

The Patients' Choice Act

The health care system in America is broken. Costs are rising at an unacceptable rate—more than doubling over the last 10 years, which is nearly four times the rate of wage growth.¹ Too many patients feel trapped by healthcare decisions dictated by HMOs. Too many doctors are torn between practicing medicine and practicing insurance. And 47 million Americans worry what will happen to them or their children if they get sick.

Although our health care system has major problems, it also has major *potential*. We have the best doctors in the world...the best scientists in the world... the best hospitals in the world. About 70 percent of Nobel Prizes in medicine come from the United States, and five of the six most important medical discoveries over the past 25 years are American.² Now America needs the best *health care system* in the world. The Patients' Choice Act would remove the barriers that separate Americans from high-value health care by enhancing individual purchasing power and creating rational government rules.

We *can* make the current system work by returning to certain core principles. Protecting the doctor-patient relationship and ensuring patient choice is fundamental to any reform. Prioritizing the needs of patients and doctors must be fundamental. Creating a market that plays by the rules is the most powerful force to increase quality and make health care more affordable. Putting health care decisions in the hands of patients, allowing them to choose the care they want and the care they need, will finally link costs to quality.

Patients would benefit from having more information on quality and costs. Rather than patients appealing denials of care or waiting to see a health care provider, insurance companies and doctors should compete for patients. Universal access to affordable health care for all Americans should be guaranteed. Congress should enact a comprehensive solution that will make our healthcare system work for *every* American *every* time.

The Patients' Choice Act would give every American the opportunity to choose the health care plan that best meets their individual needs. It will utilize state-driven exchanges to facilitate real competition between private plans and give Americans—for the first time—a choice of health care plans. Insurers should be able to provide packages which offer care for patients suffering from chronic conditions. Unlike the government-driven change being advertized today, it will truly achieve portability so that workers can take benefits with them when they change jobs. Rather than Washington and company CEOs, the Patients' Choice Act puts patients in control. This solution will actually fix the incentives in the health care system so that health providers and insurers provide higher quality plans at lower cost. This is the kind of change America's health care system needs.

In solving our health care crisis, Americans already know that government-run programs are not the solution. Washington and state bureaucracies already control more than 59.8 percent of health care spending.³ But programs run by the government are plagued with waste, fraud, and abuse. More than \$60 billion is lost each year to Medicare fraud.⁴ And over 10 percent of Medicaid money—over \$32 billion—is spent improperly each year, with that number reaching 40 percent in some states.^{5,6} And tragically, patients in government programs suffer worse health outcomes than patients in plans like the BlueCross/BlueShield standard option.⁷ Why does our health care system fail so many patients? The answer begins and ends with government intervention.

¹ Kaiser Family Foundation, "Wages and Benefits: A Long-Term View," February 2008, <http://www.kff.org/insurance/snapshot/chcm012808oth.cfm>.

² Cowen, Tyler, "Poor U.S. Scores in Medicine Don't Match Innovation," *The New York Times*, October 5, 2006 <http://www.nytimes.com/2006/10/05/business/05scene.html?ex=1317700800&en=5889b4819eaf787a&ei=5090&partner=rssuserland&emc=rss>.

³ Staff of the Joint Committee on Taxation, "Tax Expenditures for Health Care," Hearing before the Senate Finance Committee, July 31, 2008. Sisko, Andrea; Truffer, Christopher, et al; "Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook," *Health Affairs*, February 24, 2009.

⁴ Johnson, Carrie, "Medical Fraud a Growing Problem," *The Washington Post*, June 13, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/06/12/AR2008061203915.html>.

⁵ Press release, Centers for Medicare and Medicaid Services Website, "CMS Issues Improper Payment Rates for Medicare, Medicaid, and SCHIP," November 17, 2008, <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3368>.

⁶ Levy, Clifford J. and Luo, Michael, "New York Medicaid Fraud May Reach Into the Billions," *The New York Times*, July 18, 2005, <http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html>.

⁷ Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*. January 9, 2009, <http://online.wsj.com/article/SB123137487987962873.html>.

Core Concepts

Emphasize Prevention

Five preventable chronic conditions consume 75% of our health spending and cause two-thirds of American deaths. Investing in prevention will lower long-term costs and ensure Americans live longer and happier lives. Solutions should change “sick care” into “health care.”

Create a Market that Works for Patients

The status quo regulation of the insurance market does not provide incentives for insurance companies to cover chronically sick patients and many sick patients are unable to afford premiums. Businesses must play by transparent rules and compete for patients’ business. The market must work for every patient every time. Patients should have convenient and affordable options, and they should have control of those options. Doctors, hospitals, and nurses should be more involved in patient-centered care.

Guarantee Choice of Coverage Options

Patients should be able to choose from a variety of private insurance plans. The federal government would run a health care system—or a public plan option—with the compassion of the IRS, the efficiency of the post office, and the incompetence of Katrina. We cannot entrust the federal government to deliver high quality health care to every American. All Americans have a right to personalized and individual health care that will meet their unique needs.

Insist on Fairness for Every Patient

Patients already in government programs deserve a human approach to their health benefits and fewer bureaucratic barriers. Individuals struggling to purchase their own health insurance deserve the same tax breaks as Americans working in Fortune 500 Companies. Medicare beneficiaries deserve delivery choice when selecting between health benefits.

Fairly Compensate Patient Injuries

Patients should have the right to fair legal representation and fair compensation for tragic, inexcusable mistakes in the health care field. However, today’s legal system serves the self-interest of personal injury lawyers, drives up costs, and delays justice. Science-driven and results-oriented change is needed today.

No Tax Increases or New Government Spending

America spends more than \$2.4 trillion on health care every year—16.6 percent of our gross domestic product.⁸ On a per capita basis that is nearly twice what other industrialized nations spend,⁹ and it is 25 percent more than Switzerland, the next biggest spender, spends. Entitlement program liabilities threaten our nation’s long-term fiscal stability. Future generations of Americans will have to pay \$36 trillion in new taxes to keep the promises made by today’s politicians for the Medicare program alone. Without reforms, the Medicaid program will spend at least \$4.9 trillion over the next 10 years.¹⁰ Washington has already proven we cannot spend our way out of this problem. Innovative solutions should focus on making health care more affordable, especially when cost is a major barrier to access.

Restore Accountability to Government Programs

The children covered under government health care programs today will face future tax increases in order to pay the \$36 trillion unfunded liabilities in the Medicare program alone. Medicaid fraud and mismanagement waste at least \$32.7 billion in taxpayer dollars every year. Reforms must bring about efficiency, transparency, and results. Failure to act now will jeopardize our nation’s long-term fiscal security.

Include Ideas from Governors and States

Rather than one-size-fits all Washington mandates, a comprehensive solution to health reform must include governors, state legislatures, and every American citizen.

⁸ Press release, Centers for Medicare and Medicaid Services Website, “Growth in National Health Expenditures Expected to Slow by 2009 as a Result of Recession,” February 24, 2009.

⁹ Baicker, Katherine, “Health Insurance and Uncle Sam,” *Harvard Public Health Review*, Fall 2008, http://www.hsph.harvard.edu/news/hphr/files/HSPHfall08_baickerfinal.pdf.

¹⁰ Press release, U.S. Department of Health and Human Services, “Medicaid Spending Projected to Rise Much Faster than the Economy,” October 17, 2008, <http://www.hhs.gov/news/press/2008pres/10/20081017a.html>.

Prioritizing Healthy Lifestyles and Preventing Disease

An ounce of prevention is worth a pound of cure. In practical terms, prevention is worth trillions of dollars saved in medical costs, increased productivity, improved quality of life, and added years of healthy living. Researchers have found that prevention activities can increase lifespans by at least 1.3 years.¹¹

Yet, five *preventable* chronic diseases (heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes) cause two-thirds of American deaths while 75 percent of total health expenditures are spent to treat chronic diseases that are largely preventable.¹² In government programs, the problem is even worse with chronic disease spending consuming 96 cents of every Medicare dollar and 82 cents of every Medicaid dollar.¹³

Just over \$63 billion was allocated to all government prevention activities at the local, state, and federal levels, but the cost of care for preventable conditions is growing.¹⁴ Currently, more adults and children are developing diabetes and becoming overweight/obese, two conditions that can often be avoided with diet and physical activity.¹⁵ Epidemics, like HIV/AIDS, have been difficult to contain, and emerging public health threats, such as drug-resistant tuberculosis and hospital-acquired infections, pose new challenges.

Prevention requires efforts and investments today that are expected to provide long-term cost savings and other benefits. These outcomes are often difficult to measure, which hinder efforts to prioritize prevention and also allow ineffective programs to continue.

Innovative businesses have experienced significant returns on investment (ROI) from prevention programs—both in cost savings and worker productivity. The supermarket giant Safeway Inc. saved eleven percent on health care costs during the first year of a results-based prevention program.¹⁶ Johnson & Johnson's integrative prevention program saved as much as \$8.8 million in one year and reduced health risks related to high cholesterol levels, smoking, and high blood pressure.¹⁷

The fact is, we need to create a system and a society that focuses more on health, and less on care. The Patients' Choice Act would complement private-sector prevention efforts by improving government prevention initiatives in a cost-effective and measurable manner. It does so specifically by:

Coordinating Federal Prevention Efforts and Setting National Priorities with Measurable Goals

Numerous federal departments and agencies currently administer duplicative and overlapping prevention efforts. For example, both the National Institutes of Health and the Centers for Disease Control and Prevention sponsor public health awareness campaigns—often regarding the same topics.

This Act will establish an inter-agency committee to develop and coordinate a national strategic prevention plan. The committee shall include the representatives from every federal agency involved in public health promotion and prevention.

More than coordination is needed to ensure that prevention programs are working. The strategic plan will set national priorities for health promotion and disease prevention focused on science-based initiatives regarding nutrition, exercise, smoking cessation, and the nation's top five disease killers. The committee shall provide annual reports on their progress toward meeting the specific metrics outlined in the strategic plan.

¹¹ Press Release, American Diabetes Association website, "Prevention Activities Could Increase Lifespan of U.S. Adults," July 7, 2008, <http://www.diabetes.org/for-media/prevention-activities-could-increase-lifespan-adults.jsp>.

¹² Centers for Disease Control and Prevention Website, "Chronic Disease Overview," November 18, 2005, <http://www.cdc.gov/nccdphp/overview.htm#2>.

¹³ Kenneth Thorpe, Ph.D., Testimony before the U.S. House Appropriations Committee, February 4, 2008.

<http://www.fightchronicdisease.org/pdfs/KennethEThorpe.Written.HouseLabor-HSub.14Feb2008.pdf>.

¹⁴ Kenneth Thorpe, Ph.D., Testimony before the U.S. House Appropriations Committee, February 4, 2008.

<http://www.fightchronicdisease.org/pdfs/KennethEThorpe.Written.HouseLabor-HSub.14Feb2008.pdf>.

¹⁵ Partnership for Prevention, "Guide to Smart Prevention Investments," Fall 2001, http://prevent.org/images/stories/Files/publications/Invest_Final.pdf.

¹⁶ Colliver, Victoria, "Preventive Health Program May Prevent Cost Increases," *San Francisco Chronicle*, February 11, 2007, <http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/02/11/BUG02O20R81.DTL&type=printable>.

¹⁷ RJ Ozminkowski, D Ling, et al., "Long-Term Impact of Johnson & Johnson's Health & Wellness Program on Health Care Utilization and Expenditures," *Journal of Occupational and Environmental Medicine* 44(1): 21-29, 2002, http://www.icdr.us/employment2008/presentations/Tuesday/Farragut_0330/EElias_Utilization_Handout.pdf.

Empowering Individuals to Make Healthy Decisions

A large percentage of heart disease, stroke, and type 2 diabetes, as well as many cancers could be prevented if Americans would stop smoking, start eating better, and start exercising. Prevention largely requires individuals to adopt healthy lifestyles and behaviors. This can be accomplished without creating more government agencies and programs, but by providing science-based recommendations directly to individuals.

Under this Act, CDC will ensure the establishment of a web-based prevention tool that would create a personalized prevention plan for individuals based upon personal health and family history, body mass index, and other individualized health factors. The web site would provide daily healthy living recommendations developed from the latest scientific data. The Harvard University School of Public Health has developed a successful tool similar to this idea, the Disease Risk Index.¹⁸

CDC will also implement national science-based media campaigns, designed by social marketing professionals, on health promotion and disease prevention. The power of advertising that works for American businesses to sell their products will work to sell Americans a message of prevention. That message will address proper nutrition, regular exercise, smoking cessation, obesity, the nation's leading disease killers, and secondary prevention through disease screening promotion. These efforts will undergo an independent evaluation every two years and be tied to measurable outcomes.

USDA will distribute nutrition information to each individual and family enrolled in the federal Supplemental Nutrition Assistance Program. The Act also ensures that these benefits' purchasing power is directed toward healthy food choices.

Awarding Prevention Success

Seniors who adopt healthier behaviors would be rewarded with lower Medicare premiums.

The Act would give states more flexibility over their federal public health dollars in order to scale resources to address their greatest public health threats. States that demonstrate the greatest progress in reducing disease rates and risk factors and also increasing healthy behaviors could be awarded federal "Wellness Bonus Grants." States that receive wellness bonuses must demonstrate the greatest progress meeting specific science-based metrics. Bonuses could be used to make greater investments in public health.

Increasing Vaccine Availability

Vaccines provide cost-effective immunity against many diseases. The influenza vaccine, for example, is estimated to save \$30 to \$60 in hospitalization costs per \$1 spent on vaccination.¹⁹ Yet many Americans have not been vaccinated against many diseases for which vaccines are available. This bill would expand access points for federally funded vaccines and encourage states to achieve higher vaccination rates by awarding bonus grants to states with 90 percent vaccination rates.

Eliminating Ineffective and Counterproductive Government Programs

Government health programs should adhere to the Hippocratic Oath to "First, do no harm." This means federal programs should not promote or support unhealthy behaviors and taxpayers should not be expected to support programs that do not show positive results. This act would require reviews of existing programs and the consolidation of overlapping programs and the elimination of ineffective programs. Additionally, "junk food" that does not meet nutrition standards would be prohibited for purchase under the federal Food Stamp Program.

¹⁸ Harvard University School of Public Health, Disease Risk Index, <http://www.diseaseriskindex.harvard.edu/update/>.

¹⁹ Centers for Disease Control and Prevention, "An Ounce of Prevention...What Are the Returns?," U.S. Department of Health and Human Services, October 1999, Second Edition, <ftp://ftp.cdc.gov/pub/Publications/mmwr/other/ozprev.pdf>

Creating Affordable and Accessible Options through State-Based Exchanges

Our health care system should be easier to use, more predictable, and provide integrated care in a more equitable manner. The current regulation of the insurance market does not incentivize health plans to cover sick patients. And too many patients are unable to afford premiums. Americans inherently know that innovative markets work, but businesses must play by transparent rules and compete for patients' business. The market must work for every patient every time. Patients should have convenient and affordable options, and they should have control of those options. Doctors and hospitals should be more involved in patient care.

What we need—and what this Act provides—is a consistent and fair market, so that everyone can afford coverage. Patients could choose which health care provider they trust. The freedom to choose creates better competition, fosters higher quality care, and lowers costs to levels that are fair for *every* American in *every* state.

States should provide direct oversight of health insurers to make sure they are playing by fair rules. A one-size-fits-all approach dictated by Washington cannot solve the diverse problems that citizens in various states face. For example, Oklahoma has an uninsured rate of nearly twice that of Minnesota.²⁰ Many states have led the nation in finding comprehensive health care solutions for their citizens, including the well-known, bi-partisan achievement of universal health care through a private system in Massachusetts. The federal government should not impede progress, but rather partner with states to make further progress.

The Patients' Choice Act would ensure that the federal government partners with states to create State Health Insurance Exchanges with the following benefits:

- **One-stop marketplace for health insurance.** Individuals would get a hassle-free opportunity to choose the plan that best meets their needs through an Exchange.
- **Benefits by the same standard used for Members of Congress.** Plans offering coverage through an Exchange would have to meet the same statutory standard used for the health benefits given to Members of Congress.
- **Guaranteed access to care.** The Exchange would require all participating insurers to offer coverage to any individual—regardless of patient age or health history.
- **Affordable premiums.** Under the status quo, plans offering coverage to individuals often charge exorbitant premiums. The Patients' Choice Act solves this very real problem through a model that works in several European countries: independent risk-adjustment among insurance companies.²¹ A non-profit, independent board would penalize insurance companies that cherry pick healthy patients while rewarding companies that seek patients with pre-existing conditions. This solution would ensure health insurers compete based on superior products and the lowest price.
- **Simple auto-enrollment.** An Exchange would make it easy for individuals to obtain health insurance by providing new and automatic opportunities for enrollment through places of employment, emergency rooms, the DMV, etc. If individuals do not want health insurance, they will not be forced to have it. Research has shown that auto-enrollment mechanisms—which overcome inertia, complexity, and status quo bias—have achieved near universal levels of coverage.²² An auto-enrollment mechanism has also been demonstrated to increase the percentage of employee-participation in employer-provided 401(k) plans by 70 percent—from 20 percent of new employees enrolled after three months under self-employment, to 90 percent of new employees participating under auto-enrollment.²³
- **Regional Pooling Arrangements.** States could form voluntary compacts with other state Exchanges to diversify pooling, ease administrative burdens, and increase speed-to-market for innovative insurance products.²⁴

²⁰ Kaiser Family Foundation Website, "Health Insurance Coverage of the U.S. Population (2007),"

<http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3&sub=39&yr=85&typ=2>, accessed March 18, 2009.

²¹ Leu, Robert, et al., "The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets," The Commonwealth Fund, January 16, 2009, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Jan/The-Swiss-and-Dutch-Health-Insurance-Systems--Universal-Coverage-and-Regulated-Competitive-Insurance.aspx>.

²² Jeffrey Liebman and Richard Zeckhauser, "Simple Humans, Complex Insurance, Subtle Subsidies," National Bureau of Economic Research working paper, September 2008, <http://www.nber.org/papers/w14330>.

²³ Vanderkam, Laura. *City Journal*, 11 June 2008. <http://www.city-journal.org/2008/bc0611lv.html>

²⁴ The Gramm-Leachy Bliley Act of 1999 fostered model legislation to create voluntary interstate compacts for life, disability, and long-term care insurance products.

Providing Tax Cuts for Every American to Afford Health Care

An improved healthcare system means nothing unless it is fair for *all* Americans. Frankly, right now, it is not. The current system effectively subsidizes *corporations* rather than *patients*, and subsidizes health *insurance* instead of health *care*. Under the status quo, Americans working for Wall Street conglomerates rake in more than \$200 billion in tax breaks for their health benefits, but Americans struggling to buy health care on their own do not see a penny for the same plans.²⁵ Furthermore, the current system discriminates against low-income Americans: wealthy Americans receive \$2,680 in tax breaks for health care while the poorest Americans get only \$102.²⁶

Americans happy with their employer-sponsored health benefits should be able to keep what they have, but they should make that decision instead of the government. Tax breaks should go directly to every individual with a healthcare plan. This will give hardworking Americans the control and the *freedom* to *decide* how best to spend their hard earned dollars when it comes to providing superior healthcare to their families.

But not only is the current system unfair, it makes little economic sense. Economists, from Nobel Laureate Milton Friedman to President Obama's deputy economic advisor Jason Furman, have noted the link between the tax treatment of health benefits and out-of-control costs.^{27 28} Furman wrote, "Replacing the current tax preference for insurance with an income-related, refundable tax credit has the potential to expand coverage and reduce inefficient spending at no net federal cost."²⁹ Empirical evidence suggests that such a policy would reduce health spending without harming health outcomes.³⁰

Redirecting tax benefits from corporations directly to patients will increase wages for hardworking Americans. A leading health care economist from the Massachusetts Institute of Technology, John Gruber, stated that "the costs of health insurance are fully shifted to wages."³¹

Before taking over the Office of Management and Budget in the Obama Administration, Peter Orszag testified before the Senate Finance Committee, "[I]magine what the world would be like if workers [understood] that today it was costing them \$10,000 a year in take-home-pay for their employer sponsored insurance and that could be \$7,000 and they could have \$3,000 more in their pockets today if we could relieve these inefficiencies out of the health system."³² The Patient's Choice Act would effectively increase workers' wages. Higher take-home pay combined with the new tax subsidies would enable individuals to obtain more affordable and efficient health coverage.

The Patients' Choice Act shifts health care tax benefits and medical decisions from corporations to individual patients.

Americans would get an individual tax rebate to purchase health insurance. The "Medi-Choice" rebate, worth about \$2,300 for individuals and about \$5,700 for families, combined with higher wages would give individuals a wide variety of health care options. The Act would require transparency from employers regarding the value of health benefits that could equal higher employee wages.

Under the Act, individuals would have the opportunity to purchase not only health *insurance* but the health *care* that they need. This targeted approach ensures that lower-income Americans can access the same health care advantages as wealthier Americans do and can choose from the same health care options.

²⁵ Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimated for 2006," *Health Affairs*, November/December 2006, <http://content.healthaffairs.org/cgi/content/abstract/25/6/1568>.

²⁶ John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* Web Exclusive, February 25, 2004, <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1.pdf>.

²⁷ Friedman, Milton, "How to Cure Health Care," *Hoover Digest*, Winter 2001, <http://www.hoover.org/publications/digest/3459466.html>.

²⁸ Furman, Jason, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, May/June 2008, <http://content.healthaffairs.org/cgi/content/abstract/27/3/622>.

²⁹ "Furman, Jason, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, May/June 2008, <http://content.healthaffairs.org/cgi/content/abstract/27/3/622>.

³⁰ Furman, Jason, "Health Reform Through Tax Reform: A Primer," *Health Affairs*, May/June 2008, <http://content.healthaffairs.org/cgi/content/abstract/27/3/622>.

³¹ Cited in Ezekiel J. Emanuel, MD, PhD and Victor R. Fuchs, PhD, "Who Really Pays for Health Care Costs,"

Journal of the American Medical Association, March 5, 2008, <http://jama.ama-assn.org/cgi/content/extract/299/9/1057>

³² Congressional Budget Office, "Long-Term Budget Outlook and Options for Slowing the Growth of Health Care Costs," June 17, 2008, <http://www.cbo.gov/doc.cfm?index=9385>.

Putting Patients in Control of Their Own Health Care with Health Savings Accounts

Under the Patients' Choice Act, individuals and families could choose a "catastrophic" or high-deductible health plan (HDHP), which is an affordable health insurance plan that covers expenses after a deductible has been reached. In these plans, money may also be deposited into a Health Savings Account (HSA), which is essentially a personal, tax-free savings account that a patient can use to pay for health care costs.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you, rather than by your boss or a health insurer. This means that a patient can choose their own doctor and make other health care decisions without the prior approval of an insurance company.

HSAs can also pay for routine health care costs that are not typically covered by traditional health insurance. For example, most health insurance does not cover the cost of over-the-counter medicines or dental and vision care, but HSAs can. The unused balance in a Health Savings Account automatically rolls over year after year.

While this option is not for everyone, many Americans have chosen its potential for low-cost and high-value care. The number of Americans in these plans has increased six-fold since 2005. The fastest growing market for HDHP/HSA plans is with America's small business owners seeking the right balance between coverage and affordability. Nearly half of HDHP/HSA beneficiaries have a chronic condition. Not only are the vast majority of these beneficiaries offered a full range of prevention services, these beneficiaries are more likely to succeed in prevention activities.³³

Under the Patients' Choice Act, if an individual selects a high-deductible health insurance plan that is cheaper than the value of the credit, they can keep the difference in their Health Savings Account.

Furthermore, the Patients' Choice Act would build upon the success of HSAs by making a few targeted improvements.

- The Act would allow health insurance premiums to be paid tax-free from an HSA as well as increasing the amount of tax-free dollars an individual can keep for their health care. The Act would also allow employers to contribute greater amounts to the HSAs owned by acutely or chronically ill employees. The Act would allow high-deductible health plans to cover preventive services, maintenance costs of chronic diseases, and concierge-style primary care services.
- Under a concierge-style benefit, physicians get paid a specified dollar amount, for a given time period, to take care of the medical needs of a specified group of patients. Under this approach, a patient with diabetes with an HSA could purchase a high deductible plan that is specifically designed to cover the needs of diabetics.

Insisting on Fairness for Every American Patient

While we have programs that help poor people in this country, the reality is that these programs are providing outmoded benefit designs to these patients. As it stands, Medicaid patients only receive the basic treatment they *require*, with costs set by some Washington or state bureaucrat. By allowing the government to regulate how much patients pay for procedures, we have created a system dictated by cost instead of by patient comfort and care required.

According to the independent committee that advises the Centers for Medicare and Medicaid Services (CMS) on payment decisions, Medicaid reimbursement rates have resulted in 40 percent of physicians restricting access to patients in the program.³⁴ And the physicians that do offer care find it difficult to get patients access to specialized care or timely interventions. Medicaid patients often end up in the emergency room for basic health care services simply because they cannot get access to a primary care physician.

³³ America's Health Insurance Plans, "Health Savings Accounts & Accounts Based Health Plans: An Overview of Research," February 2009, <http://www.hsaalliance.org/pdf/HSA%20Market%20Overview%2002%2010%2009%20330pm%20FINAL.pdf>.

³⁴ Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*. January 9, 2009, <http://online.wsj.com/article/SB123137487987962873.html>.

This lack of access has resulted in poor patient outcomes in the Medicaid program relative to patients in private plans. A recent *Wall Street Journal* article documents several peer-reviewed medical articles regarding this disparity.³⁵

- Medicaid patients were almost 50% more likely to die after coronary artery bypass surgery than patients with private coverage or Medicare.
- Elderly Medicaid patients with unstable angina had worse care, partly because they were less likely to get timely interventions or be treated at higher quality hospitals.
- Medicaid patients presenting with heart attacks or unstable angina received cardiac catheterization less often than Medicare or private paying patients. This procedure to open blocked heart arteries has become standard care, with ample evidence showing it improves outcomes.
- Patients on Medicaid are two to three times more likely to die from [cancer] even after researchers corrected for differences in the location of the tumor and its stage when diagnosed.

Not only are outcomes for Medicaid patients worse than the general public, the taxpayers are also getting a bad deal. The current funding scheme to states for Medicaid is also inequitable with some state raking in the federal dollars and other states left in need. For example, in 2006, federal Medicaid expenditures per poor person varied from \$1,679 in Nevada to \$6,340 in New York.³⁶

In 2008, Medicaid's total costs were \$333.2 billion. According to HHS, the Medicaid improper payment rate is 10.5 percent or \$32.7 billion.³⁷ That is more than three times the average improper payment rate of other federal agencies at 3.5 percent.³⁸ In New York, that percentage may be as high as 40 percent.³⁹ If we do not restore accountability now, Medicaid spending will grow by 7.9% per year and by 2017 it will explode to \$673.7 billion. The Government Accountability Office (GAO) has repeatedly warned that entitlement spending will threaten America's international competitiveness and the federal government's long-term capacity to respond to national emergencies.

Not only is the status quo tragic, it is financially unsustainable. Some of the poorest or sickest among us may suffer the most, while the system is going broke. The greatest risk to Medicaid patients and taxpayers is to do nothing.

We can improve Medicaid and restore accountability by transitioning *away* from open-ended entitlement programs that offer little or no accountability to taxpayers and patients. A 21st century Medicaid program, under the Patients' Choice Act, would provide individualized, personalized care specifically by:

- **Integrate low-income families with dependent children into higher quality private plans** through direct assistance. In addition to a tax rebate, families would receive enough extra money to buy the private plan that best fits their needs. Keeping families together within one provider network will foster coordinated and personalized care and promote innovative patient care models such as medical homes.
- **Realign responsibility between federal and state governments in order to better coordinate benefits.** The Medicare program would assume from the states the Medicaid responsibility of premiums, cost-sharing, and deductibles for low-income seniors in order to better coordinate care. The states, in exchange, would accept a defined federal allotment for long-term care and supportive services.
- **Rebalance long-term care services to ensure choice between institutionalized and home-based care.** Long-term care subsidies that favor poor-quality institutions would be improved to offer a broad, flexible array of services and supports

³⁵ Gottlieb, Scott, "What Medicaid Tells Us About Government Health Care," *The Wall Street Journal*. January 9, 2009, <http://online.wsj.com/article/SB123137487987962873.html>.

³⁶ Robert B. Helms, Testimony before U.S. House Energy and Commerce Committee, July 22, 2008. http://energycommerce.house.gov/cmte_mtgs/110-he-hrg.072208.Helms-Testimony.pdf.

³⁷ Press release, Centers for Medicare and Medicaid Services Website, "CMS Issues Improper Payment Rates for Medicare, Medicaid, and SCHIP," November 17, 2008, <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3368>.

³⁸ CRS Report RL34164, "Improper Payments Information Act of 2002: Background, Implementation, and Assessment," Congressional Research Service, September 10, 2008, <http://apps.crs.gov/products/rl/html/RL34164.html>

³⁹ Levy, Clifford J. and Luo, Michael, "New York Medicaid Fraud May Reach Into the Billions," *The New York Times*, July 18, 2005, <http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html>.

that promote personal choice and control. Individuals wishing to stay at home with their loved ones rather than in a nursing home could use their benefits for targeted assistance.

- **Preserve Medicaid Acute Care for Individuals with Disabilities.** The Patients' Choice Act would maintain current law for benefit security and stable funding for individuals with disabilities under the Medicaid program. The Act would enhance care for the disabled by allowing for better care management.

Fixing Medicare for American Seniors

Seniors rely on Medicare to help cover the costs of their health care needs. All workers pay taxes that partially fund the Medicare Trust Fund with the assumption that the program pay for the majority of their health care needs during their retirement years. Unfortunately, the Medicare program routinely delivers care but fails to ensure quality.

Preventing reimbursement cuts to Medicare providers has become an annual battle on Capitol Hill—those cuts are slated to be 20 percent at the end of 2009 and will cost billions of dollars to prevent. Seniors have to worry about whether or not their doctor will be able to see them, because their doctor has to worry about if Medicare will pay them.

Bureaucrats are already telling doctors which drugs they can prescribe for their patients and demanding rock-bottom prices for physician services. In many areas of the country, higher spending on Medicare services has actually resulted in lower health outcomes because the current Medicare program fails to reward high-value care.⁴⁰ The only alternative to the Medicare bureaucracy for seniors is Medicare Advantage, a program dominated by HMOs, which doctors know can be as bad as traditional Medicare when it comes to doubting their professional judgment.

As designed, Medicare is susceptible to fraud and abuse—losing \$60 billion annually to fraudulent payments.⁴¹ No private company could survive such losses, yet Medicare administrators are unwilling or unable to stop it. Without immediate action, Medicare's excess costs over the long term are \$85.6 trillion—six times the size of the current U.S. economy. The Medicare Trust Fund for benefits may be depleted by 2016.⁴²

If partisan gridlock on Medicare persists, the inevitable result will be massive tax hikes, dramatic reductions in health care services, or the fiscal collapse of Medicare as we know it today. In order to protect benefits for seniors, Congress must take thoughtful action now. Medicare is about more than simply providing care to our seniors; it is about delivering that care with the quality and predictability they deserve.

The Patients' Choice Act would let seniors control the healthcare money CMS mismanages today. Seniors should be able to choose the type of care that's best for them and their doctors. That type of competition—where insurance companies will compete for seniors' business—is the only hope we have to overhaul the broken Medicare system. Additionally, the bill would make targeted solvency and payment reforms to the Medicare program. Specifically, the Act would:

Increase Choices for Seniors and Implement Fair Reimbursements for Private Plans

This Act implements a fair reimbursement mechanism for private plans providing health benefits to seniors. Rather than the current bureaucratic formula, which many contend wastes taxpayer dollars and lines the pockets of insurance executives, the Act would have plans to compete against each other. Competitive bidding would allow the market to set reimbursement rates to plans and could increase system efficiencies without negatively impacting access for seniors.

Additionally, the Act would encourage plans to design high-quality, innovative benefits because they would bid on the value of benefits. Rather than bureaucrats telling seniors what they can have, seniors would tell bureaucrats what they want. This model—

⁴⁰ Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries Quality of Care," *Health Affairs*, 2004, <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.184>.

⁴¹ Johnson, Carrie, "Medical Fraud a Growing Problem," *The Washington Post*, June 13, 2008, <http://www.washingtonpost.com/wp-dyn/content/article/2008/06/12/AR2008061203915.html>.

⁴² Pear, Robert, "Obama's Health Plan, Ambitious in Any Economy, Is Tough in This One," *The New York Times*, March 1, 2009, <http://www.nytimes.com/2009/03/02/us/politics/02health.html?pagewanted=1&r=1&ref=us>.

of competitive bidding and actuarial equivalence—is already working in Medicare’s prescription drug benefit achieving a savings of 26 percent, or \$136 billion, below original estimates.^[3] Beneficiary premiums under this model are 37 percent lower than expected.^[4]

Realign Payment Incentives to Improve Quality and Reduce Costs

Traditional Medicare’s outdated payment structure fails to reward high-value and personalized care. The average face time that patients get with their doctors is a mere 13 minutes.⁴³ Physicians get paid by how many procedures they *can* perform rather than the health of their patients. Medicare spends three times more per patient in some areas than in others, but the quality and outcomes are the same.⁴⁴

Rather than onerous new rules, the Patients’ Choice Act realigns incentives to encourage health care providers to provide better value at a lower cost. New ideas from the supply side of the market would result in physicians being paid based on quality instead of procedure: *performance for pay*.

Health care providers, including physicians, hospitals, pharmacists, nurses, and others, could form Accountable Care Organizations (ACOs) and receive bonuses if they demonstrate improvements in quality and patient satisfaction while lowering health care costs. The Act would allow physicians to purchase certain medical equipment for their offices to deliver more transparent, convenient, and cost-effective services. ACOs would have incentives to implement care coordination, wellness programs, and other innovative prevention approaches—because the ACO would receive more money for keeping patients healthy. Patients would get new opportunities to receive higher quality care. This results-based model is a win-win for providers and patients. The Congressional Budget Office has estimated that this could also be a \$5.3 billion win for taxpayers.⁴⁵

Reduce Government Handouts to Wealthier Americans

The Act would ask wealthy retirees to pay a little more for their Medicare benefits in order to avoid prevent their grandkids from facing future tax hikes. The Congressional Budget Office estimates that this would reduce entitlement spending by \$30.6 billion over the next 10 years.⁴⁶

Couples making more than \$170,000 (without an annual index to inflation) would pay more for their Part B premiums. Part D would be means-tested at the same level for wealthy retirees.

Ensuring Compensation for Injured Patients and Quality Care for All

No health care plan is complete until it ends the lawsuit abuse that affects virtually everyone. Medical lawsuits and excessive verdicts increase health care costs and result in reduced access to care. Unfortunately, terrible, indefensible mistakes do happen in the healthcare field. When they do, patients should have the right to fair legal representation and fair compensation. However, our current medical tort litigation system often serves the interest of lawyers while driving up costs and delaying justice. The crisis has two components.

The first component is the financial burden on health care providers. Instead of offering you lower prices for their services, American doctors pay as much as \$126 billion to protect themselves from lawsuits⁴⁷ while only 17 percent of lawsuits filed involve actual physician negligence.⁴⁸ Defensive medicine adds another \$70 billion to health care costs.⁴⁹

^[3] Congressional Budget Office, “The Budget and Economic Outlook: Fiscal Years 2008 to 2017,” January 24, 2007. <http://www.cbo.gov/doc.cfm?index=7731>.

^[4] Press Release, Centers for Medicare and Medicaid Services Website, “Lower Medicare Part D Costs Expected in 2009,” August 14, 2008, <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3240&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srcHData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>.

⁴³ Andrew Gottschalk and Susan A. Flocke, “Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room,” *Annals of Family Medicine*, 2005, <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1466945>.

⁴⁴ Brookings Institute and the Dartmouth Institute for Health Policy and Clinical Practice, “Issue Brief: Accountable Care Organizations,” March 2009, http://www.brookings.edu/events/2009/~/media/Files/events/2009/0311_aco/issuebriefacofinal.pdf.

⁴⁵ Congressional Budget Office, “Budget Options Volume 1, Health Care,” December 2008, <http://www.cbo.gov/doc.cfm?index=9925>.

⁴⁶ Congressional Budget Office, “Budget Options Volume 1, Health Care,” December 2008, <http://www.cbo.gov/doc.cfm?index=9925>.

⁴⁷ American Medical Association, “Medical Liability Reform-NOW! A compendium of facts supporting medical liability reform and debunking arguments against reform,” July 19, 2006, <http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf>.

The second component is the negative effect on patients. The costs doctors must pay to purchase medical malpractice insurance drives up the cost of care for patients. Furthermore, doctors perform unnecessary medical tests, not for the patient's benefit, but for the *doctors'* benefit to protect themselves from potential lawsuits. The high costs of "defensive medicine" and litigation cause patient care to suffer. When the cost of insurance becomes too high, many doctors relocate or retire prematurely, thereby reducing patients' access to care. One national study released in 2007 found that America wastes \$589 billion on excessive tort litigation. Additionally, this study indicates that by reforming the civil justice system, 2.4 to 4.3 million more Americans would have access to affordable health insurance coverage.⁵⁰

States have attempted numerous solutions to this problem with varying levels of success. The solution traditionally offered to this crisis is some form of cap on patient damages. This was the approach taken by California in the 1970s and it has created a stable medical-legal environment within the state. States have also begun to explore other options that are just as capable, if not more so, of addressing the second component of this problem—adequately compensating patient injury and improving patient care.

The crucial challenge of medical liability reform calls for innovative, results-oriented solutions in the form of specialized health courts or other state-designed options. This is the best way to limit lawsuit abuse without limiting legal justice.

Under this Act, the federal government would financially assist states in establishing solutions to medical tort litigation. These alternatives will offer injured patients the opportunity to receive compensation quickly and fairly—without ultimately losing their access to traditional court systems. At the same time, this Act will help states ensure the accessibility of care for everyone by stopping the rising costs of medical malpractice litigation in this country. Each alternative is entirely run by the state, not the federal government, enabling each state to tailor its solution to its own needs. States may not preclude any party to a dispute from having legal representation at any point in any of the alternatives. Specific solutions include:

Establishing an Expert Panel to Resolve Medical Disputes

Medical malpractice trials often become a "battle of the experts." Each party hires an expert to testify, and the most convincing expert gains the trust of the jury. Under this Act, states will ensure that experts continue to play a pivotal role in malpractice cases. Instead of the opposing parties picking their own experts, however, the head of the state agency responsible for health will appoint a panel of six independent experts to review each case. Three of the experts will be attorneys, who can bring an understanding of the law relating to the injuries alleged in each dispute. The other three experts will be medical professionals who are particularly qualified to evaluate the type of alleged injury.

The expert panel will reach a determination about whether a health care provider is responsible for a patient's injury, and if so, what penalty is appropriate. If both the health care provider and patient are satisfied with the decision, they can accept it and end the dispute. Such a swift resolution stands in stark contrast to the months or even years of hearings, trials, and appeals that are currently necessary for a patient to receive compensation for their injuries.

Establishing Independent Health Courts with Qualified Judges for Dispute Resolution

States may elect to establish a State Administrative Health Care Tribunal, or "health court" under this alternative. Each health court will be presided over by a judge with health care expertise, who can commission experts and make the same binding rulings that a state court can make.

The health court makes a final, binding determination as to liability and compensation using the same legal standard that would otherwise be used in a state court of competent jurisdiction. Even at this point in the process, the parties will receive a much swifter resolution than if they had pursued their case in state court.

⁴⁸ David M. Studdert, Michelle M. Mello, and Troyen A. Brennan, "Medical Malpractice," *The New England Journal of Medicine*, Vol. 350, No. 3 (January 15, 2004), p. 285.

⁴⁹ Christopher J. Conover, "Health Care Regulation: A \$169 Billion Hidden Tax," Cato Institute *Policy Analysis* No. 527, October 4, 2004, at www.cato.org/pubs/pas/pa527.pdf (December 5, 2005).

⁵⁰ "Jackpot Justice: The True Cost of America's Tort System," Pacific Research Institute, March 27, 2007. http://liberty.pacificresearch.org/docLib/20070327_Jackpot_Justice.pdf

Nonetheless, if either party is not satisfied with the health court's decision, this Act explicitly provides that the states receiving federal funds must allow parties to have access to state courts to appeal the decision.

Combination of an Expert Panel and a Health Court

The final alternative is a combination of the expert panel and health court systems above. The requirements are the same as the individual models, but this alternative requires a claim to proceed in two steps. First, the parties must present their case to an expert panel in accordance with the above requirements. Second, if either party is not satisfied, they must then present their case to the health court. If the parties proceed to the health court, they forfeit any award made by the expert panel. Finally, if either party is still not satisfied with the result after these two steps, that party may file a claim in state court.

The three solutions to lawsuit abuse would create a fair and efficient system. To encourage parties to rely on these alternatives, parties that appeal to state courts; but are not satisfied with the state court's decision; forfeit the ability to receive compensation previously awarded by the alternative system. In addition, the Act clarifies that any state that may already have an alternative to litigation in place for a specific category of disease may retain its current system for that category. However, the state must also elect one of the four models in this Act for all other diseases in order to take advantage of the funding opportunity.

Increasing the Efficiency and Security of Medical Records

Every doctor's office contains shelves and shelves of color-coded folders containing valuable and private medical information. Every time you visit your doctor, a nurse must record the same health and family history that you shared the last time you visited the same doctor. It can take months for the insurance company to pay your doctor after you have gone for a check-up. Instead of money going to pay for treatment, dollars get caught up in the administrative quagmire that exists under our outdated medical information system. It is little wonder that one out of three health care dollars does not help anyone get well.

This Act proposes adopting the same model used by the financial services industry in promoting the use of automated teller machines (ATMs). Individuals could get a card — just like their ATM card — that would maintain their insurance and medical history information from an independent health record bank. Every time you visit your doctor, you would swipe the card for instant access to your medical history and insurance payment information. If used correctly, potential savings from use of health information technology is estimated to be billions of dollars. More importantly, the better information about medical histories can improve medical outcomes and save lives.

The legislation would provide the charter for creating member-owned Independent Health Record Bank accounts that are operated cooperative institutions (much like member-owned credit unions are in the financial services industry). Medical information would adhere to strict privacy guidelines yet be computerized and readily-available when you need it.

Additionally, this legislation would create incentives for faster adoption of health information technology by hospitals and individual providers.

Ensuring that Veterans Get the Care They Deserve

Veterans—who have made the greatest of sacrifices for all Americans—deserve the best medical care available at the doctor and hospital that is closest to their home and loved ones. This Act encourages the Secretary of the Veterans Administration to allow just that right. Competition from private facilities will also ensure that VA facilities provide the best medical care possible for our great American heroes.

Giving Choice to American Indians

The Secretary of the Indian Health Service would have the ability to set up a system for eligible American Indians to access medical care outside of the Indian Health Service facilities. Not only will this give American Indians more choice in where they receive medical care, it will challenge Indian Health facilities to provide the best care possible to American Indians.

Establishing Transparency in Health Care Price and Quality

For individuals and families to shop for their health care, they must have a better sense of what they are expected to pay – and what they are getting for their money. Making data on the pricing and effectiveness of health care services widely available is critical to the success of an effective health care marketplace. So far, however, the market has been unable to develop a process for defining industry-accepted metrics that measure “quality” and define “price.” The result has been a flurry of reports by trade organizations, specialty groups, and government agencies, each using different terminology and definitions. The lack of uniform standards has prevented effective, “apples-to-apples” comparisons.

The Patients’ Choice Act would allow for a public/private partnership to establish uniform and reliable measures by which to report quality and price information. To accomplish this goal, the PCA restructures the current Agency for Healthcare Research and Quality [AHRQ] and removes it from the Department of Health and Human Services. The new agency, renamed the Healthcare Services Commission [HSC], will be governed along the same lines as the Securities and Exchange Commission, and managed by five commissioners chosen from the private sector (with no more than three from the same political party), appointed by the President, and approved by the Senate.

The HSC’s purpose – to enhance the quality, appropriateness, and effectiveness of health care services through the publication and enforcement of quality and price information – will be guided by a standard-setting Forum for Quality and Effectiveness in Health Care. The group will play a role similar to that of Financial Accounting Standards Board in establishing accounting principles. The forum will consist entirely of private-sector representation, with the authority to establish and promulgate metrics to report price and quality data. Forum members will represent views from medical providers, insurers, researchers, and consumers, and will serve independently of any other employment.

The forum, designed to keep pace with innovation, will publish, for public comment, a preliminary analysis on standards for reporting price, quality, and effectiveness of health care services. After the comment period, the group will publish a final report containing guidelines for regulating the publication and dissemination of health care information. The HSC will be authorized to enforce these standards.