

# The Patient Choice, Affordability, Responsibility, and Empowerment Act

## *A Legislative Proposal*

### **Title 1: Repeal the President's Health Care Law**

#### **Section 101: Repeal Obamacare**

Despite promises that Obamacare would lower health care costs, costs continue to skyrocket for patients, families, taxpayers, and businesses. Today's health care law is not the solution to the health care crisis facing our nation, and the American people continue to reject it because they know that the current course is simply unsustainable. An alternative approach is necessary to fulfill the promise to lower health care costs, advance patient-centered reforms, and provide needed relief from job-crushing mandates, while at the same time ensuring affordable health care for patients and taxpayers. We can achieve sustainable, affordable, health care that puts patients – not the government – in charge of their health decisions and pocketbooks.

The first step toward achieving sustainable, affordable, patient-centered health care is to repeal the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA).<sup>1</sup>

### **Title 2: Replace Obamacare With Sustainable, Patient-Centered Reforms**

#### **Section 201: Adopt Common-Sense Consumer Protections**

We believe all Americans deserve access to common-sense consumer protections in health coverage. Our proposal adopts a series of commons-sense measures that do not have costly mandates, which drive up health care costs, or put the federal government between patients and their doctors.

Under our proposal, insurance companies would be prohibited from imposing lifetime limits on a consumer. This means that any group health plan or health insurance issuer offering group or individual health insurance may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary.

Under Obamacare, insurance companies are banned from charging an older, sicker individual more than three times what they charge a young healthy person. Actuaries and non-partisan experts agree that this restrictive rating requirement significantly increases health insurance premiums, especially for younger consumers.<sup>i</sup>

Our proposal would repeal this costly mandate and return the power of regulating health insurance to the states, which have historically been the primary regulators of health insurance. To stabilize the market initially, our proposal would adopt a age rating ratio that limits the amount an older individual will pay to no more than five times what a younger individual pays in premium dollars (5 to 1) as a federal baseline, since the vast majority of states already utilized this rating ratio before Obamacare. This less restrictive rating ratio will have the effect of helping to immediately lower health care costs for millions of Americans. However, after the adoption of our

<sup>1</sup> All provisions of PPACA and HCERA are repealed except for the changes to Medicare. Medicare reforms should be considered in the context of reforms to improve Medicare and prevent its insolvency. Previous Medicare reform proposals have been proposed by Sen. Hatch ( <http://goo.gl/EgDgVU> ) and Sens. Burr and Coburn (<http://goo.gl/2efRL>)

proposal, any state could decide they want to instead adopt rating rules that are more or less restrictive than a 5 to 1 ratio. If this were the case, that state would simply need to pass a law opting out of this provision for the plans it regulates.

Our proposal would also require health plans to offer dependent coverage up to age 26, in the interest of stabilizing the market during the transition. While we believe fewer young consumers will utilize this option as the cost of health insurance decreases, retaining this policy has a very marginal effect on premiums and provides consumers with more choices. Similar to the federal baseline for insurance plan rating, any state could choose to opt out of this provision for the plans it regulates.

Guaranteed renewability under our proposal would ensure that patients would be able to renew their coverage—insurers would be prohibited from refusing to renew a health insurance policy solely because of the health status of an individual. Insurance companies would also be banned from making unfair coverage terminations of health coverage. Only in limited circumstances, such as cases of fraud or misrepresentation on behalf of a consumer or failure to pay premiums, could a health insurance company cancel an individual policy. This would give patients peace of mind knowing that a health insurance plan could not simply rescind coverage on a whim. Even in cases of fraud or misrepresentation, health insurance companies would be required to give consumers appropriate prior notice.

### **Section 202: Create a New Protection To Help Americans With Pre-Existing Conditions**

To help consumers with pre-existing conditions, our proposal would create a new “continuous coverage” protection. Under this new protection, individuals moving from one health plan to another—regardless of whether it was in the individual, small group, or large employer markets—could not be medically underwritten and denied a plan based on a pre-existing condition *if they were continuously enrolled in a health plan*. This new consumer protection helps incentivize responsible behaviors by encouraging consumers to keep their health coverage.

Here’s how it would work. As long as an individual maintains continuous coverage from one plan to another, they could not be medically underwritten and denied coverage based on a pre-existing condition. Insurers would be required to offer coverage at standard rates based on age and residence to individuals who have stayed continuously insured with at least catastrophic coverage for a period of at least 18 months, without a significant break in coverage, similar to the HIPAA protections that exist under some circumstances today. So long as an individual, or family in the case of a family policy, has stayed continuously covered, they should not be forced to pay a higher premium solely because of a costly health condition when switching plans.

Unlike the individual mandate which unfairly forces Americans to buy insurance or face financial penalties, these alternative provisions strike the right balance between strongly encouraging individuals to become insured, while ensuring greater regulatory predictability and market stability, which in turn helps to keep health care costs down. This protection ensures that individuals can transition from employer-based coverage to insurance in the individual market without being forced to face high premiums solely because of a costly underlying health condition. In the event an individual loses their employer-sponsored insurance, they would be able to choose whether or not to avail themselves of coverage under COBRA, or move immediately to the individual market with the benefit of the enhanced continuous coverage protections.

For those who may be uninsured when our proposal is adopted, we envision a one-time open enrollment period in which individuals would be able to purchase coverage regardless of their health status or pre-existing conditions. This would provide a path for all individuals, regardless of whether they are sick or may develop an illness, to obtain insurance coverage. However, if an uninsured individual were to forgo enrolling during the one-time open enrollment period or during their applicable creditable coverage window, they would still be able to

enroll during an annual enrollment period; however, they would not be able to avail themselves of the continuous coverage protections. Accommodations for life-events would also be accounted for, just as they are today for many individuals and their families.

Over the longer-term, this approach would have the effect of helping reduce the turn-over of consumers coming in and out of the individual market, thus making this market more stable, predictable, and ultimately affordable for consumers. This change will also encourage portability of health plans and more strongly encourage health plans to focus on wellness and offer innovative benefit designs, as an average individual may be enrolled in their plan over a longer period of time.

### **Section 203: Empowering Small Business and Individuals with Purchasing Power**

Surveys show that the health coverage problem that most small businesses and individuals face is costs: costs are simply too high. Expensive health plans are often the chief reason small businesses and families drop their health coverage.

While repealing Obamacare will help lower costs, we also believe that small businesses and individuals should also be empowered with purchasing power. Under our proposal, we not only lower costs through structural insurance reforms, but we provide targeted help to help stabilize the market and encourage it to be more competitive and transparent.

Our proposal would provide a targeted tax credit to certain individuals which could solely be used for the purpose of helping to buy health care. Individuals working for a small business with 100 or fewer employees would be eligible to receive the credit. Individuals who do not work at a large employer would also be eligible for the credit, to help them buy a plan in the individual market. These two categories of persons are deemed eligible because they often have fewer options in a less competitive market, and are often more likely than their peers to experience episodic coverage or a lack of coverage over time. And rather than being forced to buy the kind of insurance that the federal government mandates you must buy like is happening under Obamacare, under our proposal individuals would have the freedom to choose the health plan that best meets their individual health care needs.

Individuals with annual income up to 300 percent of the Federal Poverty Level (FPL) (\$34,470 in 2013) would be eligible to receive an age-adjusted, advanceable, refundable tax credit to buy health coverage or health care services. The value of the tax credit would be reduced in value as an individual's income increased between 200 to 300 percent of FPL. Individuals with annual income above 300 percent FPL would not be eligible for a credit, and only American citizens would be eligible for a credit. The tax credit would be indexed to CPI+ 1, to encourage slower growth in health care spending over time.<sup>2</sup> We envision the value of the credits under 200 percent of FPL to be outlined approximately as follows:

Age	Individual	Family
18-34	\$1,560	\$3,400
35-49	\$2,530	\$6,610
50-64	\$3,720	\$8,810

<sup>2</sup> These health tax credits would be prohibited from being used to purchase health plans that cover abortions in circumstances other than those codified by the long-standing Hyde protections (rape, incest, and life of the mother), therefore respecting rights of conscious.

Our proposal envisions an Office of Health Financing at the U.S. Department of Treasury to ensure that the health tax credits are administered in a manner that is secure, responsible, and safe. By law, this new entity would have strict program integrity requirements and safeguards in place to limit its function to only administering the health tax credits. There would be a prohibition on the agency sharing personal health information with any other federal office or agency. This firewall is essential for ensuring the protection of consumer information and a targeted administration of the new health care tax credits. This agency would also be subject to rigorous Congressional oversight and reporting requirements, as well as specialized program compliance reviews by the Treasury Inspector General, to ensure program integrity, transparency, and accountability to the American people.

#### **Section 204: Empowering States With More Tools to Help Provide Coverage While Reducing Costs**

States have a key role to play in extending access to coverage and helping to lower costs. As the traditional regulators of health insurance, under our proposal, states would be given new tools and authorities to help their citizens and manage their costs.

In the case of individuals who have a health tax credit, but who fail to make an affirmative choice in choosing a plan within a specified timeframe, states would be allowed to utilize default enrollment. In this case, states would be responsible for designating several insurance plans as default options to which these individuals would be assigned on a random basis if they failed to sign up for coverage on their own. We envision states would use auto-enrollment, to design sustainable insurance options for individuals who do not choose a plan. For example, they may be able to create a default enrollment option with premiums equal to the value of the tax credit, so that the individual assigned to the plan would not be charged any additional premium. States could also work with health plans to set up deductibles so that the cost of the designated plans does not exceed the federal credit.

However, under our plan, every American will be able to access a health plan, but no American is forced to have health insurance they do not want. So, if an individual did not like the initial default plan selected for them, they would be able to switch plans, or affirmatively opt-out of coverage altogether.

For years, states have administered high-risk pools to help patients with the costliest chronic medical conditions who are otherwise without insurance. These patients often have life-long chronic conditions and benefit from disease-management and coordinated care. But for others, these patients can drive up premium costs in the individual market. State high-risk pools have helped to mitigate the impacts to the individual market.

Under our proposal, states could leverage such high-risk pools, with targeted federal funding, as a tool for ensuring that the patients with the costliest conditions have access to coverage while balancing the cost impact for other consumers in that state, as market changes are phased in. States would work with insurers to help identify the individuals with the highest health care costs among the a state's insured population and establish strong disincentives for excessive referrals to the high-risk pool, such as penalizing insurers seeking subsidization for individuals who are found to be unqualified for the pool.

Small businesses would be free under our proposal to band together to negotiate small business health plans, similar to how large employers are able to leverage purchasing power through their size. This step could help some businesses expand access to coverage and lower health care costs for these smaller firms.

States would also be allowed to enter into interstate compacts to facilitate greater pooling and ease the administrative burden of advancing innovative plan designs. This would give consumers the ability to shop for health plans across state lines while protecting the primacy of states regulating health insurance products.

## **Section 204: Expand and Strengthen Consumer Directed Health Care**

Consumer directed health care accounts have been critical for empowering patients' to help manage their health care costs, particularly for patients with chronic conditions. These accounts are well-liked by many Americans for good reason. Unfortunately, the full potential of these accounts has not been realized because of unfair policies regarding their use and eligibility. As a consequence of the health care law, funds in a Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Arrangement (HRA), and Archer Medical Savings Accounts (MSAs) may no longer be used to purchase over-the-counter medications. Repealing the health care law takes the critical step of restoring the ability to use these accounts for the purchase of over-the-counter medications as a qualified medical expense.

Targeted, commonsense reforms would help to expand eligibility for and the use of health savings accounts for consumers. Under our proposal, restrictions that limit the ability for veterans, service members, and individuals receiving care through the Indian Health Service would be removed in order to ensure that these individuals also have the ability to benefit from health savings accounts in managing their health care needs and expenses. HSAs would be further enhanced by allowing HSA funds to be used to pay premiums for long-term care insurance, COBRA coverage, and HSA-qualified policies. Spouses would be allowed to make catch-up contributions to the same HSA account. Taken together, these targeted, common-sense reforms would help to enhance HSAs as a tool for helping patients meet their health care needs and manage costs.

## **Title 3: Modernize Medicaid to Provide Better Coverage and Care to Patients**

### **Section 301: Transition to Capped Allotment to Provide States with Predictable Funding and Flexibility**

The status quo of today's Medicaid program is unsustainable. Federal spending is on an unsustainable course, yet federal mandates and bureaucracy too often restrict states' ability to make their programs more efficient, effective, and compassionate. Too often, this joint federal-state program promises coverage only to deny or delay access to care. In the face of rising health care costs and insufficient flexibility to make improvements, states are forced to make cuts to providers, which only further limits patients' access to care. Nationally, some 40 percent of physicians on average do not even see Medicaid patients. Modernizing Medicaid to provide better coverage and care to patients is part of putting our nation's health care system on a sustainable course.

Rather than reform Medicaid, Obamacare largely just expanded the broken status quo in ways that are unfair. For example, under Obamacare, federal taxpayers are on the hook for 90 cents on the dollar of care provided to working adults above poverty. This is unfair to the low-income mother with children, or the elderly blind person—the kinds of individuals who Medicaid was originally designed to help.

The truly compassionate approach to Medicaid is not expansion, but reform. Toward that end, states should be empowered with the financial certainty and programmatic flexibility to implement reforms that will strengthen and improve care for the low-income patients in their states. Financing reforms will make the program more sustainable for state and federal taxpayers, and better program management tools will make the program more fair, efficient, and accountable to the patients who depend on it.

At the individual level, to protect patients' choice, individuals eligible for Medicaid would also be eligible for and have the choice to use the health tax credit to help purchase health coverage. If a state auto-enrolled an eligible individual into Medicaid, that individual could retain the right to opt-out of Medicaid and use the health tax credit to purchase health coverage.

Building on bipartisan proposals of the past, states would adopt a capped allotment, where federal Medicaid dollars would "follow the patient" based on the patient's health status, age, and life circumstances. Under this

approach, states would continue to receive taxpayer-provided pass-through health care grants for pregnant women, low-income children, and low-income families. States would also receive a defined budget for long-term care services and support for low-income elderly or disabled individuals who do not avail themselves of the tax credit. These health grants would provide states with financial predictability and flexibility in designing and operating their programs to provide medical assistance for pregnant women and low-income families with children whose income and resources are insufficient to meet the costs of necessary medical care. Importantly, no changes would be made to the funding for the acute care of low-income elderly and disabled individuals.<sup>3</sup>

For the first year of implementation, funding for the health grants would be based on federal program costs for the previous year for the affected populations.<sup>4</sup> Funds would be allocated to states based on the number of low-income individuals at or below 100 percent of FPL. This capped allotment would grow over time at CPI+1 and reflect demographic and population changes. Basic program integrity and reporting requirements would ensure state accountability and transparency for taxpayers.

Empowering states with flexibility in administering the Medicaid program is also a critical aspect of modernizing the program to improve the quality of care offered and lower costs. Ultimately, this approach can better serve patients and taxpayers. States have asked for flexibility to better manage their states' needs for years. States and stakeholders have provided numerous recommendations we adopt that will improve states' abilities to better meet their patients' needs, including:<sup>5</sup>

- Offering value-based insurance design, premium assistance programs, care coordination and unique benefit design approaches to incentivize healthy behaviors and better manage or address complex, specific, or unique health care needs of Medicaid patients;
- Better integrating physician and behavioral care services;
- Carefully designed cost-sharing as a tool to encourage patients to follow treatment regimens and seek care in the most appropriate care setting;
- Empowering states with exclusive authority to establish provider rates and align provider incentives to increase accountability for episodes of care that will result in better outcomes for patients through more coordinated care at lower costs;
- Reducing federal Administrative barriers, such as more timely response to Medicaid waiver requests and waiver reciprocity so that the Department of Health and Human Services (HHS) would be required to approve a state's waiver request if a similar waiver had previously been approved for another state; and
- Providing states the option to define and negotiate a broad outcome-based Program Operational Agreement with the Centers for Medicare and Medicaid Services (CMS).

### **Section 302: Reauthorize Health Opportunity Accounts To Empower Medicaid Patients**

The Deficit Reduction Act (DRA) of 2005 established a 5-year demonstration program allowing up to 10 states to test alternative health benefits under Medicaid. States participating in the demonstration program were required to establish savings accounts—known as Health Opportunity Accounts (HOA)—that beneficiaries could use to pay for out-of-pocket medical expenses. The state and federal government could fund the accounts with up to \$2,500 annually for an eligible adult and \$1,000 for a child. The HOA had to be offered in conjunction with a high-deductible health plan as another way to better meet Medicaid patients' health care needs.

<sup>3</sup> The pre-Obamacare FMAP is continued for the acute care for the aged, blind, and disabled.

<sup>4</sup> Federal Medical Assistance Percentage (FMAP) allotments, Children's Health Insurance Program (CHIP) allotments, administrative costs, long-term care costs, and Disproportionate Share Hospital (DSH) allotments would be included in this calculation.

<sup>5</sup> We envision adopting the vast majority of reforms outlined in the Upton-Hatch "Making Medicaid Work" blueprint, as well as the "A New Medicaid" proposal, outlined by the Republican Governors Association. These documents are available online at: <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130501Medicaid.pdf> and <http://www.rga.org/homepage/gop-govs-release-medicare-reform-report/>

## **Title 4: Reducing Defensive Medicine Practices And Getting Rid of Junk Lawsuits**

### **Section 401: Medical Malpractice Reforms**

A majority of consumers and physicians agree that getting rid of junk lawsuits by reforming our medical malpractice system is a key component of lowering health care costs. Experts agree that the practice of defensive medicine adds billions to our nation's health care costs. Sadly, many of these costs come in the form of unnecessary medical tests, not based on the patient's benefit, but driven by a provider's worry about protecting themselves from costly junk lawsuits. While most litigation against health care providers does not result in a ruling against a provider, just one of these lawsuits can take years and consume thousands of dollars. Unfortunately, the costs of "defensive medicine" ultimately take a toll on patients' access to care—when the cost of insurance becomes too high, providers relocate or retire prematurely, thereby reducing patients' access to care. For example, a 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.<sup>6</sup>

Our proposal envisions adopting or incentivizing states to adopt a range of solutions to tackle the problem of junk lawsuits and defensive medicine. One crucial opportunity for medical liability reforms is to provide innovative, results-oriented solutions that offer injured patients the opportunity to receive compensation quickly and fairly without losing their access to the traditional court systems. For example, states could establish expert panels to provide an avenue for swift resolution informed by individuals qualified to evaluate the type of alleged injury. States could also elect to establish a state Administrative Health Care Tribunal, or "health court," 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. States could also encourage settlement of medical malpractice cases sooner by adopting patient compensation system reforms modeled after worker's compensation. Other ideas worthy of consideration include capping non-economic damages for claims tied to hospital admissions under the federal EMTALA mandate.

## **Title 5: Increasing Price Transparency to Empower Consumers and Patients**

### **Section 501: Requiring Basic Health Care Transparency to Inform And Empower Patients**

While supporters of Obamacare promoted the ability of consumers to compare the costs and coverage details of health insurance plans, the law itself drove up costs because of its rating requirements, heavy mandates, and expensive policies. Our proposal would lower health costs while adopting new measures to increase transparency on cost, quality, and outcomes, so all consumers are empowered with better information for their health care decision-making. Such information should be provided in an easy to use and accessible manner for consumers.

For example, health insurance plans would be required to disclose covered items and services, any plan limitations or restrictions, potential cost sharing, the actual cost of services, the claims appeal process, as well as the number and type of providers participating in the plan. This administrative simplification and disclosure of basic information is important so consumers have more comprehensive information.

We also would incentivize states with enhanced Medicaid grants if they establish and maintain requirements regarding the disclosure of information on hospital charges and make such information publicly available, and provide individuals with information about estimated out-of-pocket costs of health care services.

---

<sup>6</sup> "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](http://liberty.pacificresearch.org/docLib/20070327_Jackpot_Justice.pdf)

Today, many hospitals benefit from a range of specialized Medicare payments and non-profit hospitals benefit from favorable tax status. Therefore, as a principle of basic fairness, our proposal would require hospitals who participate in Medicare to provide to consumers the average amount paid by uninsured and insured patients for the most common inpatient and outpatient procedures. They would also be required to publicly post their charity care policies along with the amount of charity care provided. This would also help to increase transparency regarding health care costs and help inform patient's health care decisions.

## **Title 6: Reducing A Distortion in the Tax Code That Increases Health Costs**

### **Section 601: Capping the Exclusion of An Employee's Employer-Provided Health Coverage**

Today's tax treatment of health insurance is unfair to individuals and families who do not receive employer-sponsored health insurance, because the tax code is biased in favor of individuals who work for large companies.

But imposing taxes and mandates on individuals and businesses to pay for an unaffordable, massive new government entitlement is also unfair. Obamacare included more than a dozen new taxes, including taxes on pharmaceutical drugs and medical devices. We repeal those taxes which non-partisan experts agree will *increase* the cost of health coverage.

To help lower the cost of health coverage, our proposal takes a measured step to reduce a distortion in the tax code—the unlimited exclusion from a worker's taxes of employer-provided health coverage. This step is necessary and important, because economists across the political spectrum largely agree that the current distortion in the tax code helps to artificially inflate the growth in health care costs.

Therefore, our proposal caps the tax exclusion for employee's health coverage at 65 percent of an average plan's costs. The value of employer-sponsored health insurance would be capped and indexed to grow at an annual rate of CPI +1. This approach is certainly fairer than Obamacare, and it provides for more equitable tax treatment of health insurance, whether an individual is self-employed or works for a Fortune 500 business.

We believe Americans who enjoy their employer-sponsored health insurance should be able to continue to receive employer-sponsored insurance. Under our proposal, employers would retain the incentive to continue providing health coverage to their employees, because the provision of health coverage would still be deductible for the business. More importantly, our plan repeals the employer mandate which is one of the major drivers of erosion of employer-sponsored coverage under Obamacare. Therefore, this targeted approach would protect employer-sponsored health insurance.

The reforms outlined above are intended to achieve lower health care costs, and empower patients in their insurance choices and health care decisions, in a sustainable manner that at the very least does not add one dollar to our deficit if not reducing the deficit. Taken together, these reforms will better serve patients and the American people.

---

<sup>1</sup> For example: <http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/analysis/20130305PremiumReport.pdf>