CHAPTER 4: CONFRONTING HEALTH CARE CHALLENGES

- Chapter 4 of the *Report* offers the Obama Administration's defense of its signature law, the *Affordable Care Act*.
- The ACA has failed to make health care more affordable and accessible. It has left patients with fewer choices and less flexibility and facing rising costs.
- The *Better Way* health reform plan offers a framework for replacing the ACA with patient-centered reforms including: more choices, lower costs, more effective health care, and less bureaucracy.

THE FLAWED LEGACY OF THE AFFORDABLE CARE ACT

A Failed Rollout and New Federal Command to Purchase Insurance

The ACA was an attempt by the Obama Administration to make health insurance more affordable and prevalent through a top-down design reliant on a complex web of regulations, taxes, and incentives. However, the shrinking individual marketplaces, one of the pillars of the ACA, shows the failure of this government-centered approach.

Obamacare directed the establishment of a Federal health insurance marketplace for states that elected not to create their own exchange. Individuals without employer-sponsored insurance or coverage by a Government program—but with incomes too high to qualify for Medicaid—are required to purchase government-approved insurance either through the

ACA-established marketplace exchanges, or otherwise through the individual market. Those who choose insurance through Federal or State exchanges with incomes between 133 percent and 400 percent of the poverty line are eligible for Federal premium subsidies, which are sent directly to the insurer they select.[i]

In order to enforce the requirement that Americans have insurance that meets ACA requirements, the ACA created a tax on uninsured Americans known as the individual mandate that becomes more severe over time. The tax is now the higher of 2.5 percent of household income (capped at the national average price of a Bronze plan on the exchange) or $695 per adult and $347.50 per child (capped at $2,085).[ii]

The rollout of Obamacare was error-prone from the start. While the idea of an online health insurance marketplace was hardly innovative (for example, eHealthinsurance.com had operated since 1998),[iii] the Centers for Medicare and Medicaid Services (CMS) utterly botched the rollout of the Healthcare.gov website. The project was plagued from the outset with conflicting government directives and cost overruns. A Government Accountability Office (GAO) report found CMS incurred "cost increases, schedule slips, and delayed system functionality… From September 2011 to February 2014, [Federal marketplace] obligations increased from $56 million to more than $209 million. Similarly, data hub obligations increased from $30 million to nearly $85 million."[iv]

As if the growing costs were not bad enough, the website repeatedly crashed upon going live to the public.[v] Even after months of troubleshooting,[vi] Healthcare.gov continued to experience crashes.[vii] In March 2016, GAO released another report on Healthcare.gov's several ongoing weaknesses in security that could place sensitive information of enrollees at risk of disclosure, modification, or loss.[viii]

Subdued Enrollment and Missing Millennials

Privately funded insurance is based on sharing among a large group of policyholders the cost of adverse events that have an equal chance, as far as an insurance company can ascertain, of befalling any one of them and that is less than a certainty. Policyholders in such a group who choose the same coverage will pay the same premium. In the case of health insurance, that means policyholders who have the same risk of incurring medical costs and filing claims for cost reimbursement within a similar range are charged the same premium.

The ACA prohibits insurers from refusing to cover enrollees based on medical history or preexisting conditions.[ix] The ACA also narrowed the age-rating ratio band to 3:1 nationwide,[x] essentially meaning that older patients could not be charged more than three times what younger people paid for their policy. Prior to Obamacare, the most common ratio was 5:1. These requirements detach the premiums insurers can charge from the differential risks of and reimbursements paid to different groups of policyholders. Furthermore, the requirement to provide coverage, while well-intentioned, motivates consumers to avoid paying premiums while healthy and wait until they become ill before they purchase insurance, which raises the probability to insurers of having to reimburse them to 100 percent.

This is the problem of adverse selection: an increasing percentage of people who buy insurance need medical care and file insurance claims, which raises the cost of insuring the pool and drives up premiums. Young and healthy people who as a group face low risk and low medical expenses are charged premiums that exceed the value of insurance to them and cause them not to buy it. This development increasingly constricts the private insurance model built on cost sharing among large groups of policyholders with similar risk and reimbursement profiles. Obamacare relied on the individual mandate and associated taxes to combat adverse selection,[xi] but these measures and the program's design were not successful.

The technology magazine *WIRED* pointed out how technology failures added to the problem of adverse selection:

> *Since would-be buyers of health insurance in 36 states have no other options, many of them will simply not bother, regardless of the individual mandate. This goes especially for the 'healthy young people' demographic without whom the economics of Obamacare fall apart. Are 23-year-olds who don't really think they need health insurance anyway really going to 'queue' until Healthcare.gov deigns to let them in?* [xii]

Healthcare economists both inside the Obama Administration[xiii] and outside it[xiv] projected that the insurance exchanges would need roughly 40 percent of their enrollees to be young adults between the ages of 18-34 years of age. In reality, only about 28 percent of exchange enrollees were in this essential age bracket, and that percentage has changed little in the following years.[xv] Without these younger people sharing the cost of care for the older, sicker population, insurers are forced to increase the price of insurance or leave the marketplaces entirely.

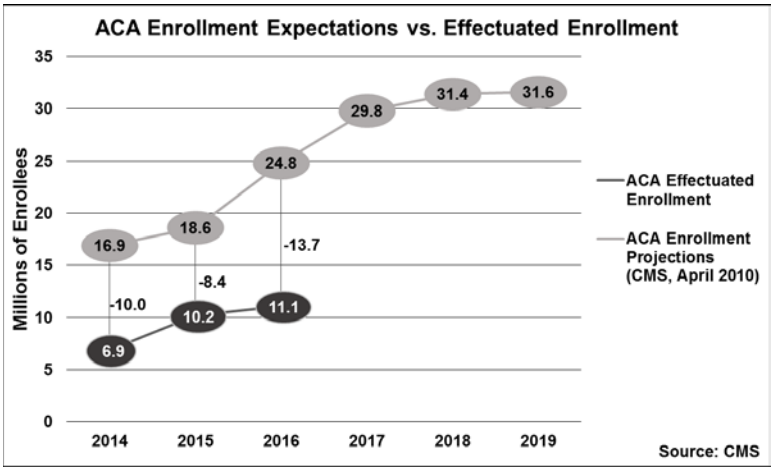
A 2016 report from BlueCross BlueShield found that its enrollees in ACA plans tended to be sicker overall and had expenses 22 percent higher than enrollees in its employer-sponsored plans.[xvi] The Obama Administration suggested this should not be a surprise since the ACA mandated everyone regardless of health status have access to health insurance.[xvii] However, Obamacare was expressly written with incentives and punishments intended to keep these premium costs down and enrollment numbers of healthy people up. The Obama Administration's complex web of Federal policy failed to do so.

Enrollment of younger and healthier individuals is not the only lagging projection. Total enrollment in the Obamacare exchanges has also underperformed expectations. In 2010, the chief actuary

of CMS predicted that in 2014, the first year of marketplaces implementation, 16.9 million people would enroll.[xviii] CBO made more conservative estimates in 2010 with a prediction of eight million exchange enrollees.[xix] The actual effectuated enrollment, measuring those who both selected a plan and paid their premium, fell far short of the rosy CMS projection. Only 6.9 million people signed up and paid for a plan in 2014.[xx]

Actual, effectuated enrollment continues to underperform in the ACA individual marketplaces. CMS projected that in 2015 18.6 million people would be enrolled, 24.8 million would be enrolled by 2016, and 29.8 million would be enrolled by 2017. Even the more conservative CBO projections, which varied depending on the year, as recently as January 2015 predicted that 2015 enrollment would be 12 million people, 2016 would see 21 million people enrolled, and 25 million people would be enrolled by 2017.[xxi] Actual enrollment in the first quarter of each year was well below expectations with 10.2 million in 2015[xxii] and 11.1 million in 2016 (Figure 4-1).[xxiii]

Figure 4-1



The 2017 numbers are not shaping up to be much better. According to the most recent report from CMS, 11.5 million people selected a 2017 marketplace plan as of December 24,

2016.[xxiv] The Department of Health and Human Services (HHS) predicted that 13.8 million people will select a plan by the end of open enrollment on January 31, 2017.[xxv] On average about 13 percent of open enrollees will not be effectuated by paying the first month's premium by the end of the first quarter. Assuming that the Obama Administration will finally accurately predict enrollment, and the usual drop-off between enrollment and effectuation occurs, then only 11.9 million people will remain enrolled by the end of the first quarter. Additionally, CBO continues to downgrade projections on ACA marketplace enrollment and projects just ten million people on average will be enrolled in the marketplace through 2017, less than occurred in 2016.[xxvi]

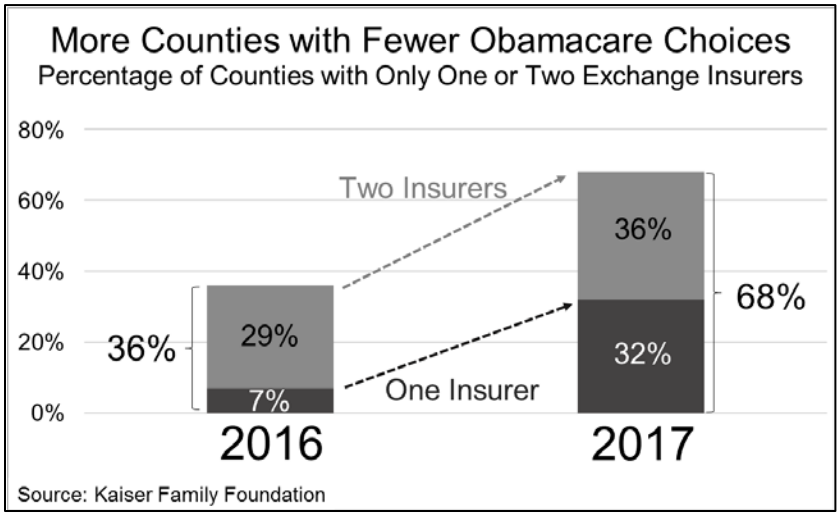
Failing to meet enrollment targets has consequences far beyond embarrassing the ACA's proponents. A larger risk pool helps to ensure costs such as premiums and deductibles stay low for the people who enroll in these plans. Insurance companies must raise rates in order to pay for the increased costs of caring for a smaller risk pool with sicker enrollees. Failing to meet expectations has very real, very expensive consequences on a population the ACA was intended to help.

Insurers Leaving the Marketplace

A common Obama Administration claim was that if customers shopped around on the ACA marketplaces, they could lower their premium costs.[xxvii] While it is true that more competition tends to drive down costs, this method of controlling costs works more effectively in markets where consumers have an actual choice. Unfortunately, that is not the case in many states. From 2016 to 2017, the number of counties nationwide with only one insurer offering insurance on the exchange increased from 225 to 1,021. Five states will have just one insurer in their marketplace in 2017, up from one in 2016.[xxviii] As the chart below illustrates (Figure 4-2), the number of counties with only two insurance choices also increased significantly. In total, roughly seven in ten counties now

have only one or two insurers in their exchanges, which is hardly a meaningful choice.

Figure 4-2



Obamacare architect Jonathan Gruber understood that competition helps lower premiums,[xxix] and the Obama Administration as recently 2016 stated, "Increased numbers of issuers in a market means more competition. More competition tends to put downward pressure on premiums."[xxx] In a report from 2015, HHS found that counties with three or more insurance choices had ACA benchmark plan premiums that were nine percent lower than counties with just one or two providers.[xxxi] As insurers continue to leave the ACA marketplaces, more Americans will face higher premiums and fewer choices.

The Obamacare CO-OP Implosion

Unsurprisingly, the *Report* contains no discussion of the ACA's Consumer Operated and Oriented Plans (CO-OPs). Insurers participating in CO-OPs were given $2.4 billion in Federal support to create plans that were ultimately incapable of being sustained. The Obama Administration originally provided funding for 24 CO-OPs, one of which failed before open enrollment even began, leaving 23 CO-OPs across 25 states. The likelihood of CO-OP

failure was clear from the beginning; even initial HHS estimates predicted about one-third of all loans would not be repaid, amounting to roughly $792 million not including forgone interest.[xxxii] Yet, the Obama Administration never established criteria to determine whether a CO-OP was viable or sustainable,[xxxiii] further increasing the risk to the Federal Government. As a result of the flawed design, 21 of the CO-OPs reported net losses in 2014.[xxxiv] Another was forcibly taken over by the Iowa State Insurance Commissioner because of financial instability and was ultimately liquidated.[xxxv]

As of 2017, only five of the 23 CO-OPs have not failed, and many of the survivors are suffering financially.[xxxvi] The cost of these failing CO-OPs will be borne by the taxpayers, based upon the Obama Administration's initial assumptions. Worse than the original HHS estimates that one-third of the CO-OP loans would not be repaid,[xxxvii] the total taxpayer loss as of 2017 approaches $1.9 billion.[xxxviii]

Examining the experience in Ohio, the CO-OP InHealth Mutual recorded a loss of $80 million in 2015, including a $32 million cushion for expected losses in 2016.[xxxix] Upon entering the exchanges, InHealth experienced tripling enrollment and an almost sevenfold increase in revenue. But the influx in new enrollees and revenue was not enough to keep the insurer operating. By May 2016, InHealth faced the choice of raising premiums by at least 60 percent in 2017 or shutting down to prevent further losses. The insurer had completely used its capital cushion from 2015 and almost all of the $113 million loaned to it from the Federal Government.[xl] InHealth became another CO-OP casualty of Obamacare and forced 22,000 Ohioans to scramble to find a new insurer within 60 days or go without health coverage.[xli]

In Utah, Arches Health Plan applied to raise its 2016 insurance prices by an average of 43 percent. Even with such drastic rate increases, Arches failed in October 2015. Its failure sent 66,000 consumers searching to find new insurers. Those 31,000 Utahans

who bought Arches on the exchanges were faced with a familiar problem under Obamacare: approximately two-thirds of Utah counties only had one insurer on the exchange.[xlii] Doctors and hospitals also suffered from the collapse of Arches. By the middle of 2016, Arches still had not paid over $30 million to hospitals throughout Utah.[xliii] It remains to be seen how much of the over $89 million Federal loan given to Arches will be repaid.[xliv] In many ways, InHealth and Arches exemplify a common problem with the ACA: Americans facing a loss of their plans are forced into making more expensive choices, while taxpayers are liable for much of the cost.

Rising Rates

The degree to which premiums increase can vary depending on the condition of the insurance markets in a particular state. Between 2014 and 2015, average marketplace premiums increased modestly.[xlv] However, premiums for 2017 plans have skyrocketed in both the exchanges and elsewhere in the individual market. In an analysis of individual market plans, weighted by the number of people covered by each plan, the Committee Majority found that the national average premium faced by consumers increased by over 25 percent.[xlvi] On the exchanges, the price of the benchmark silver plans increased by an average of 22 percent nationwide. Among other reasons, missing healthy enrollees and lack of competition are causing the premiums for insurance in ACA plans to increase.

Figure 4-3

STATE	RATE INCREASE
National Average	**25.2%**
Alabama	**36.1%**
Alaska	**7.3%**
Arizona	**53.7%**
Arkansas	**9.6%**
California	**14.3%**
Colorado	**20.4%**
Connecticut	**24.8%**
District of Columbia	**7.3%**
Delaware	**31.5%**
Florida	**19.1%**
Georgia	**27.4%**
Hawaii	**31.2%**
Idaho	**24.0%**
Illinois	**50.3%**
Indiana	**18.7%**
Iowa	**30.1%**
Kansas	**36.6%**
Kentucky	**24.4%**
Louisiana	**31.6%**
Maine	**23.5%**

Maryland	**25.1%**
Massachusetts	**9.2%**
Michigan	**16.7%**
Minnesota	**55.5%**
Mississippi	**15.8%**
Missouri	**27.9%**
Montana	**48.2%**
Nebraska	**33.1%**
Nevada	**10.6%**
New Hampshire	**8.3%**
New Jersey	**8.5%**
New Mexico	**29.5%**
New York	**16.6%**
North Carolina	**24.3%**
North Dakota	**2.0%**
Ohio	**16.6%**
Oklahoma	**76.0%**
Oregon	**26.8%**
Pennsylvania	**32.5%**
Rhode Island	**1.5%**

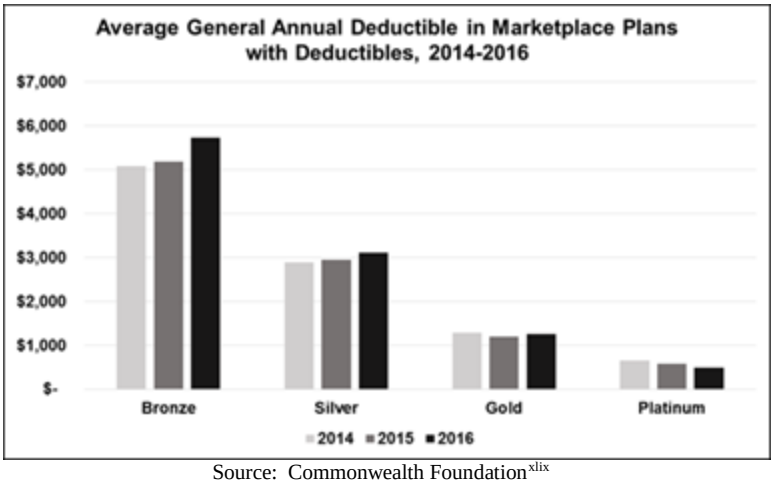
Figure 4-3 (Continued)

STATE	RATE INCREASE
South Carolina	**27.0%**
South Dakota	**37.0%**
Tennessee	**56.2%**
Texas	**34.0%**
Utah	**31.1%**
Vermont	**7.0%**
Virginia	**18.5%**
Washington	**13.6%**
West Virginia	**36.3%**
Wisconsin	**15.9%**
Wyoming	**7.4%**

Source: JEC Staff Calculations.

Aside from the harm inflicted by rising premiums, deductibles and other out-of-pocket costs are also increasing. In 2016, bronze-level plans had deductibles over $5,700 and silver plan deductibles climbed to $3,100.[xlvii] High deductibles make using the health insurance that consumers are forced to buy even more expensive to use. Numerous media reports describing how consumers cannot afford to use their ACA health insurance should not be surprising.[xlviii]

Figure 4-4



Source: Commonwealth Foundation[xlix]

"If You Like Your Insurance…"

For many, one of the most infuriating effects of the ACA was the damage it did to the existing health insurance landscape. Repeatedly, President Obama and his Administration pledged that if people liked their doctor, they could keep their doctor and if they liked their health insurance plan, they could keep their plan.[l] In practice, however, this proved to be untrue. Fact checkers from various media outlets rated the President's claims as "false,"[li] or a "pants on fire"[lii] lie. Politifact called President Obama's much-repeated claim the Lie of the Year in 2013.[liii]

Obamacare required all health insurance plans to meet Federally mandated minimum standards, including requiring them to cover types of care an individual may not want or need.[liv] After the ACA's enactment, millions of people who were enrolled in health plans received notices that their plan would no longer be offered.[lv] By some estimates, roughly four million Americans lost their health insurance despite the President's promises.[lvi] While some plans could be grandfathered and allowed to continue, these plans must have existed on March 23, 2010, covered a particular person as of that date, and not have changed substantially since then.[lvii] These caveats made it difficult for plans to qualify for or maintain

grandfathered status, thus rendering the original promise functionally moot.

Employer-Sponsored Insurance under the ACA

Employer-sponsored health insurance (ESI) plans cover half of the non-elderly population in the United States.[lviii] As a result, government tinkering with ESI affects a large number of Americans across the nation. Given this, proposed changes to the ESI market should be carefully considered.

The Obama Administration attempted to take credit for the relatively slow premium increases in the employer-sponsored insurance market.[lix] But there are several problems with this claim. The first is that the trend of smaller growth in premiums predates the Obama Administration, and evidence suggests broader economic trends slowed the growth of health care spending. Second, President Obama promised repeatedly that his Administration would significantly *decrease* costs for the average American family.[lx]

The *Report* stated, "The average premium for employer-based family coverage was nearly $3,600 lower in 2016 than it would have been if nominal premium growth since 2010 had matched the average rate recorded over the 2000 through 2010 period."[lxi] This overview ignores that the "slowdown" in premium growth actually began in 2005. According to CBO, "private insurance premiums grew more slowly from 2005 to 2013 (4.5 percent per year, on average) than they did from 2000 to 2005 (9 percent per year)."

+[lxii] This slower growth found by CBO is in line with average growth rates seen in the first years of the ACA, but it is a trend that predates both the ACA and the Obama Administration.

Premiums may have increased more slowly than in the prior decade, but employees are taking on a larger share of those premiums. According to a Kaiser Family Foundation survey, employees with single coverage were expected to cover roughly

14 percent of their premiums in 1999, but 18 percent by 2016. For family coverage, employees were expected to cover 27 percent of their premiums in 1999, but by 2016 this increased to 30 percent.[lxiii] To make matters worse, premiums have increased faster than wages.[lxiv] Employee pay raises are outstripped by premium growth.

In summary, the last Administration claimed that premiums would decrease for the typical American family, but premiums have increased. The *Report* claimed that the ACA has lowered the rate of increasing premiums, but broader structural trends contributed significantly to slower growth in health care spending and premiums. CEA named a section of the *Report* "Higher Wages, Lower Premiums, and Lower Out-of-Pocket Costs for Workers." However, wages have increased more slowly than premiums and workers shoulder a greater share of plan costs.[lxv]

"I will not raise taxes on the middle class…"

Despite President Obama's pledge not to raise taxes on those making less than $200,000 ($250,000 if filing jointly) per year,[lxvi] several new taxes among the over $1 trillion in Obamacare tax increases hit Americans with incomes far below that threshold.[lxvii] The Joint Committee on Taxation (JCT) confirmed that many ACA taxes affect lower-income taxpayers, either directly by increasing their tax burden or indirectly through higher consumer prices arising from taxes on insurance and health care products. Significantly, JCT found that one tax alone—the tax increase on people with high medical expenses—will hurt more low- and middle-income Americans in 2017 than will be helped with premium tax credits.[lxviii]

While JCT and CBO have not provided detailed estimates of each of the taxes in recent years, the House Ways and Means Committee compiled information contained in Figure 4-5 based on 2012 projections. Provisions in bold represent taxes affecting the middle class. Figure 4-5 also illustrates how the size of the

total tax increase nearly doubled from 2010 estimates as more taxes phased in and grew in severity.

Figure 4-5

Provision	2010 10-year estimate	2012 10-year estimate
Additional 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)	210.2	317.7
"Cadillac tax" on high-cost plans	**32**	**111**
Employer mandate	**52**	**106**
Annual tax on health insurance providers	**60.1**	**101.7**
Individual mandate	**17**	**55**
Annual tax on drug manufacturers / importers	**27**	**34.2**
2.3 percent excise tax on medical device manufacturers / importers	**20**	**29.1**
Limit flexible spending arrangements (FSAs) in cafeteria plans	**13**	**24**
Raise 7.5 percent adjusted gross income floor on medical expense deduction to 10 percent	**15.2**	**18.7**
Deny eligibility of "black liquor" for cellulosic biofuel producer credit	23.6	15.5
Codify economic substance doctrine	4.5	5.3
Increase penalty for nonqualified health savings account (HSA) distributions	**1.4**	**4.5**
Limit use of HSAs, FSAs, and health reimbursement arrangements to purchase over-the-counter medicines	**5**	**4**
Impose fee on insured and self-insured health plans for patient-centered outcomes research trust fund	**2.6**	**3.8**
Eliminate deduction for expenses allocable to Medicare Part D subsidy	4.5	3.1

Figure 4-5 (Continued)

Provision	2010 10-year estimate	2012 10-year estimate
Impose 10 percent tax on tanning services	**2.7**	**1.5**
Limit deduction for compensation to officers, employees, directors, and service providers of certain health insurance providers	0.6	0.8
Modify section 833 treatment of certain health organizations	0.4	0.4
Other revenue effects	60.3	222
Additional requirements for section 501(c)(3) hospitals	Negligible	Negligible
Employer W-2 reporting of value of health benefits	Negligible	Negligible
Form 1099 reporting for small businesses	17.1	Repealed by P.L. 112-9
TOTAL GROSS TAX INCREASE (BILLIONS OF DOLLARS)	569.2	1,058.3

Source: House Ways and Means Committee, 2012

Additionally, other taxes aimed at higher-income individuals may diminish job opportunities for lower-income Americans by increasing business tax burdens. As mentioned in Chapter 8 of this *Response*, the ACA's 3.8 percent investment income tax contributed to the top tax rate on small businesses rising from 35 percent when President Obama took office to 44.6 percent today.[lxix]

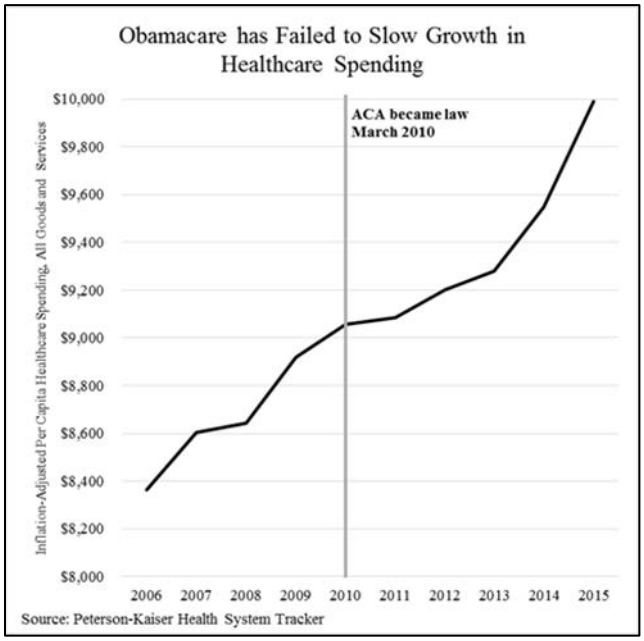
Addressing the Costs of Health Care

The *Report* claimed that the ACA has been responsible for slowing costs in the American health care system by fundamentally altering the cost structure.[lxx] It is true that measurements from 2011 to 2013 showed unusually low growth in health care spending, partially due to low growth in the economy as a whole.

However, health care spending growth had been on a long-run downward trajectory before the Obama Administration, casting doubt on the claimed positive impact of the ACA. Health care economists from Johns Hopkins and the University of Southern California found that at "…least 70 percent of the recent slowdown in health care spending can likely be explained by long term patterns…the Great Recession's effect on reduced real per capita income and subsequent effect on reduced health care spending, as about 41 percent of the recent slowdown can be explained by these reductions in income." [lxxi] Since health care spending grew more slowly in the last recession, it follows that spending growth would continue to be slow a few years into the slowest economic recovery in the modern era.[lxxii]

Further, spending returned to its previous course in 2014 and 2015. National Health Expenditures (NHE) grew 5.3 percent in 2014 (the first year of the ACA exchanges) and 5.8 percent in 2015, with CMS predicting average annual NHE growth of 5.8 percent per year from 2015 to 2025.[lxxiii] From 2001 to 2005, NHE grew by an average of 8.1 percent per year; from 2006 to 2010 by 5.1 percent, and from 2011 to 2015 by 4.3 percent.[lxxiv] The projected 5.8 percent increase per year from 2015 to 2025 represents a steeper trend than the expenditure growth seen from 2006 to 2010 prior to Obamacare passage. CMS projects that health care expenditure growth will continue to outpace GDP growth by 1.3 percentage points per year through 2025, with NHE increasing to more than a fifth of GDP by 2025, up from 17.5 percent in 2014.[lxxv] Additionally, the Obama Administration's CMS found that part of the recent and future expected acceleration in health spending is due to the ACA.[lxxvi] The chart below shows the sharp uptick in costs per person in recent years as the ACA became fully implemented.

Figure 4-6



Further, the Obama Administration's CMS attributed some slowdown in spending growth to "trends such as increasing cost-sharing in private health insurance plans and various Medicare payment update provisions."[lxxvii] As noted previously, unaffordable deductibles discourage Americans from seeking care.

SOLUTIONS FOR CONSUMER-DRIVEN HEALTH CARE

As discussed later in this chapter, consumer-driven health care is a much better method of controlling costs, since it both provides patients a means of affording cost-sharing and empowers them to make wise decisions about how their health care dollars are spent. Improvements in efficiency driven by market forces is beneficial for patients and the system as a whole, but making health care so unaffordable that patients cannot access the care they need should not be an acceptable method of cost containment. Unfortunately, the ACA's poor design has caused skyrocketing premiums for plans with increasingly unaffordable deductibles.

A Better Way

In light of Obamacare's failure to fix the health care system through onerous regulation and mandates, the Committee Majority recommends moving in a more productive direction. To that end, the *Better Way: Health Care*[lxxviii] blueprint provides a useful framework for replacing the ACA. The *Better Way's* health proposals are structured around a number of major principles and policies that aim to maintain access to coverage, improve portability and consumer control, and contain health care costs.

Consumer-Directed Health Care

One of the most unfortunate features of Obamacare was that it placed the Federal Government in the center of managing health care for many Americans. Rather than one-size-fits-all prescriptions from Washington, the *Better Way* proposes improved consumer involvement through the expansion of Health Savings Accounts (HSAs) tied to High-Deductible Health Plans (HDHPs). This combination protects consumers from unexpected catastrophic health care expenses while allowing patients themselves to manage day-to-day health care expenses using funds in tax-favored accounts. This provides greater patient control over health care decisions, allowing consumers to understand the costs of care and make their own decisions about when and where to seek treatment.[lxxix]

The Kaiser Family Foundation has estimated that 29 percent of covered workers who obtain insurance from their employer are enrolled in HDHP/HSA or HDHP/Health Reimbursement Arrangement (HRA)[lxxx] plans, compared to only 4 percent in 2006. However, this popular type of health insurance was treated unfavorably by the ACA. The *Better Way* would roll back undue restrictions imposed by the ACA and also make several reforms, including allowing spouses to make catch-up contributions to a joint HSA account, allowing qualified medical expenses from 60 days prior to the start of coverage to be reimbursed from an HSA,

setting the contribution limit for HSAs equal to the combined deductible and out-of-pocket expense limit of the associated HDHP, and expanding access to HSAs to groups such as those covered by TRICARE and the Indian Health Service. The *Better Way* provides consumers the flexibility to choose the plan, whether HDHP/HSAs or another option, that best meets their health care needs.[lxxxi]

Price Transparency in Health Care

One serious flaw in the American health care market is a lack of price transparency. Patients and consumers are not able to comparison-shop effectively for coverage and care if cost levels are opaque and only become apparent once care has been received. This information asymmetry leads to higher prices for consumers and an inefficient health care market. Thus, a critical aspect of reforming the system must be requiring price transparency, which will bring down prices by allowing consumers to make informed decisions about their health care purchases and injecting competitive pressures into the health care sector that lower costs. This approach is particularly important when paired with consumer-direct health care options such as increasingly popular HDHP/HSAs.

Health Insurance Portability

Another major issue confronting the American health care system is the lack of portable health insurance. For millions of Americans, access to affordable insurance means finding work with an employer who offers coverage and staying with that employer to maintain it. The *Better Way* envisions a future in which Americans can transition easily from employer-based group coverage to individual plans without major disruptions in their health care. The cornerstone of this plan is a universal refundable tax credit, adjusted for age and inflation, for those who do not have access to care through their employer, Medicare, or Medicaid. This credit would facilitate access to private insurance, allowing

consumers to select a plan with coverage that is right for them rather than approved by Washington bureaucrats. This will fill the coverage gaps left by Obamacare, eliminate the work disincentives in Obamacare's core structure,[lxxxii] and free workers from being locked into a job to maintain insurance. A secondary benefit is that the tax credit structure will help control premium costs. While Obamacare subsidies automatically increase payouts to insurers when insurers raise rates, the *Better Way* premium tax credit is tied to broader measures of inflation that will require insurance companies to compete and control costs for consumers.[lxxxiii]

Purchasing Coverage across State Lines

In the current health care system, consumers are confined to purchasing health plans licensed in their state of residence. This restriction reduces competition and can drive up insurance prices. In contrast, *Better Way* reforms allow individuals to purchase plans licensed in other states, thereby increasing competition and consumer choice while driving down prices. Additionally, expanding the health insurance markets across state lines opens up new opportunities with interstate pooling compacts.[lxxxiv]

Expanding Opportunities for Pooling

In 2015, a National Federation of Independent Businesses survey identified cost as the single largest obstacle small businesses face in offering health insurance to their employees.[lxxxv] While Obamacare has failed to address this barrier, the *Better Way* proposes a different path that allows small business to band together (pool) to offer small business health plans, also called association health plans (AHPs). This would allow small businesses and voluntary organizations to join in offering health coverage at lower prices through improved bargaining power and more diverse risk pools. The *Better Way* would prohibit plans from selecting only the healthiest individuals and prevent plans

from charging more to those who are sick in excess of state statutory limits.[lxxxvi]

Similarly, the *Better Way* would allow individuals to band together into individual health pools (IHPs). Like AHPs, IHPs allow individuals to leverage more market power to drive down costs. IHP enrollees would have the same protections against undue discrimination as those in AHPs and would see the same advantages of access to affordable coverage.[lxxxvii]

Protecting Employee Wellness Programs

Many employers support programs that reward employees for taking steps to improve their health, such as participation in smoking cessation and weight loss programs. Unfortunately, the Obama Administration took a different view with increasing regulatory burdens and legal challenges that undermines the ability of insurers to promote these mutually beneficial programs for employees. The *Better Way* guarantees that employers may offer wellness programs that include financial rewards or surcharges, so long as those programs do not exceed limits imposed under current statutes. Additionally, it provides legal protections for these programs, while ensuring that voluntary collection of medical information from an employee's family member complies with the *Genetic Information Nondiscrimination Act*. Taken together, these steps would allow employers to offer wellness programs without fear of costly litigation and regulation from Washington.[lxxxviii]

Protecting Flexibility for Employers to Self-Insure

Many companies in the United States choose to provide health insurance directly to their employees rather than contracting with a third-party insurer. This allows companies to design a structure that is best for their workforce. However, they also assume the financial risk involved in paying for claims directly. For this reason, many companies with self-insurance arrangements purchase stop-loss insurance to protect against extreme,

unexpectedly high claims or expenses. This is a necessary part of making self-insurance flexible and affordable.[lxxxix]

Unfortunately, rather than encouraging these tools, the Obama Administration has tried to block employers from self-insuring through costly regulation and has threatened to define these stop-loss insurance policies as "group health insurance," subjecting these intentionally narrow policies to Federal regulatory burdens and limits on their use. Instead of undermining an effective and flexible insurance arrangement because it doesn't conform to one-size-fits-all Washington mandates, the *Better Way* protects employers' ability to both self-insure and to purchase stop-loss coverage without Federal interference.[xc]

Medical Liability Reform

Washington's failure to enact medical liability reform has had negative repercussions for many Americans. The system has imposed enormous unnecessary costs both on physicians and patients. Estimates show that reforming medical liability would save the nation's health care system $300 billion in costs each year.[xci] California and Texas, among other states, have made progress in medical liability reform. In the states without reform, injured patients receive only 46 cents of every dollar awarded; the rest is lost to attorneys and administrative fees.[xcii] The reforms proposed in the *Better Way* cap non-economic damages at reasonable levels while ensuring that wronged patients are able to recover all economic damages and that these damages will not be diverted to excessive contingency fees. The plan will also work with the states to develop innovative ways to reduce frivolous lawsuits and defensive medicine, while improving accountability and encouraging professionalism in the medical community.

Pre-Existing Condition Coverage and Other Reforms

The *Better Way* plan would prohibit insurers from turning away or limiting coverage on the basis of a pre-existing condition. The plan also allows dependents to stay on their parents' plan through

age 26 and prohibits insurers from imposing lifetime limits on coverage. In addition, the framework bars insurers from cancelling or refusing to renew coverage to any American simply because of illness or health condition.[xciii]

Continuous Coverage Protections

The *Better Way* expands protections for Americans that maintain continuous health insurance coverage—already a successful feature of the employer-based market—to apply to the individual insurance market. Under the blueprint, any American who maintains continuous coverage cannot be charged more than standard rates when they change insurers due to a qualifying life event. This ensures that insurance is portable, and no longer ties an individual to a particular employer or insurance plan.[xciv]

One-Time Open Enrollment

The *Better Way* will provide a one-time open enrollment period to allow previously uninsured Americans to purchase coverage regardless of their health or age as if they had previously been insured. This would allow patients to take advantage of the new continuous coverage protections. Individuals could choose to forego enrollment without penalty, but doing so would forfeit the continuous coverage protections, which could lead to higher health insurance premiums in the future.[xcv]

Fixing Age Rating Bands

Prior to the ACA, most states used a 5:1 age rating ratio under which the standard premium of an older individual's plan could be no more than five times that of a younger person's standard premium. However, the ACA mandated a universal 3:1 age rating ratio, which in practice has proved unrealistic and has led to an insurer market bereft of younger and healthier Americans. The *Better Way* returns the default age rating ratio to the proven 5:1 standard, but allows individual states the flexibility to adjust it at

their discretion to better suit the conditions of their markets and the needs of their citizens.[xcvi]

Grants for State Innovation

States have long been laboratories of government policy, testing new and innovative approaches to solve problems within their communities. The *Better Way* invests at least $25 billion in performance-based, sliding-scale State Innovation Grants to reward states that find effective ways to make health care more accessible and less expensive.[xcvii]

Robust High-Risk Pools

State-based high-risk pools provide financial assistance to high-risk individuals who are priced out of traditional insurance markets. The *Better Way* allocates at least $25 billion in Federal funding for high-risk pool programs, which the Federal Government would operate in partnership with the states.[xcviii]

The Need for Medicaid Reform

Medicaid is a crucial safety net for our nation's most vulnerable patients. It currently covers almost 72 million Americans, with estimates approaching 98 million who could be covered by the program at some point in a given year.[xcix] Largely because of the expansion under the ACA, Medicaid spending has increased dramatically and is expected to double over the next decade.[c]

The GAO has designated Medicaid as a program with a high risk for fraud and abuse because of its "size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight."[ci] As Medicaid struggles to contain these issues, it also faces issues with excessive red tape and major lapses in oversight that led to continuing payments to banned providers and millions of dollars in benefits for deceased beneficiaries.[cii]

Additionally, the ACA changes to Medicaid detract from the core mission of the program by providing a higher rate of Federal

matching funds for able-bodied adults with household incomes above the poverty line than it does for those who are disabled, elderly, or living in poverty. This creates a perverse budgetary incentive for states with financial challenges to cut services for the more vulnerable traditional Medicaid population.[ciii]

These new issues combine with older, longer-standing flaws and perverse incentives to cause a drag on the entire Medicaid system. The *Better Way* plans to bring Medicaid into the 21st century by providing Medicaid recipients and states with more choices and flexibility.

Fixing Obamacare's Medicaid Trap

Obamacare expanded eligibility for Medicaid to individuals with incomes up to 138 percent of the poverty level.[civ] At the same time, it prohibited those eligible for Medicaid from receiving insurance subsidies in the exchanges. In the states that did not expand Medicaid income eligibility to 138 percent, ACA guidelines required individuals to earn at least 100 percent of the poverty level to qualify for a premium subsidy. That left two and a half million low-income Americans below 100 percent of the poverty level with a dilemma: in spite of Obamacare's command that they have insurance, they earned too much to qualify for traditional Medicaid and too little to get help affording a private plan.[cv] Essentially, Obamacare left them with no meaningful coverage option.

Others in the Medicaid system discovered that they could not obtain necessary care. A report from the HHS Office of Inspector General examined the most prevalent type of Medicaid structure and found a troubling lack of access to care:

> *We found that slightly more than half of providers could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but said that they were not participating*

> *in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month, and 10 percent had wait times longer than 2 months. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times.* [cvi]

A Kaiser Family Foundation survey found similar results with 67 percent of primary care physicians refusing to accept new Medicaid patients, compared with 94 percent who accept new patients with private insurance.[cvii] A study by the nonpartisan Medicaid and CHIP Payment and Access Commission (MACPAC) observed that over a third of "Medicaid enrollees report greater difficulty obtaining care from specialists."[cviii] Clearly, patients with private insurance have an advantage in accessing care. Further, while those newly covered through Medicaid are accessing more care than those without insurance, no data suggest their health outcomes are better now thanks to the ACA.[cix]

Unlike the ACA, which provides only a one-size-fits-all choice for low-income Americans—and in some cases no choice at all—the *Better Way* would allow those eligible for Medicaid to leave that system and use the premium tax credit to purchase a higher-quality private plan.[cx]

More Medicaid Choices for States

Under the current system, states must ask the Federal Government for waivers—which are not always granted—if they seek to adjust Medicaid requirements to better suit the needs of their population.[cxi] The *Better Way* provides states more authority to design Medicaid to fit the needs of their state, including allowing them to expand coverage. It will also provide transition relief in

the states that have already expanded coverage. States could choose a more traditional approach by receiving a per capita allotment based on the history of Medicaid spending in that state, or a block grant that would allow more flexibility and innovation in serving the Medicaid population. Under either option, states would be required to fulfill the Medicaid purpose of serving the most vulnerable populations.[cxii]

Promoting Innovation in Health Care

The *21st Century Cures Act*, which was passed by Congress and signed by President Obama on December 13, 2016,[cxiii] was a bipartisan effort to accomplish a variety of health objectives. In particular, the legislation reduces regulatory barriers to analyzing health data, modernizes the process for clinical trials, provides incentives and funding for research into curing new diseases, and seeks to unleash the power of precision medicine and other new technologies to improve health care in the United States. Enactment of this legislation was a major step forward, and the *Better Way* seeks to build on it by reforming restrictions on electronic health records in order to spur innovation and technology-driven improvements in care while protecting patient privacy. These records would be portable for consumers, freeing patients from paperwork burdens each time they see a new provider and preventing medical errors that occur because of incomplete information about medical history.[cxiv]

Preserving and Protecting Medicare

Medicare currently serves 57 million older Americans and people with disabilities. However, the program faces a number of critical challenges in the 21st century that render it unsustainable in the longer term due to both its expected spending growth and complex structure. Obamacare's treatment of Medicare has been described in the *Better Way* as "raid and ration." First, the ACA instituted cuts to the Medicare program that now amount to $800 billion. Rather than using program savings to ensure the long-term

sustainability of the program for beneficiaries, the ACA diverted those funds to finance other Obamacare programs. Another unpopular feature of the ACA established the unelected Independent Payment Advisory Board, which some fear will lead to rationed care for beneficiaries, as described next. The *Better Way* instead focuses on a three-step approach to make Medicare sustainable for current and future beneficiaries: repealing the most damaging Obamacare provisions, adopting bipartisan reforms to make the program sustainable and offer greater choice to beneficiaries, and placing Medicare on a sound long-term path.[cxv]

Repeal IPAB

The Independent Payment Advisory Board (IPAB) is a 15-member panel of bureaucrats created by Obamacare with the task of reducing Medicare spending if it exceeds certain targets. However, the panel is prohibited from changing beneficiary cost-sharing eligibility or benefit levels; as a result, rationing care is the only legal option available to it. It is also empowered with significant rulemaking powers that can only be reversed with an overwhelming vote in both chambers of Congress. The *Better Way* provides a more humane way to contain costs through market-driven competition and structural reform.[cxvi]

The Status Quo is Unsustainable

CBO's January 2017 baseline projects that, under current law, the Medicare Hospital Insurance (HI) trust fund will be exhausted in 2025, a full year earlier than its March 2016 projections had anticipated.[cxvii] That same year, total spending on Medicare will exceed any offsetting receipts by more than a trillion dollars, worsening as more time passes. The current course will not preserve Medicare for future generations.

Strengthening Medicare Advantage

Medicare Advantage (MA), originally established in 2003, is a voluntary program within Medicare that allows seniors to seek

benefits from a Medicare-approved private health plan. Today, nearly 32 percent of Medicare recipients choose Medicare Advantage, and CBO projects this will increase to nearly 41 percent in 2027.[cxviii] However, the ACA made a number of negative changes to MA, including limiting the ability of seniors to switch plans in response to unexpected changes, capping quality bonuses in a way that undermines plan incentives to provide a high-quality product, and cutting the program's funding by $150 billion.[cxix] The *Better Way* would repeal the caps on quality bonuses, restore flexibility for seniors to adapt to unexpected plan changes, and limit the ability of the executive branch to arbitrarily cut MA funding.[cxx]

Merging Medicare Parts A and B and Other Reforms

Since Medicare's creation in 1965, the private insurance system has transformed, but Medicare has not kept pace with the changes.[cxxi] The old-style structure of Medicare features a confusing array of copays and deductibles for different programs and a fee for service (FFS) structure that rewards cost rather than quality. At the same time, three separate assistance programs are designed to help low-income beneficiaries with Part B premiums. The *Better Way* would consolidate the assistance programs into one simplified program, and also merge Medicare Part A (covering hospital related services) and Part B (covering physician and outpatient services) into a single program with a combined deductible, a single annual out of pocket maximum, and uniform 20 percent cost-sharing for all services.[cxxii]

Protect Flexibility in Doctor-Patient Relationships

The *Better Way* recognizes that, despite the many diverse and important actors in the health care sector, the most important factor is the relationship between patients and their doctor. However, this relationship has been strained by numerous onerous regulations and requirements that have been forced on physicians in the last decade. The *Better Way* seeks to reduce these

regulations and elevate the doctor-patient relationship back to the forefront of medical practice.[cxxiii]

Information Sharing in Medicare: Medicare Compare

The *Better Way* proposes a Medicare Compare system that empowers seniors to easily compare traditional Fee-for-Service Medicare to available Medicare Advantage plans on a number of core quality measures.[cxxiv]

Greater Choice and Competition through a Premium Support Option

Beginning in 2024, the *Better Way* would offer Medicare beneficiaries a choice of remaining in traditional Medicare or selecting a private plan. Private plans would compete on a Medicare Exchange modeled on the successful Federal Employee Health Benefit (FEHB) exchange program. Beneficiaries could choose the specific plan that best suits their needs, with a support payment subsidizing the cost sent directly to the insurer. The competitive structure proven successful by the Medicare Part D prescription drug program would be a check on premium increases. Ultimately, premium support would ensure that the Medicare program remains affordable by embracing a market-driven approach to providing care as a check on waste while combating skyrocketing premiums. It would also provide seniors a choice as to which plan best suits their needs and preferences, preserving the positive aspects of traditional Medicare while ensuring the program will continue to serve future generations.[cxxv]

CONCLUSION

On the metrics of providing affordable and accessible care for patients and controlling health care costs, the Committee Majority believes the Obamacare experiment has proved to be a failure. We urge the new Congress and Administration to pursue patient-centered reforms such as those in the *Better Way* in order to fix our broken health care system.

Recommendations

Specifically, the JEC Majority recommends that Congress consider:

- Providing patients with more control and choice over the health insurance they choose, including through enhanced HSAs, purchases across state lines, pooling arrangements for purchasing power, or another option they select;
- Promoting portability of insurance with the assistance of a tax credit with protections for patients with pre-existing conditions;
- Relieving Americans from burdensome ACA taxes;
- Empowering states with more authority to design a Medicaid program that best suits the needs of their population; and

Rescuing Medicare from impending bankruptcy and providing seniors with more choices in order to preserve this important program for current and future beneficiaries.

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