of unelected bureaucrats, called the Independent Payment Advisory Board (IPAB) that is tasked with making recommendations to cut Medicare spending if it exceeds certain targets. IPAB is prohibited from adjusting beneficiary cost-sharing, eligibility, and benefits, so cutting provider payment rates is the only option, leading to de facto rationing of the program. The board is empowered with “fast track” legislative powers that can only be turned off by an overwhelming vote in both chambers of Congress.

IPAB demonstrates a key flaw of the Medicare fee-for-service system's inability to tackle health care inflation: instead of reforming the program, Obamacare bypassed those elected to represent Medicare's beneficiaries and gave the task to an unelected and unaccountable board of bureaucrats. Further, reforming the Medicare program entails much more than just cutting provider payments. Real reform empowers seniors by allowing health plans and providers to compete for their business— a far better method to increase quality and lower costs.

- *Repeal of the Center for Medicare and Medicaid Innovation*

Obamacare created the Center for Medicare and Medicaid Innovation (CMMI), a center tasked with testing and evaluating various payment and service delivery models. Unfortunately, it is operating beyond its intended authority, with a complete lack of transparency and disregard for the input of stakeholders most affected by their proposals. Many members of Congress have expressed concern that CMMI's experiments on seniors' health services could limit access to care for Medicare's sickest beneficiaries and disrupt how health care providers serve patients in the future.<sup>89,90</sup> The CMMI could ultimately result in seniors receiving different standards of care based solely on where they live in the country. Our policy would repeal the CMMI beginning January 1, 2020—the date at which the CMMI's funding would otherwise be replenished with another \$10 billion from the Medicare Trust Funds.

- *Repeal of the Ban on Physician-Owned Hospitals*

Obamacare established a moratorium on physician-owned hospitals, beginning December 31, 2010—leaving only nine months for hospitals that were mid-build to complete construction before the moratorium began. Since Obamacare has been signed into law, there has been a marked increase in consolidation among

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<sup>89</sup> Members of Congress, [Letter to Express Concerns About Medicare Part B](#), U.S. House of Representatives, May 2, 2016.

<sup>90</sup> Members of Congress, [Letter to Express Concerns About Medicare Part B Payment](#), U.S. House of Representatives, April 27, 2016.



hospitals.<sup>91</sup> Lifting the ban on physician-owned hospitals will make markets more competitive by driving down prices and increasing quality.

- *Repeal of the Bay State Boondoggle*  
CMS adjusts the amount paid to hospitals for differences in wages to reflect the cost of services in different geographic areas. A particular hospital's wage index can be adjusted according to a variety of factors. Most changes to the wage index are done on a budget-neutral basis—when one hospital or group of hospitals benefit, other hospitals end up being penalized. In order to minimize the impact of these budget-neutral changes within the wage index, over time, both Congress and CMS have instituted changes to the hospital wage index system. Obamacare changed the budget-neutrality characteristics, resulting in a windfall for certain states, such as Massachusetts. This windfall came at the expense of hospitals located in other states. This is nothing more than corporate cronyism. Hospitals should be paid according to performance rather than handouts and backroom deals.

### ✓ **Structural Reforms to Preserve the Promise of Medicare**

Today's traditional fee-for-service (FFS) Medicare program isolates beneficiaries from the true cost of health care. For example, Medigap policies provide something called first-dollar coverage—which allows the system to be gamed in order to avoid cost-sharing obligations required today. The confusing and disjointed collection of deductibles, copayments, and coinsurance in the current FFS program ensures chaos for beneficiaries. Any attempt to bend the Medicare cost curve must require greater transparency of the cost of health care and the flexibility to incentivize high-value patient-centered care.

- *Medicare Advantage Value-Based Insurance Design*  
A major limitation under current law is the “one-size-fits-all” policy under the benefit structure for Medicare Advantage (MA). Plans are required to provide the exact same benefit to all beneficiaries, regardless of comorbidity or chronic conditions and regardless of how helpful certain benefits could be to improve health care outcomes. Benefit design flexibility would allow insurers to design their plans to push providers and beneficiaries to make decisions together while participating in high-value quality services and benefits, and curtailing low-value or unnecessary services. When we give plans this flexibility to serve our most vulnerable seniors, along with strong policies that encourage the most accurate and transparent risk-adjustment for all seniors, MA will result in personalized and high-quality care. Our plan would allow for value-based insurance design (VBID) throughout MA.
- *Medigap Reform*  
Beneficiaries often purchase Medigap plans because of the certainty these plans bring: predictable copays instead of coinsurance and protection against high out-of-pocket (OOP) costs. The Medicare Payment Advisory Commission (MedPAC) has found that Medicare spending is 33 percent higher when beneficiaries have Medigap insurance and 17 percent higher when beneficiaries have job-based coverage.<sup>92</sup> Our policy would begin in fiscal year 2020. It would restrict Medigap plans from covering cost-sharing below a combined and limit the plan from covering no more than half of the cost sharing between the deductible and the OOP cap of.
- *Combining Medicare Parts A and B*  
The Medicare program was created in 1965. It was modeled after Blue Cross Blue Shield plans that were prevalent throughout the nation at that time. Since then, private insurance coverage has transformed dramatically, yet the traditional Medicare benefit has remained largely unchanged, with an array of confusing coinsurance and deductible levels and a FFS structure that inhibits care coordination and encourages overuse. To further complicate the situation, the Medicare program has three disparate assistance programs commonly

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<sup>91</sup> [Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform](#), U.S. Government Accountability Office, Dec. 2015.

<sup>92</sup> [Chapter 3: Medicare's Fee-for-Service Benefit Design](#), The Medicare Payment Advisory Commission, June, 2011.

referred to as “Medicare Savings Programs” (MSP) that cover Medicare Part B monthly premiums. MedPAC has recommended that all three MSP programs be streamlined into one MSP program.<sup>93</sup>

Our policy would begin in fiscal year 2020. It would combine Medicare Parts A and B and would have a unified deductible. For example, rather than require the \$1,288 deductible for a hospital stay and a separate \$166 deductible for a physician visit, the beneficiary would be charged a combined deductible. Further, the policy would institute an annual maximum OOP cap on the amount of money a beneficiary pays each year. This new feature of the FFS program would create parity between FFS and MA—as MA plans are required by statute to provide an OOP cap for beneficiaries. Our policy would also institute a 20 percent uniform cost-sharing requirement for all services. Finally, our policy would streamline the current MSP programs into one program that requires states to use one uniform asset test for qualification in the new MSP program.

- o *Protecting the Patient-Doctor Relationship*

While our health care system is made of many diverse actors - from providers, suppliers, innovators, and entrepreneurs – the center of health care delivery remains between a patient and his or her doctor or other health care provider. Without the trust of this relationship, the foundation for quality health care erodes. The dramatic changes within health care over the past decade, however, have not only strained this relationship, but have also led many physicians to leave the practice of medicine rather than expending the time and financial resources necessary to comply with new, overly complex, and burdensome regulatory requirements. Our plan puts forward several proposals that seek to ease these burdens and thus restore this fundamental relationship.

Currently under Medicare, for example, beneficiaries and physicians (and other providers) are not allowed to agree to a different treatment regimen for a Medicare covered service. Our plan would develop a personalized care demonstration program that would give beneficiaries and health care professionals the ability to voluntarily enter into an arrangement for items and services outside of the Medicare system. While participating in this voluntary demonstration project, Medicare beneficiaries would still retain their Medicare benefits. With the proper oversight, this is a common-sense approach to giving our seniors the opportunity to make medical financing decisions with their physicians without direct interference from Washington. These freedoms can also help to ensure that Medicare beneficiaries maintain the access to health care professionals they deserve by increasing flexibility and thus the number of physicians who participate in Medicare.

Additionally, our plan would allow providers to retain the freedom to choose which health care plans they participate in without fear of losing their medical license - safeguarding medical providers against the prospect of mandated participation - recognizing that a diverse market of physician practice types and specialties is essential for fostering patient choice and access.

- o *Uncompensated Care Reform*

There are two types of Disproportionate Share Hospital (DSH) payments to support care for low-income patients, one for the Medicare program and one for the Medicaid program. Approximately 75 percent of inpatient acute hospitals receive DSH payments.

The *Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986* established Medicare DSH payments. Since 1986, several additional Congressional bills have increased DSH funding, but DSH remained consistent in its application since its inception until it was dramatically changed by Obamacare. Today, Medicare DSH hospitals continue to receive 25 percent of the amount that they would have otherwise received using the pre-Obamacare law formula (the “empirically justified amount”), as an add-on payment. The pool of money that comprises the remaining 75 percent of DSH funds is reduced based on a measurement of the annual nationwide reduction in uninsured levels.

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<sup>93</sup> [Ibid](#)

Obamacare also changed the federal contribution to national Medicaid DSH funds. Originally, Obamacare mandated a graduated decrease of federal contribution that is available for reimbursing Medicaid DSH. However, several laws passed by Congress after Obamacare was signed into law have delayed the Medicaid DSH cuts. To date, no Medicaid DSH cuts have occurred. However, cuts are scheduled to begin with fiscal year 2018.

Due to lower than anticipated enrollment in health care exchanges and optional expansion of Medicaid in some states, the basis on which the Obamacare DSH cuts were justified has turned out to be flawed. Therefore, our policy would provide immediate relief to America's hospitals by repealing the fiscal year 2018 and 2019 Medicare DSH cuts and the fiscal year 2018 through 2020 Medicaid DSH cuts. Cuts occurring in these fiscal years were included in the original Obamacare language, even though the Medicaid DSH cuts have been reduced through subsequent laws.

Further, beginning with fiscal year 2021 and thereafter, the Secretary would be required to create one combined national pool of uncompensated care (UCC) funds. Finally, our policy would require the Secretary to distribute funds from the UCC pool to DSH hospitals based on the use of certain federally collected (S-10) data.<sup>94</sup> In applying S-10 data, the Secretary would be required to use data defined as charity care only.

o *Medicare Compare*

A key to moving away from FFS to a more market-based system is ensuring FFS and MA compete on quality. Beginning with calendar year 2020, our policy would require the HHS Secretary to publicly report performance on a new Medicare Compare web site, comparing MA and traditional fee-for-service FFS for each Metropolitan Statistical Area (MSA) on a core set of quality measures. An additional aspect of our policy would be to prohibit the Secretary from placing a greater emphasis (commonly referred to as "weighting") on patient experience of care measures than the emphasis placed on outcome or clinical process of care measures in any of CMS' quality reporting and value-based purchasing programs. Prior to establishing Medicare Compare, the Secretary would be required to go through notice and comment rulemaking on the following:

- Defining MSAs for both the MA and FFS programs;
- Attributing Medicare providers/suppliers to either the MA or FFS program using an attribution methodology;
- Risk adjustment for socio-economic status or another adjustment deemed necessary (beyond the methodologies currently embedded in the underlying quality measures); and
- Adding additional future quality measures pertaining to measurement of functional status—which must be aligned with the measures in the *Improving Medicare Post-Acute Care Transformation Act of 2014*.

By no later than June 2021, MedPAC would be required to submit a Report to Congress developing a prototype competitive bidding system to inform the future of Medicare that adjusts the amount of premium a beneficiary would receive taking into account: 1) the historical bid amount for the MA plan and the equivalent FFS "bid" amount; and 2) the MA/FFS MSA performance on the core quality measures.

This new system of measurement would replace the antiquated National Quality Strategy (NQS) included in Obamacare. In doing so, after 2016, the annual NQS, Intra-Agency and Multi-Stakeholder Reports to Congress would no longer be required. Further, beginning in fiscal year 2018 all additional funding to the National Quality Forum (NQF) would go through the annual appropriations process.

o *Match the Social Security Retirement Age*

One of the nation's greatest achievements during the 20th century was the dramatic increase in the average life expectancy, increasing life spans by almost thirty years.<sup>95</sup> As Americans' health improves, extending their lives,

<sup>94</sup> [Medicare: Provider Reimbursement Manual](#), Department of Health and Human Services, Centers for Medicare and Medicaid Services, Dec. 2010.

<sup>95</sup> [Life Expectancy In the USA, 1900-1998](#), UC Berkeley.

many enjoy the benefits of employment later in life. As recognized by the Social Security program, and in order to further ensure Medicare's long-term sustainability, our plan would gradually increase the Medicare retirement age beginning in 2020 to correspond with that of Social Security.<sup>96</sup>

### ✓ **Preserving Medicare for Future Generations**

The final step to save the program is transforming the benefit into a fully competitive market-based model—known as premium support.

Beginning in 2024, Medicare beneficiaries would be given a choice of private plans competing alongside the traditional FFS Medicare program on a newly created Medicare Exchange. Our plan would ensure no disruptions in the Medicare FFS program for those in or near retirement, while also allowing these grandfathered individuals the choice to enroll in the new premium support program. Medicare would provide a premium support payment either to pay for or offset the premium of the plan chosen by the beneficiary, depending on the plan's cost.

The Medicare recipient would choose, from an array of guaranteed-coverage options, a health plan that best suits his or her needs. This is not a voucher program. A Medicare premium support payment would be paid, by Medicare, directly to the plan or the fee-for-service program to subsidize its cost. The program would operate in a manner similar to the Federal Employees Health Benefits (FEHB) program, where plans compete for individuals' choice based upon premium amount and a certain percentage – or a defined contribution – is offset by the government to lower the cost of coverage. Additionally, the program would adopt the competitive structure proven successful by Medicare Part D, the prescription drug benefit, to ensure affordability through market-based competition.

The Medicare premium support payment would be adjusted so that the sick would receive higher payments if their conditions worsened; lower-income seniors would receive additional assistance to help cover out-of-pocket costs; and wealthier seniors would assume responsibility for a greater share of their premiums. Health plans that choose to participate in the Medicare exchange would agree to offer insurance to all Medicare beneficiaries, to avoid cherry-picking, and to ensure that Medicare's sickest and highest-cost beneficiaries receive coverage.

This approach to strengthening the Medicare program is based on a long history of bipartisan reform plans, including the 1999 Breaux-Thomas Commission and the 2010 Domenici-Rivlin Report.<sup>97</sup> It would ensure security and affordability for seniors now and into the future. In September 2013, the CBO analyzed illustrative options of a premium support system.<sup>98</sup> CBO found that a program in which the premium support payment was based on the average bid of participating plans would result in savings for affected beneficiaries as well as the federal government.

This reform ensures affordability by fixing the currently broken subsidy system and letting market competition work as a real check on widespread waste and skyrocketing health care costs. Furthermore, it gives seniors the freedom to choose plans best suited for them, guaranteeing health security throughout their retirement years. It resolves the concerns regarding Medicare's long-term sustainability, while also lowering costs for beneficiaries. With the adoption of patient-centered improvements, this program would preserve the positive aspects of traditional Medicare, while modernizing the program to reflect the changes to health care delivery in the 21<sup>st</sup> century.

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<sup>96</sup> [Retirement Planner: Benefits by Year of Birth](#), Social Security Administration.

<sup>97</sup> [Building a Better Medicare for Today and Tomorrow](#), National Bipartisan Commission on the Future of Medicare, March 16, 1999.

<sup>98</sup> [A Premium Support System for Medicare: Analysis of Illustrative Options](#), Congressional Budget Office, September 2013.

## Conclusion

Over the past six years, the Affordable Care Act has failed to make health coverage more affordable for the majority of Americans and, in too many cases, has been harmful to individuals and families. Increasing health coverage is a worthwhile goal, but the law has increased health care costs, reduced access to providers, and restricted patients' ability to choose the coverage that best suits themselves and their families.

As this plan shows, there is another way – a better way – to provide all Americans with health care that is accessible, affordable, and sustainable. In this plan, innovative, market-based, patient-centered solutions replace Obamacare's one-size-fits-all, Washington-knows-best approach. This plan empowers patients with access to affordable, portable health care options. It provides every American with the freedom to pick a plan that best fits his or her unique health care needs – not coverage mandated by Washington. It protects those individuals with pre-existing conditions and promotes innovation to encourage health care competition, to lower costs, and to foster new cures for patients.

Crucially, this plan not only replaces Obamacare, but it reforms our health care security programs. In 2015, total health care expenditures nationwide exceeded \$3 trillion – nearly one-fifth of the economy – with nearly \$1 trillion spent on federal health care programs. The plan would reverse this trend and bend the health care cost curve down while preserving health security for America's seniors and most vulnerable by modernizing Medicare and Medicaid to provide more efficient, effective, high-quality care.

The development of this plan involved ongoing engagement with Members, stakeholders, the Congressional Budget Office, and the Joint Committee on Taxation. This set of solutions would reduce average non-group insurance premiums by double digits, lowering overall health care costs for all Americans. Data also suggest robust participation in employer-based coverage as more Americans will be able to access diverse products that fit their needs. Separately, CBO has already found that repeal of the President's health care law itself raises economic output. And unlike Obamacare, under this plan, total federal spending would decline significantly, reducing the deficit by hundreds of billions of dollars within the first decade after enactment.

Changes to a substantial part of the economy should only be undertaken through an open and thoughtful process that engages the public as a whole. This plan is not the final piece of the puzzle. This overall plan, and the policy solutions within it, is part of a larger conversation with the American people about what their health care needs truly are.

No matter how much we spend, health care remains, at its core, a personal experience between a patient and the provider. All Americans have an interest in patient-centered health care that is truly accessible, affordable, and responsive to the people it serves. The [Report from the Health Care Reform Task Force](#) is an important step toward achieving that goal.