

THE FREEDOM AND EMPOWERMENT PLAN:  
THE PRESCRIPTION *for* CONSERVATIVE  
CONSUMER-FOCUSED HEALTH REFORM



**AMERICA** → **NEXT**

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# THE PROBLEM of AMERICAN HEALTH CARE

**B**y many measures, the American system of health care is the best in the world. It is a source of incredible innovation at the cutting edge of medical science, providing high quality care to people who need it. We have some of the best doctors, nurses, researchers, and provider systems on earth. When world leaders need complex surgery and lifesaving treatment, they fly to us. It is here, in America, where treatments are discovered, methods are improved, and diseases are cured.

But by all sorts of other measures, the American system of health care is the worst of both worlds—and that was true before Obamacare. For starters, it is extraordinarily expensive. This is partly because we aren't interested in just managing pain, but in curing diseases; partly because market-warping government policies and regulations drive costs higher and incentivize monopolization over competition; partly because Americans have a limited choice of health insurance options; and partly because patients and providers are insulated from the true costs of health care services.

the specialist can spend five minutes examining the lightbulb and telling you what new one you need to buy. The specialist used to be in a small practice, but now he's in a big group, because there are all sorts of government regulations he has to deal with, and only big systems can afford to deal with them. He also has to overcharge your private insurer for this brief visit, because he spends a third of his time seeing people on government entitlement programs who dramatically underpay for his services.

The specialist gives you a nearly illegible prescription for a new lightbulb, but you can't buy it just anywhere—your homeowners insurance has a network of stores, and going out of network means you'll face penalties. You have to drive across town to an in-network hardware store, and then wait for someone to get the right lightbulb out of the back. You have no idea how much the lightbulb actually costs, or if it would be cheaper at the store ten minutes away—you just have a small co-pay for it, and the rest is covered by your insurer—or how much the specialist is paid to tell you which one to buy. And in a few months when the light burns out again, you'll have to go through all of this all over again.

When you start to think about the American health insurance system in this context, you start to understand why things are so upside down when it comes to the costs of care. At each stage, everyone is insulated from costs, and most people have no incentive to shop and compare prices and services as they do in every other market. And government policies and sweeping regulations have only served to make it worse.

Health care represents one of the most complex arenas of public policy. It was an animating interest for me from a young age, in part because it is an area that touches every American during the course of their lives in profound ways. I worked at the U.S. Department of Health and Human

The status quo of American health care and insurance is simply not defensible.

Imagine for a moment if other forms of insurance worked the same way as American health insurance does today. Say you arrive home one day and find that the lightbulb on your front porch has burned out. This happens every couple of months, and it's predictable as clockwork—or a chronic condition. But because your homeowners insurance policy works like health insurance does, you can't just drive to a store and buy a lightbulb, oh no. Instead, you have to call and set up an appointment with a highly-paid and highly-educated expert lightbulb specialist.

You go in the waiting room wait for two hours so

Services, the National Bipartisan Commission on the Future of Medicare, and the Louisiana Department of Health and Hospitals. During my lifetime, many attempts have been made to try and fix the broken aspects of our system, some more successful than others. President Obama's health care law is just the latest in a long line of wrongheaded steps—but it is by far the worst yet.

As someone who believes in empowering patients and using market forces to improve American health care, I oppose President Obama's law and believe we must repeal all of it—no matter what the conventional wisdom in Washington says. But we must also enact positive reforms to move our health system in the right direction, because the status quo of American health care and insurance is simply not defensible.

What the President said in the course of selling his signature legislation actually sounded good to me—it's what he did that was awful. The President sold his law as a path to lower premium costs, promising that he'd cut them by \$2,500 by the end of his first term. He said he wanted people to be able to keep their health plans and their doctors if they liked them. He said he wanted to bend the cost trajectory down while improving quality. I'm for all of that—but unfortunately that's not what his law does. At best the President was horribly naïve about how

The most fundamental question in health care policy is: do you want the patient to be in control, working with his or her own doctor and health care provider, or do you want a bureaucrat—whether from the government or your insurer—to be in control?

our health care system works, and how to reform it. At worst he was deliberately untrue, and sold his government-centric plan as a “conservative” proposal because he knew the American people would never accept the truth.

We want to make sure that people have access to affordable high quality health care. We want to create a solid safety net for the poorest of the poor and the sickest of the sick. This is, according to President Obama, what he wants, too. But from my perspective, he never stepped back and really looked at what's wrong with our system, and asked what we want it to look like if we can tear down the existing market-warping problems and start afresh.

America needs a health care system where it is easy for the consumer to be in control, and where government won't get in between you and your doctor. Sometimes on the right we're blind to the fact that health care bureaucracy isn't just Medicare and Medicaid personnel—it also could be a big insurance bureaucrat, and they're little better. At each point, this system of bureaucracy, monopolization, and the lack of price transparency serves to drive costs higher and higher for all of us. The most fundamental question in health care policy is: do you want the patient to be in control, working with his or her own doctor and health care provider, or do you want a bureaucrat—whether from the government or your insurer—to be in control?

The left has its answer to this question: empowering government. Instead, we should be empowering patients. How should we go about doing that? Well, there are several things that have to change, steps that will push health care in this country toward being a true competitive marketplace, and which make providers understand once again that the individual patient is their customer.

Big changes never happen organically in Washington, and many of the big stakeholders were heavily invested in Obamacare just a few years ago. But as President Obama's monopartisan

program has stumbled, it presents the opportunity for conservatives to make the case for real reform. It is now obvious to everyone that his plan simply won't deliver on the many promises he made along the way. And that's because, from the beginning, his approach was wrongheaded. He trusted the government to fix the problems and get everything right, instead of trusting the American people to know what's best. We shouldn't make that mistake twice.

## A CONSERVATIVE ALTERNATIVE

In the debate surrounding the Patient Protection and Affordable Care Act, more commonly referred to as Obamacare, conservatives have consistently faced one myth, perpetuated by President Obama himself and his political allies: That there is no alternative to Obamacare, and that opponents of the law have offered no solutions on health care themselves.

Nothing could be further from the truth. In November 2009, House Republicans offered their alternative to Obamacare during a debate on the House floor; not a single Democrat voted for the legislation.<sup>1</sup> One more recent compilation lists more than 200 pieces of health care legislation offered by conservative Members of Congress in 2013 alone.<sup>2</sup> Conservatives have consistently proposed alternatives to Obamacare, and publicly advocated on their behalf, yet the President finds it easier to peddle untruths than to engage the

Rather than making health care more affordable for all Americans, Obamacare gave America a law it can't afford to keep.

1. Vote on Boehner Substitute Amendment to H.R. 3962, Affordable Health Care for America Act, House Roll Call Vote 885, 111th Congress, November 7, 2009, <http://clerk.house.gov/evs/2009/roll885.xml>.

2. "Republican Study Committee Policy Brief: Members' Health Care Initiatives in the 113th Congress," November 25, 2013, <http://rsc.scalise.house.gov/>

[uploadedfiles/113th\\_112513\\_rsc\\_healthcare\\_menu.pdf](http://uploadedfiles/113th_112513_rsc_healthcare_menu.pdf).

3. Remarks in Democratic presidential debate sponsored by CNN and Congressional Black Caucus Institute, January 21, 2008, <http://www.cnn.com/2008/POLITICS/01/21/debate.transcript2/index.html>.

## Obamacare By The Numbers

- **\$2,100 per family increase** in premiums on the individual market (CBO, 11/30/2009)
- **At least 4.7 million Americans** losing their health plans (*Associated Press*, 12/26/2013)
- **More than \$2 trillion** in new spending (CBO, 2/2014)
- **Increasing taxes by over \$1 trillion** (CBO, 7/4/2012)
- **47 new IRS provisions** to implement (GAO, 6/11)
- **2.3 million fewer workers** in the American workforce (CBO, 2/4/14)
- **Employers reducing hours and eliminating jobs** (*Investor's Business Daily*, 2/3/14)

American people on why his unpopular law is "better" than alternative reforms.

One reason President Obama fails to recognize conservative alternatives to Obamacare lies in a fundamental dispute about the root problems plaguing the American health care system. Conservatives believe that the best way to improve access to health insurance coverage is to make that coverage more affordable. Many conservatives may agree with then-Senator Obama, who stated during his 2008 presidential campaign: "I believe the problem is not that folks are trying to avoid getting health care. The problem is they can't afford it."<sup>3</sup>

Candidate Obama may have talked like a conservative in his rhetoric highlighting health costs and opposing mandates, but President Obama has governed as a liberal. Instead of tackling the root of the health care problem, and lowering costs first, Obamacare focused on spending trillions of dollars to expand health coverage, creating massive new entitlements in the process. Rather than making health care more affordable for all Americans, Obamacare gave America a law it can't afford to keep. The law is fiscally unsustainable, its tax increases economically damaging, and its enshrinement of greater government control of every aspect of health care is more dangerous than some in Washington appreciate.

**F**or these reasons and more, any conservative health reform must start with repealing Obamacare. *But conservative health reform must not end there.* Even prior to Obamacare, the *status quo* was, and remains, unacceptable. Many Americans struggle every day with the high cost of health care, and Americans with pre-existing conditions cannot access the care they need. America's health care system does need reforms—but it needs the *right* reforms.

The policy solutions put forward by America Next in this paper focus on preserving what's right with American health care, while fixing what's wrong. Fixing what's wrong involves restoring one basic American principle—freedom—that has been eroded due to Obamacare. While it is wise for any individual to have health insurance coverage, Washington cannot—and should not—attempt to compel such behavior.

After restoring those freedoms, we can enact the reforms the American health system needs.

We focus first and foremost on reducing health care costs—because while most Americans want to buy health care and health insurance, many of them struggle to afford it. We also work to preserve and strengthen the safety net for the most vulnerable in our society, including those with pre-existing conditions. And we focus on enhancing patient choice, removing obstacles to portability and consumer selection, including many put into place by Obamacare itself. These principles should form the foundation for true health reform—one that puts doctors and patients, not government bureaucrats, at the heart of all policy decisions.



Governor Bobby Jindal  
Honorary Chairman

# PRINCIPLE #1: LOWERING HEALTH COSTS

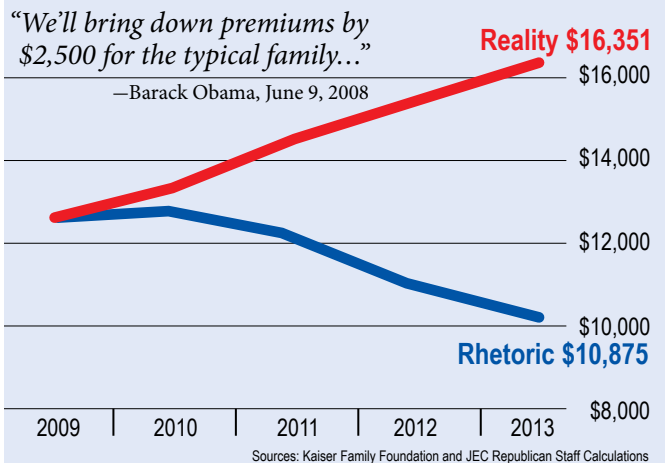
When running for President in 2008, candidate Obama promised that his health plan would lower premiums—in fact, he promised on numerous occasions that his plan would reduce costs for the average family by \$2,500 per year.<sup>4</sup> Unfortunately, the law President Obama signed bears little resemblance to that campaign pledge. Obamacare moves American health care in the opposite direction—raising health costs and premiums, not lowering them. The non-partisan Medicare actuary has concluded that Obamacare will raise total health spending by \$621 billion dollars in its first decade alone.<sup>5</sup> Likewise, independent analysts at the Congressional Budget Office (CBO) concluded that Obamacare would raise premiums for those buying health insurance on the individual market by an average of \$2,100 per year.<sup>6</sup>

The higher premiums due to Obamacare are discouraging many people from enrolling in coverage under the law. A recent survey by analysts at McKinsey found that only 27 percent of Americans selecting insurance plans were previously uninsured—the group Obamacare intended to target for expanded coverage.<sup>7</sup> The same survey found that half of those individuals who shopped for insurance coverage but did not select a plan cited affordability reasons in deciding not to purchase coverage: “I could not afford to pay the premium.”<sup>8</sup> For many Americans, the measure dubbed the “Affordable Care Act” has proven anything but affordable.

Obamacare is raising health costs because its mandates and regulations force customers to buy health insurance products they may not want or

need, merely because a government bureaucrat tells them they must. Conversely, true reform would provide incentives for consumers to serve as smart health care shoppers, saving money by engaging in healthy behaviors and taking control of their health care choices.

## Rhetoric vs. Reality on Premium Costs



**TAX EQUITY:** When it comes to health insurance, today’s tax code contains two notable flaws. First, it includes a major inequity: workers can purchase employer-provided coverage using pre-tax funds, but individuals who buy coverage on their own must use after-tax dollars to do so. Second, because cash wages provided by an employer are taxable, but health insurance benefits are not taxed, no matter how generous the benefit, the tax code currently gives a greater value to health insurance than increases in cash wages. This disparity has resulted in employers scaling back pay raises to help fund rapidly rising health plan costs. The Congressional Budget Office has also noted that this disparity has exacerbated the growth in health costs, and that capping the tax subsidy for employer-provided

4. A video compilation of candidate Obama’s remarks on this issue from the 2008 campaign is available at <http://freedomeden.blogspot.com/2010/03/obama-20-promises-for-2500.html>.

5. Gigi A. Cuckler, et al., “National Health Expenditure Projections: Slow Growth Until Coverage Expands and Economy Improves,” *Health Affairs* October 2013, <http://content.healthaffairs.org/content/32/10/1820>.

6. Congressional Budget Office, letter to Sen. Evan Bayh regarding premium

effects of the Patient Protection and Affordable Care Act, November 30, 2009, <http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>.

7. Amit Bhardwaj, et al., “Individual Market Enrollment: Updated View,” McKinsey Center for U.S. Health System Reform, March 2014, <http://healthcare.mckinsey.com/sites/default/files/Individual-Market-Enrollment.pdf>.

8. Ibid.

insurance would help slow cost growth.<sup>9</sup> Reforms could result in employers raising cash wages if their health costs grow more slowly over time—and slowing the growth of health care costs would yield benefits for the broader economy.

A conservative health reform would transform the existing tax exclusion for employer-provided health insurance into a standard deduction for *all* forms of health insurance, regardless of where they are purchased. First proposed in 2007, this concept was also recently introduced in legislative form in the House of Representatives.<sup>10</sup> This proposal would not raise taxes; following Obamacare's repeal, total government revenues would remain at pre-Obamacare levels. In other words, this proposal would not repeal Obamacare's tax increases, only to replace them with other tax hikes.

our current tax code. The standard deduction would create equity between those who buy health coverage through their employer, and those who buy health coverage on their own. In 2007, one analysis noted this change could reduce the number of uninsured Americans by 9.2 million.<sup>11</sup> Over time, this policy might encourage more individuals to buy coverage independent of their employer plans, but such a change would likely be *gradual* and *voluntary*—as opposed to the millions of Americans who lost their existing health coverage last fall, because their plan did not meet Obamacare's bureaucratic standards.

**J**ust as importantly, the new standard deduction would contain in-built mechanisms to slow the growth of health costs. Individuals who purchase insurance costing less than the amount of the standard deduction would still retain the full tax benefit from it—giving them reason to act as smart health care shoppers. In addition, the slower growth rate of the deduction would give both insurance companies and consumers a greater incentive to maximize efficiencies in the health care system. For decades, the tax code's perverse incentives have accelerated spiraling health costs, but creating a standard deduction will help reduce costs rather than raising them.

#### **STATE HEALTH INSURANCE PROGRAM:**

Although millions of Americans without access to employer-sponsored health coverage will benefit from the standard deduction for health insurance, some individuals with minimal tax liability—primarily those with incomes under about 150 percent of the federal poverty level—will receive little benefit from a tax deduction. Instead, eligible individuals should receive an explicit government subsidy to purchase affordable health insurance. This health reform plan proposes a pool of \$100

This health reform plan proposes a pool of over \$100 billion in federal funding over the next ten years for states to subsidize affordable health insurance for low-income individuals and individuals with pre-existing conditions.

Under this model, the standard deduction would grow at higher rates initially, but as the other efficiencies take effect and the growth in health spending slows, the deduction would in time rise annually according to consumer price inflation. Much as the current exclusion for employer-provided coverage applies to both income and payroll taxes, the standard deduction would apply towards income and payroll taxes as well.

These reforms would solve several problems with

9. Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008, <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9924/12-18-keyissues.pdf>, pp. 84–87.

10. The White House, "Affordable, Accessible, and Flexible Health Coverage," January 2007, <http://georgewbush-whitehouse.archives.gov/stateoftheunion/2007/initiatives/healthcare.html>; Republican Study Committee,

"The American Health Care Reform Act," September 18, 2013, <http://rsc.scalise.house.gov/solutions/rsc-betterway.htm>.

11. John Sheils and Randy Haught, "President Bush's Health Care Tax Deduction Proposal: Coverage, Cost, and Distributional Impacts," The Lewin Group, January 28, 2007, [http://www.lewin.com/~-/media/Lewin/Site\\_Sections/PressReleases/BushHealthCarePlanAnalysisRev.pdf](http://www.lewin.com/~-/media/Lewin/Site_Sections/PressReleases/BushHealthCarePlanAnalysisRev.pdf).



billion in federal funding over the next ten years for states to subsidize affordable health insurance for low-income individuals and individuals with pre-existing conditions. The funding would be provided to states with minimal restrictions:

1. States must achieve measurable reductions in average health insurance premiums in the individual and small group markets, and must ensure that individuals have access to affordable health insurance—with premiums that do not exceed a defined percentage of that state's median income.
2. States must establish and maintain a form of guaranteed access for individuals with pre-existing conditions—a high-risk pool, a reinsurance fund, or some other risk transfer mechanism. States could use some of their federal allotment to help fund the costs of covering high-risk individuals.
3. Obamacare reduced disproportionate share hospital (DSH) payments by half to finance expensive, unaffordable health coverage; this plan would instead restore that funding to help fund more affordable health insurance options.<sup>12</sup> In order to access state grants, states must direct this restored funding toward covering eligible populations, reducing the amount of uncompensated care provided by instead subsidizing health insurance. States will receive about \$10 billion per year in DSH funding; re-directing some of these funds would supplement the \$100 billion provided by the federal government.<sup>13</sup>

This reform model relies on federalism to promote innovation in health care and health insurance. The federal government sets key

Overall, estimates suggest that, when compared to Obamacare, this state-based approach could reduce premiums on the individual health insurance market by nearly \$5,000 per family.

goals—keeping insurance premiums affordable, and expanding access to low-income individuals and those with pre-existing conditions—and allows states to meet those goals in the manner they believe will work best for their state. For example, if a state wants to incorporate an account-like savings mechanism to promote healthy behaviors, as Indiana has done, it can pursue that option.

**E**mpowering states with flexibility and freedom can be a powerful tool in reducing health costs. Analyzing a similar proposal put forward as part of the House Republican alternative to Obamacare in 2009, the non-partisan Congressional Budget Office (CBO) found that state innovation grants, coupled with lawsuit reform and other common-sense solutions, would lower small business health insurance premiums by 7 to 10 percent, and would lower individual health insurance premiums by 5 to 8 percent.<sup>14</sup> This reduction is even more stark when compared to the premium increases CBO predicted will occur (and are occurring) due to Obamacare. Overall, estimates suggest that, when compared to Obamacare, this state-based approach could reduce premiums on the individual health insurance market by nearly \$5,000 per family.<sup>15</sup>

12. Patient Protection and Affordable Care Act (P.L. 111-148), Section 2551.  
13. Congressional Budget Office, Medicaid baseline, May 2013, [http://cbo.gov/sites/default/files/cbofiles/attachments/44204\\_Medicaid.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/44204_Medicaid.pdf).  
14. Congressional Budget Office, analysis of House Republican substitute amendment to H.R. 3962, November 4, 2009, <http://cbo.gov/sites/default/files/>

[cbofiles/ftpdocs/107xx/doc10705/hr3962amendmentboehner.pdf](http://cbofiles/ftpdocs/107xx/doc10705/hr3962amendmentboehner.pdf).  
15. Press release by House Ways and Means Committee Ranking Member Dave Camp, November 5, 2009, <http://waysandmeans.house.gov/news/documentsingle.aspx?DocumentID=153186>.

Washington has tried a top-down approach to health care; it hasn't worked. Allowing states to serve as laboratories of innovation could slow the growth in health insurance costs and premium increases. In addition, the \$100 billion in federal funding, coupled with the matching funds from state DSH payments, would expand health care access for low-income individuals who do not benefit from the standard insurance deduction and those with pre-existing conditions. This state-based model, not more Washington mandates and regulations, represents the best route to true health care reform.

**HEALTH SAVINGS ACCOUNTS:** One of the innovations over the past decade that has helped slow the growth in health care costs has been Health Savings Accounts (HSAs), which couple a high-deductible health plan with a tax-free savings account. The high deductible plans provide lower premiums for consumers, who can

are now covered by HSA-eligible health plans.<sup>16</sup> Many are using tools provided by these plans to take better control of their health and health spending, seeking out preventive care, using generic drugs more frequently, and utilizing plan-provided decision support tools.<sup>17</sup> These plans are also saving Americans money; in 2013, the average HSA plan provided by an employer cost \$1,318 less per family than non-HSA plans—even after firms placed an average of \$1,150 per family into the HSA to fund health expenses.<sup>18</sup> A recent study found that more widespread adoption of HSA coverage could reduce health spending by as much as \$73.6 billion per year.<sup>19</sup>

Obamacare moves in the opposite direction by placing limits on the effectiveness of HSAs. For example, it prohibits the use of funds from an HSA to purchase over-the-counter medications without a prescription.<sup>20</sup>

Conservative health reforms should build upon the success of HSAs by offering new options to make HSA plans more flexible for patients and consumers. Congress should allow HSA funds to be used to purchase health insurance in all cases, making it easier for consumers who save to fund their health coverage. Another possible reform would create more flexible insurance policies, linking the size of the deductible for an HSA plan to customers' account balances, incomes, or other assets; in this way consumers with sizable savings could choose coverage with an even lower premium in exchange for a higher deductible. These changes would further accelerate a health coverage model that has already helped slow the growth of health costs for millions of Americans.

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then deposit the savings in their HSAs to use for routine health expenses. And because funds in an HSA accumulate from year to year tax-free, they provide motivation for consumers to serve as smart purchasers of health care.

First made available in 2004, HSAs have grown in popularity; more than 15 million Americans

16. America's Health Insurance Plans, Center for Policy and Research, "January 2013 Census Shows 15.5 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs)," June 2013, [http://www.ahip.org/HSA\\_Census2013PDF/](http://www.ahip.org/HSA_Census2013PDF/).

17. America's Health Insurance Plans, Center for Policy and Research, "Health Savings Accounts and Account-Based Health Plans: Research Highlights," July 2012, [http://www.ahip.org/HSA\\_Highlights\\_Report072012/](http://www.ahip.org/HSA_Highlights_Report072012/).

18. Kaiser Family Foundation and Health Research and Educational Trust, "Em-

ployer Health Benefits: 2013 Annual Survey," August 2013, <http://kaiserfamily-foundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>, Exhibit 8.8, p. 140.

19. Amelia M. Haviland, M. Susan Marquis, Roland D. McDevitt, and Neeraj Sood, "Growth of Consumer-Directed Health Plans to One-Half of All Employer-Sponsored Insurance Could Save \$57 Billion Annually," *Health Affairs*, May 2012, <http://content.healthaffairs.org/content/31/5/1009.abstract>.

20. Patient Protection and Affordable Care Act (P.L. 111-148), Section 9003.

### **GREATER INCENTIVES FOR WELLNESS:**

One of the few areas of bipartisan agreement during the Obamacare debate was a consensus around the “Safeway model”—namely, providing financial incentives for individuals and employees to engage in healthy behaviors.<sup>21</sup> At the time, employers could vary premiums by up to 20%



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to reward participation in various wellness programs. However, then-Safeway CEO Steve Burd noted that a 20% premium variation did not allow the company to recoup all the higher costs associated with unhealthy behaviors like smoking.

**C**ongress can and should do more to enhance these innovative efforts to reduce health costs. First, it can provide explicit statutory authority for premium variations of up to 50%. It can also allow employers (or insurance companies selling individual insurance plans) to offer any financial incentives for healthy behaviors on a tax-free basis, by placing the money in new Wellness Accounts. As with HSAs, the money in these accounts could then be used tax-free for health expenses, or withdrawn for other

purposes. This reform would marry two proven successes—HSAs and wellness incentives—turbocharging efforts to slow the growth in health costs by encouraging Americans to engage in healthy behaviors.

**CRACK DOWN ON FRAUD:** Health costs have grown at a rapid rate at least in part due to widespread fraud in government health programs. Unfortunately, a recent case in which 49 Russian diplomats were charged with fraudulently obtained Medicaid benefits—lying about their immigration status and income on application forms, even as they purchased goods from Tiffany’s and Jimmy Choo—is not an aberration.<sup>22</sup> Several years ago, the *New York Times* cited expert analysis that as much as 40 percent of that state’s Medicaid spending was either questionable or outright fraudulent.<sup>23</sup> The Medicare program for the elderly also faces widespread fraud—\$60 billion per year, according to a *60 Minutes* investigation.<sup>24</sup>

While the private sector has a series of programs and protocols in place to combat fraud, government health programs have traditionally lagged; their focus has been on paying claims quickly, whether real or fraudulent. In recent years, some government programs have

Several years ago, the *New York Times* cited expert analysis that as much as 40 percent of that state’s Medicaid spending was either questionable or outright fraudulent.

21. Steven A. Burd, “How Safeway Is Cutting Health Costs,” *Wall Street Journal* June 12, 2009, <http://online.wsj.com/news/articles/SB124476804026308603>.

22. Christopher Matthews, “U.S. Accuses Russian Diplomats of Medicaid Fraud,” *Wall Street Journal* December 5, 2013, <http://online.wsj.com/news/articles/SB10001424052702303497804579240163174732486>.

23. Clifford Levy and Michael Luo, “New York Medicaid Fraud May Reach into Billions,” *The New York Times*, July 18, 2005, <http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html>.

24. CBS News, “Medicare Fraud: A \$60 Billion Crime,” *60 Minutes*, September 5, 2010, [http://www.cbsnews.com/8301-18560\\_162-5414390.html](http://www.cbsnews.com/8301-18560_162-5414390.html).

improved their efforts to combat fraud; for instance, Louisiana's new Bayou Health managed care model built in robust savings from fraud detection, requiring plans participating in Bayou Health to crack down on suspicious transactions or face financial penalties. But Congress should do more to end the current "pay and chase" model, which attempts to track down fraud after-the-fact, and enhance penalties for those who steal or traffic in Medicare patient numbers and other personal health information.

### **PRICE AND QUALITY TRANSPARENCY:**

In many cases, consumers who wish to serve as "smart shoppers" of health care do not have the information to do so. For far too long, price and quality transparency data have been lacking in the health sector, meaning patients face a dearth of information when they have to make potentially life-altering decisions about their care. The good news is that these trends are slowly changing, and that transparency has provided consumers with useful, and powerful, information:

There is emerging evidence that when hospitals publish prices for surgical procedures, costs decrease without a loss of quality. The Surgery Center of Oklahoma, for example, has been publishing its prices for various procedures for the past four years. Because the center's prices tend to be lower than those of other hospitals, patients started coming from all over the country for treatment. In order to compete, other hospitals in Oklahoma began listing surgical prices; patients were able to comparison shop, and hospitals lowered their prices.<sup>25</sup>

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Further efforts at transparency could help to reduce an estimated \$105 billion paid in health costs annually due to uncompetitive pricing levels by medical providers.

pricing levels by medical providers.<sup>26</sup> Just as importantly, patients could have more objective sources of information about doctors and medical treatments than recommendations from friends or acquaintances. Online posting of price and quality data can easily lead to new *Consumer Reports*-type rating systems, which will empower patients with trusted data and provide providers a greater incentive to improve their quality practices.

25. Lisa Rosenbaum, "The Problem with Knowing How Much Your Health Care Costs," *The New Yorker* December 23, 2013, <http://www.newyorker.com/online/blogs/elements/2013/12/price-transparency-health-care-costs.html>.

26. Institute of Medicine, *The Health Care Imperative: Lowering Costs and Improving Outcomes—Workshop Summary*, February 2011, <http://www.iom.edu/reports/2011/the-healthcare-imperative-lowering-costs-and-improving-outcomes.aspx>.

## PRINCIPLE #2: PROTECT THE MOST VULNERABLE

In trying to provide all Americans with health insurance, Obamacare may actually detract from efforts to protect those who need health care most. The law provides a more sizable federal match for states to expand their Medicaid programs to childless adults than it does for states to cover individuals with

conditions—without necessitating the upheaval caused by the President’s 2,700-page health law.

### **GUARANTEED ACCESS FOR PRE-EXISTING CONDITIONS:**

Obamacare was sold as a way to address the very real problem of Americans with pre-existing conditions—but the size of the problem did not warrant such a massive overhaul. One estimate found that approximately 2-4 million individuals under age 65 may face difficulties purchasing health insurance.<sup>29</sup> The Obama Administration has attempted to claim that up to 129 million Americans “could be denied coverage” due to pre-existing conditions.<sup>30</sup> But when Obamacare created a high-risk pool to provide temporary coverage for those with pre-existing conditions, under 150,000 Americans ever enrolled in it<sup>31</sup>—far fewer than the 600,000-700,000 originally projected to seek enrollment in the program.<sup>32</sup>

Ironically enough, Obamacare has failed to deliver on its promise for individuals with pre-existing conditions. The Administration froze enrollment in the law’s high-risk pools due to funding constraints,<sup>33</sup> and the unintended consequences of over-regulation meant that 17 states lost access to child-only health insurance plans.<sup>34</sup> Some patients have also found that their Obamacare plans don’t include the specialists or hospitals they need; for instance, many plans do not offer access to advanced cancer centers.<sup>35</sup>

Ironically enough, Obamacare has failed to deliver on its promise for individuals with pre-existing conditions.

disabilities.<sup>27</sup> At a time when more than half a million Americans with disabilities are on state lists waiting to qualify for long-term supports and services, it is both uncompassionate and unfair for the Administration instead to focus on covering childless adults, most of whom are able to work or prepare for work.<sup>28</sup>

True health reform would focus first and foremost on targeting government resources to the most vulnerable in our society—protecting the safety net rather than stretching it past its breaking point. These reforms would help individuals with pre-existing conditions, senior citizens, individuals with disabilities, and the unborn. Making these populations the centerpiece of coverage efforts would meet one of Obamacare’s core goals—providing access for individuals with pre-existing

27. Chris Jacobs, “How Obamacare Undermines American Values: Penalizing Work, Marriage, Citizenship, and the Disabled,” Heritage Foundation *Background* No. 2862, November 21, 2013, <http://www.heritage.org/research/reports/2013/11/how-obamacare-undermines-american-values-penalizing-work-marriage-citizenship-and-the-disabled>.

28. Kaiser Family Foundation, “Waiting Lists for Medicaid Section 1915(c) Home and Community-Based Services (HCBS) Waivers,” December 2012, <http://kff.org/medicaid/state-indicator/waiting-lists-for-hcbs-waivers-2010/#table>.

29. James C. Capretta and Tom Miller, “How to Cover Pre-Existing Conditions,” *National Affairs* Summer 2010, [http://www.nationalaffairs.com/doclib/20100614\\_CaprettaMiller\\_Web.pdf](http://www.nationalaffairs.com/doclib/20100614_CaprettaMiller_Web.pdf), pp. 114-15.

30. U.S. Department of Health and Human Services, Office of Planning and Evaluation, “At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans,” November 2011, <http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml>.

31. Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, “Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition

Insurance Plan Program,” January 31, 2013, [http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip\\_annual\\_report\\_01312013.pdf](http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_report_01312013.pdf).

32. Congressional Budget Office, letter to Senator Mike Enzi (R-WY), June 21, 2010, [http://cbo.gov/sites/default/files/cbofiles/ftpdocs/115xx/doc11572/06-21-high-risk\\_insurance\\_pools.pdf](http://cbo.gov/sites/default/files/cbofiles/ftpdocs/115xx/doc11572/06-21-high-risk_insurance_pools.pdf).

33. Department of Health and Human Services, Pre-Existing Condition Insurance Plan, notice of enrollment suspension, February 15, 2013, [https://www.pcip.gov/Notifications/021513-ENROLLMENT\\_SUSPEND.html](https://www.pcip.gov/Notifications/021513-ENROLLMENT_SUSPEND.html).

34. Report by Senate Health, Education, Labor, and Pensions Committee Ranking Member Mike Enzi, “Health Care Reform’s Impact on Child-Only Health Insurance Policies,” August 2, 2011, <http://www.help.senate.gov/imo/media/doc/Child-Only%20Health%20Insurance%20Report%20Aug%20202011.pdf>.

35. Ricardo Alonso-Zaldivar, “Concerns about Cancer Centers under Health Law,” Associated Press March 18, 2014, [http://hosted2.ap.org/apdefault/3d281c11a96b4ad082fe88aa0db04305/Article\\_2014-03-18-Health%20Overhaul-Top%20Cancer%20Centers/id-d5caff9619ec4bc6aa875800d96fc270](http://hosted2.ap.org/apdefault/3d281c11a96b4ad082fe88aa0db04305/Article_2014-03-18-Health%20Overhaul-Top%20Cancer%20Centers/id-d5caff9619ec4bc6aa875800d96fc270).

Conversely, conservative health reform would ensure that states have the incentive of funding to provide guaranteed access for Americans with pre-existing conditions. Many states use various vehicles to cover these individuals—whether high-risk pools, reinsurance programs, or some other risk transfer mechanism.<sup>36</sup> The incentive pool of federal dollars would allow states to determine the best mechanism for providing access to those with pre-existing conditions, and a stable source of funding for those endeavors.

Much of the case for Obamacare was made on the basis of an issue which affects a small portion of consumers: the challenge of pre-existing conditions. Since 1996, federal law included a requirement of guaranteed renewability in the individual health insurance market—so long as you paid for your policy, you were guaranteed the ability to renew your plan. Policy cancellations—also called rescissions—were rare, and nearly always due to fraud, impacting according to some measures just four-tenths of one percent of the private individual market (which is itself just 10 percent of the insured marketplace).<sup>37</sup> Though relatively small in number, the issue of pre-existing conditions raised concerns for many Americans—who feared that they, or someone they knew, would be affected if they developed an illness that made them uninsurable.

Obamacare was supposed to solve the problem of pre-existing conditions, but in many respects, the law actually made things worse. It took away the coverage renewability guarantee, by forcing insurance companies to cancel the policies of millions of Americans. Even as they made the case that if you liked your plan you could keep it, those who favored the president's legislation knew they were about to repeal the existing guaranteed renewability for millions of Americans. By doing this, Obamacare has completely disrupted the individual market, forcing many people who were

Obamacare was supposed to solve the problem of pre-existing conditions, but in many respects, the law actually made things worse.

satisfied with their coverage and the access they had to doctors and specialists being dumped into more costly and less comprehensive insurance simply because of Obamacare.

This lie should not be allowed to stand. Guaranteed renewability should ensure that patients have the ability to renew their coverage, regardless of their health status, so long as they have not committed fraud. Thus, people who maintain continuous coverage should be protected from premium spikes and have confidence their insurance will be there when they need it.

**T**he central irony of Obamacare is that it hurt the very people it was supposed to help. For Americans signing up for new insurance, guaranteed renewability should offer peace of mind that their insurer cannot drop them merely for getting sick. For those Americans for whom access to guaranteed renewability contracts has been destroyed by Obamacare, the incentive pool of state dollars for more innovative approaches, coupled with greater flexibility for individuals leaving employer plans, will be there to help them get the coverage they need in a post-Obamacare system.

**PREMIUM SUPPORT:** Medicare faces a dire financial predicament. According to the annual report by the program's trustees—including members of the Obama Administration—the Part A trust fund financing hospital care will be insolvent by 2026. In the short term, the program has taken a hit from the recession and

36. Information on various state plans for covering high-risk individuals can be found on the website of the National Association of State Comprehensive Health Insurance Plans, [www.naschip.org](http://www.naschip.org).

37. John C. Goodman, "Rescissions: Much Ado About Nothing," *Kaiser Health News*, May 13, 2010, <http://www.kaiserhealthnews.org/Columns/2010/May/051310Goodman.aspx>.

slow economic recovery; the Medicare trust fund ran \$105.6 billion in deficits during the years 2008-12.<sup>38</sup> In the longer term, the outlook is even worse: Medicare faces 75-year unfunded obligations of at least \$27.3 trillion, and even this estimate may understate the program's liabilities, due to various budgetary and accounting gimmicks.<sup>39</sup>

Among the biggest gimmicks understating Medicare's financial shortfalls is Obamacare itself. In October 2011, Nancy Pelosi admitted what all Americans realize Democrats did as part of Obamacare: "We took a half a trillion dollars out of Medicare in...the health care bill," to pay for that law's new entitlements.<sup>40</sup> Yet the Obama Administration utilized an "only-in-Washington" logic to argue otherwise, citing trust fund accounting to assert that the Medicare provisions

A 2011 study by the Kaiser Family Foundation found that under one version of reform, Medigap premiums would plummet by an average of over 60%, from nearly \$2,000 per year to only \$731.

in the law could be used both to "save Medicare" and to "fund health care reform."<sup>41</sup> There are two kinds of people in politics—those that want to fix Medicare and those who want to use it to score political points. Sadly, Obamacare followed the latter course. Current and future generations of seniors deserve better—they deserve true reform that makes Medicare more sustainable.

One bipartisan solution to Medicare's fiscal shortfalls would give seniors a choice of plans, with the federal government providing a generous subsidy to purchase coverage. This premium support concept was developed, and endorsed, by a bipartisan majority in a commission created by Congress and President Clinton, whose Executive Director was Bobby Jindal.<sup>42</sup> The commission's work was in turn endorsed by the Democratic Leadership Council.<sup>43</sup> More recently, Rep. Paul Ryan, the Republican Chairman of the House Budget Committee, and Sen. Ron Wyden, the Democratic Chairman of the Senate Finance Committee, submitted a bipartisan health reform plan that included a premium support proposal for Medicare beneficiaries.<sup>44</sup>

The key feature of a premium support proposal is the ability of competition among health plans to bring down costs and provide better care to America's seniors. Former Clinton Administration official Alice Rivlin testified before Congress in 2012 that nearly nine in ten seniors live in areas where private health plans have costs lower than traditional, fee-for-service Medicare; under a premium support proposal, these seniors could save money by choosing to enroll in a private plan.<sup>45</sup> Likewise, the Congressional Budget Office recently analyzed one premium support proposal, and found that it could reduce Medicare spending by \$15 billion annually, while *also* reducing overall out-of-pocket spending by beneficiaries by an average of 6 percent.<sup>46</sup>

38. Centers for Medicare and Medicaid Services, 2013 Medicare trustees report, May 31, 2013, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2013.pdf>, Table I.B.4, p. 58.

39. Suzanne Codespote, memo from Office of the Actuary, Centers for Medicare and Medicaid Services, to Senate Budget Committee Ranking Member Jeff Sessions, June 3, 2013.

40. Maria Bartiromo, "One-on-One with Nancy Pelosi," CNBC interview, October 28, 2011, <http://video.cnbc.com/gallery/?video=3000054002>.

41. Kathleen Sebelius, testimony before the House Energy and Commerce Committee hearing on "Fiscal Year 2012 HHS Budget," March 4, 2011, video available at <http://archives.republicans.energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=8281>.

42. The National Bipartisan Commission on the Future of Medicare was chaired by Sen. John Breaux (D-LA) and Rep. Bill Thomas (R-CA); its work can be

found at <http://medicare.commission.gov/medicare/index.html>.

43. Testimony of David Kendall, Progressive Policy Institute Senior Analyst for Health Policy, before Senate Finance Committee hearing on "Modernizing Medicare," May 26, 1999, [http://dlc.org/ndol\\_ci04fb-2.html?kaid=111&subid=141&contentid=1790](http://dlc.org/ndol_ci04fb-2.html?kaid=111&subid=141&contentid=1790).

44. Sen. Ron Wyden and Rep. Paul Ryan, "Guaranteed Choices to Strengthen Medicare and Health Security for All: Bipartisan Options for the Future," December 15, 2011, <http://budget.house.gov/uploadedfiles/wydenryan.pdf>.

45. Alice Rivlin, testimony before the House Ways and Means Health Subcommittee on "A Bipartisan Approach to Reforming Medicare," April 27, 2012, [http://waysandmeans.house.gov/uploadedfiles/rivlin\\_testimony\\_final\\_4-27-2012.pdf](http://waysandmeans.house.gov/uploadedfiles/rivlin_testimony_final_4-27-2012.pdf), p. 4.

46. Congressional Budget Office, "A Premium Support System for Medicare: Analysis of Illustrative Options," September 2013, <http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-18-PremiumSupport.pdf>.

As part of the transition to premium support, the traditional Medicare benefit itself should be modernized. For the first time ever, Medicare should provide a catastrophic cap on out-of-pocket expenses—so that seniors would know their spending. At the same time, Medigap insurance, which provides supplemental coverage of co-payments and deductibles for some seniors, should also be reformed, so that seniors would no longer be pre-paying their health coverage by over-paying to insurance companies.

**U**nder Medigap reform, seniors' premium costs would fall substantially. A 2011 study by the Kaiser Family Foundation found that under one version of reform, Medigap premiums would plummet by an average of over 60%, from nearly \$2,000 per year to only \$731.<sup>47</sup> Because less money from Medigap policy-holders would be diverted to administrative overhead, seniors would be able to keep their own money to finance their own health care.

Medigap reform not only lowers seniors' premiums, it also lowers their overall health costs. A 2011 Kaiser Family Foundation study

This package of proposals represents a true “win-win:” Current seniors would save on their health expenses, while seniors-to-be would have greater confidence that the promises made to them can be kept when they prepare to join Medicare themselves.



*Under Medigap reform, seniors' premium costs would fall substantially.*

concluded that “the savings for the average beneficiary” under Medigap reform “would be sufficient to more than offset his or her new direct outlays for Medicare cost sharing.”<sup>48</sup> According to Kaiser, nearly four in five Medigap policy-holders would receive a net financial benefit from this reform—with those savings averaging \$415 per senior each year.<sup>49</sup>

What's more, modernizing traditional Medicare and Medigap would drive greater efficiency within the health care system. The Congressional Budget Office estimates that this reform would make Medicare more sustainable for future generations, by as much as \$114 billion in its first decade alone.<sup>50</sup> As with premium support, this package of proposals represents a true “win-win:” Current seniors would save on their health expenses, while seniors-to-be would have greater confidence that the promises made to them can be kept when they prepare to join Medicare themselves.

For all these reasons and others, this modernization of Medicare carries broad support from across the

47. Kaiser Family Foundation, “Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs,” July 2011, <http://www.kff.org/medicare/upload/8208.pdf>, Exhibit 2, p. 6.

48. *Ibid.*, p. 8.

49. *Ibid.*, p. 8.

50. Congressional Budget Office, “Options for Reducing the Deficit: 2014 to 2023,” November 13, 2013, [http://cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-2\\_1.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/44715-OptionsForReducingDeficit-2_1.pdf), Health Option 7, p.



political spectrum. Bipartisan endorsers of Medigap reform include the Simpson-Bowles Commission,<sup>51</sup> the Rivlin-Domenici commission on debt and deficits,<sup>52</sup> Sen. Tom Coburn (R-OK) and former Sen. Joe Lieberman (D-CT),<sup>53</sup> and even President Obama's most recent budget.<sup>54</sup>

slowed the growth of health costs in that state. A 2011 Lewin Group report found that the global compact waiver “generated significant savings”—more than \$50 million from the small state's Medicaid budget—and did so not by reducing care, but by improving it:

The mandatory enrollment of disabled members in care management program [*sic*] reduced expenditures for this population while at the same time generally resulting in improved access to physician services.<sup>55</sup>

Since the Lewin study in 2011, Rhode Island's success in managing its Medicaid program has continued. The state has reduced its *per capita* Medicaid spending by more than five percent over the past three fiscal years, resulting in three straight years of minimal expenditure growth, even as the state's Medicaid caseload increased.<sup>56</sup>

**T**hese remarkable accomplishments come *despite* the Obama Administration's efforts, not because of them. The 2011 Lewin report notes that passage of Obamacare and the “stimulus” bill, both of which imposed new restrictions on state Medicaid programs, “had a profound impact” on the Rhode Island waiver, because “the flexibility sought did not always materialize.” For instance, the original waiver gave Rhode Island the authority to assess modest premium charges for some beneficiaries, but the Obamacare mandates took this flexibility away.<sup>57</sup>

Other states have also acted to reform their Medicaid programs. Louisiana has transitioned its Medicaid program toward a managed care model, named Bayou Health. The program has furthered the goals of the Birth Outcomes Initiative, claims

The error of Obamacare's Medicaid expansion was to double down on a program whose health outcomes range from the marginal to the horrendous—the result of paying doctors pennies on the dollar and cramming Medicaid recipients into already overburdened systems.

Seniors deserve the potential savings and better care these reforms can provide. Seniors' plan choices would include some of the same options available to Americans under age 65, along with the traditional, government-run fee-for-service model, updated with new and more flexible options. Likewise, future generations deserve the peace-of-mind that comes from knowing Medicare has been placed on a more sustainable path. It is long past time for Washington to enact true Medicare reform.

**MEDICAID REFORMS:** Despite Obamacare's massive new regulations, some states have already acted to reform their Medicaid programs. For instance, Rhode Island's global compact waiver—in which the state received additional regulatory flexibility from the federal government in exchange for a cap on its Medicaid budget—has successfully

51. *The Moment of Truth*, report of the National Commission on Fiscal Responsibility and Reform, December 2010, [http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12\\_1\\_2010.pdf](http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf), p. 39.

52. *Restoring America's Future*, report of the Bipartisan Policy Center's Debt Reduction Tax Force, November 2010, <http://bipartisanpolicy.org/sites/default/files/BPC%20FINAL%20REPORT%20FOR%20PRINTER%2002%2028%2011.pdf>, pp. 52-53.

53. Overview of Coburn/Lieberman Medicare reform proposal, June 2011, [http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File\\_id=1ea8e116-6d15-46ba-b2e0-731258583305](http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=1ea8e116-6d15-46ba-b2e0-731258583305)

54. Office of Management and Budget, Fiscal Year 2015 Budget, March 4, 2014, <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/budget.pdf>, pp. 31-32.

55. Lewin Group, “An Independent Evaluation of Rhode Island's Global Waiver,” December 6, 2011, [http://www.ohhs.ri.gov/documents/documents11/Lewin\\_report\\_12\\_6\\_11.pdf](http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf).

56. Testimony of Gary Alexander before the Congressional Commission on Long-Term Care, August 1, 2013, <http://ltccommission.lmp01.lucidus.net/wp-content/uploads/2013/12/Garo-Alexander.pdf>.

57. Lewin Group, “An Independent Evaluation,” pp. 11-12.

data for which reveal a reduction of 23,000 in statewide neonatal intensive care unit days paid by Medicaid—meaning more babies were carried to full term.

**T**he Hoosier State’s Healthy Indiana Plan includes a personal responsibility component, and provides incentives to engage in wellness screenings, and imposes co-payments on beneficiaries who make non-urgent visits to the emergency room. The plan also requires participants to make modest contributions to an account to fund their health needs, ensuring patients have incentives to manage their health spending and health care. The financial requirements are not onerous; approximately 70% of beneficiaries consider the required account contributions just the right amount, and 94% of members report being satisfied or highly satisfied with their coverage.<sup>58</sup> Yet, Obamacare could put this innovative plan out of business entirely, due to its Washington-imposed mandates on state Medicaid programs.<sup>59</sup>

Because the federal government provides states with at least a 1:1 match on their Medicaid expenses, states have a built-in incentive to spend more on Medicaid when compared to other state priorities like education, transportation, and corrections. This open-ended entitlement drastically reduces states’ incentives to make efficient choices in managing their health care systems. A more conservative approach should better align incentives to focus states’ efforts on improving care and reducing costs, instead of merely “gaming the system.”

Medicaid is not merely a fiscal failure, however. The error of Obamacare’s Medicaid expansion

A more conservative approach should better align incentives to focus states’ efforts on improving care and reducing costs, instead of merely “gaming the system.”

was to double down on a program whose health outcomes range from the marginal to the horrendous—the result of paying doctors pennies on the dollar and cramming Medicaid recipients into already overburdened systems. Compared to both those patients with private insurance and those without any insurance at all, Medicaid patients stay in the hospital longer, cost more while they are there, and yet are significantly more likely to die before they leave.<sup>60</sup> The recent Oregon Medicaid study, which offered real-world examples of Medicaid recipients compared to those who were not on the program, answered questions about just how significant the benefits of modern Medicaid are.<sup>61</sup> The study authors found that after two years, Medicaid “had no significant effect” on physical health outcomes compared to being uninsured.<sup>62</sup> Spending nearly half a trillion dollars a year on a program which is so ineffective is unacceptable and immoral.

**M**ore than two years ago, Republican governors presented a report laying out common-sense reforms to the Medicaid program—from modernizing benefit design to simplifying accountability to eliminating unnecessary requirements.<sup>63</sup> While the Obama Administration has not implemented most of the

58. Indiana Family and Social Services Administration, Healthy Indiana Plan 1115 Waiver Extension Application, February 13, 2013, [http://www.in.gov/fssa/hip/files/HIP\\_WaiverforPosting.pdf](http://www.in.gov/fssa/hip/files/HIP_WaiverforPosting.pdf), pp. 19, 6.

59. Mitch Daniels, “We Good Europeans,” *The Wall Street Journal* March 26, 2010, <http://online.wsj.com/article/SB10001424052748704094104575144362968408640.html>.

60. Avik Roy, “The Medicaid Mess: How Obamacare Makes It Worse,” *The Manhattan Institute*, March 2012, [http://www.manhattan-institute.org/html/ir\\_8.htm](http://www.manhattan-institute.org/html/ir_8.htm)

61. Katherine Baicker, Sarah Taubman, Heidi Allen, Mira Bernstein, Jonathan

Gruber, Joseph P. Newhouse, Eric Schneider, Bill Wright, Alan Zaslavsky, Amy Finkelstein, and the Oregon Health Study Group, “The Oregon Experiment – Effects of Medicaid on Clinical Outcomes” *New England Journal of Medicine*, May 2013, <http://www.nejm.org/doi/full/10.1056/NEJMsa1212321>

62. The Oregon Health Insurance Experiment, <http://www.nber.org/oregon/>  
63. Republican Governors Public Policy Committee Health Care Task Force, “A New Medicaid: A Flexible, Innovative, and Accountable Future,” August 30, 2011, <http://www.scribd.com/doc/63596104/RGPPC-Medicaid-Report>.

report's 31 separate suggestions, they represent a good place to start when it comes to updating this important program and prioritizing the actual health care of those who need a safety net.

The best way to reform Medicaid lies in a global grant approach, which empowers states with maximum flexibility in exchange for a fixed funding allotment from the federal government. The allotment would be adjusted annually for inflation and eligible population growth, and could be adjusted if a state receives a sudden increase in its population with disabilities. Rhode Island's innovative waiver demonstrates how it can be done—and further illustrates that indexing the grant to inflation can be achieved without cutting benefits, or harming beneficiaries' access to care.

States should have additional flexibility to manage their Medicaid programs in a manner that they believe best meets the needs of their citizens—while facing clear and simple accountability metrics from the federal government. Rather than focusing on managing processes and completing forms, state Medicaid programs should emphasize improving outcomes. In return, the federal government should revamp its accountability process to hold states to these higher standards. Those who want to micro-manage states do so because they do not trust the people and their locally elected leaders.

**PRO-LIFE PROTECTIONS:** Among its many other flaws, Obamacare represents an intrusion on the moral values many Americans hold dear. Contrary to prior practice, the law has seen federal tax dollars flow to fund health insurance plans that cover abortions.<sup>64</sup> The law also forces many Americans to choose between violating the law and violating their consciences, imposing mandates on non-profit and other institutions that violate their deeply-held religious beliefs. As a result, literally dozens of institutions nationwide have taken Obamacare's anti-conscience mandate to court; the Supreme Court is scheduled to rule on the issue later this summer.<sup>65</sup>

**R**epeal of Obamacare will remove the law's anti-conscience mandates, and the funding of plans that cover abortions. But true health reform should go further, instituting conscience protections for businesses and medical providers, as well as a permanent ban on federal funding of abortions, consistent with the Hyde Amendment protections passed by Congress every year since 1976.<sup>66</sup> There is much in health care about which Americans disagree, but protecting all Americans' religious liberty should be one principle that warrants bipartisan support. The government should not force religious people to abandon their faiths in order to keep their doors open.

Among its many other flaws, Obamacare represents an intrusion on the moral values many Americans hold dear.

64. Sarah Torre, "Obamacare's Many Loopholes: Forcing Individuals and Taxpayers to Fund Elective Abortion Coverage," Heritage Foundation *Background* No. 2872, January 13, 2014, <http://www.heritage.org/research/reports/2014/01/obamacares-many-loopholes-forcing-individuals-and-taxpayers-to-fund-elective-abortion-coverage>.

65. A full list of the court cases, and further information regarding them, can be

found through the Becket Fund for Religious Liberty, <http://www.becketfund.org/hhsinformationcentral/>.

66. Chuck Donovan, "Obamacare: Impact on Taxpayer Funding of Abortion," Heritage Foundation *WebMemo* No. 2872, April 19, 2010, <http://www.heritage.org/research/reports/2010/04/obamacare-impact-on-taxpayer-funding-of-abortion>.

## PRINCIPLE #3: PORTABILITY AND CHOICE

In an address to Congress in September 2009, President Obama attempted to sell Obamacare as offering consumers “competition and choice.”<sup>67</sup> At least 4.7 million Americans—those who have already received cancellation notices due to the law—would beg to differ with the President.<sup>68</sup> While the President offered a short-term concession—unilaterally waiving portions of Obamacare, and permitting some who lost health coverage to keep their plan until the 2016 presidential election—the cancellation notices are likely to continue for some time. A 2010 Administration document admitted that more than half of all workers, and up to four in five employees in small businesses, would lose their pre-Obamacare health coverage.<sup>69</sup>

At least 4.7 million Americans—those who have already received cancellation notices due to the law—would beg to differ with the President.

Obamacare undermines choice by dictating what type of insurance health plans must offer—and then dictating to firms that they must offer, and individuals that they must buy, this type of coverage. Conversely, true health reform would smooth the problems of portability that occurred prior to the law’s enactment, while offering more personalized choices so consumers can buy

the plan they want, not the plan a government bureaucrat tells them to purchase.

### STATE REFORMS TO EXPAND ACCESS:

For many decades, many states have held laws on their books that block access to care. At least 36 states have certificate of need (CON) requirements, which force organizations to obtain clearance from the state before building new health care facilities. In addition to the offensive nature of this approach—entities must ask government bureaucrats for permission to create a facility that will help patients—CON requirements have proven ineffective at their stated goal of reducing costs. One recent analysis noted that states without CON requirements have significantly lower health costs than those states with certificate of need mandates.<sup>70</sup> Congress repealed the law that created CON requirements nearly three decades ago; states can follow suit.<sup>71</sup>

Similarly, state licensing requirements can impose unnecessary burdens on medical practitioners, also limiting access to health care. Given that the supply of doctors is not expected to keep up with projected demand, policy-makers should allow other medical professionals to utilize more of their expertise to provide more affordable and convenient care for patients.<sup>72</sup> In 2011, the Institute of Medicine recommended that all professionals should be empowered to practice to the full scope of their professional training.<sup>73</sup> States should modify their licensing requirements to remove artificial barriers impeding the ability to provide high-quality care. States must also act prudently to protect patient quality and maintain

67. President Barack Obama, remarks to a Joint Session of Congress on Health Care, September 9, 2009, [http://www.whitehouse.gov/the\\_press\\_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care](http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-a-Joint-Session-of-Congress-on-Health-Care).

68. Associated Press, “Policy Notifications and Current Status, by State,” December 26, 2013, <http://money.msn.com/business-news/article.aspx?feed=AP&date=20131226&id=17219856>.

69. Interim final rule by Departments of Labor, Treasury, and Health and Human Services regarding grandfathered health insurance status, released June 14, 2010, [http://www.federalregister.gov/OFRUpload/OFRData/2010-14488\\_PL.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2010-14488_PL.pdf) Table 3, p. 54.

70. Jordan Bruneau, “The Great Healthcare CON,” Foundation for Economic Education, January 15, 2014, [http://www.fee.org/the\\_freeman/detail/the-great-](http://www.fee.org/the_freeman/detail/the-great-healthcare-con#axzz2qbUCvcC2)

[healthcare-con#axzz2qbUCvcC2](http://www.fee.org/the_freeman/detail/the-great-healthcare-con#axzz2qbUCvcC2).

71. There may need to be some very targeted consideration given to specific health care markets so dependent on government programs that taxpayers end up paying for unused capacity.

72. Association of American Medical Colleges, Center for Workforce Studies, “Recent Studies and Reports on Physician Shortages in the U.S.,” October 2012, <https://www.aamc.org/download/100598/data/>.

73. Institute of Medicine, “The Future of Nursing: Focus on Scope of Practice,” *Report Brief*, October 2010, <http://www.iom.edu/~media/Files/Report%20Files/2010/The-Future-of-Nursing/Nursing%20Scope%20of%20Practice%202010%20Brief.pdf>.

high standards. Doing so would expand access to care, allowing Minute Clinics and other similar entities to treat patients quickly and at lower cost than hospital emergency rooms or other sources of care.

**B**oth certificate of need and artificial scope of practice restrictions sometimes prioritize the interests of incumbent members of the health system over the needs of patients. In 2008, the Justice Department testified that CON laws “create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets’ ability to contain health care costs.”<sup>74</sup> Likewise, a seminal 2004 report on competition in health care by the Federal Trade Commission and Justice Department noted that scope of practice laws

insurance coverage through their employers means that individual health insurance plans have traditionally occupied a smaller segment of the marketplace.<sup>76</sup> As a result, most individuals transition from one employer plan to another when they switch jobs. However, moving from employer coverage to an individual plan can often prove more difficult and costly.

While not undermining the employer coverage that many Americans currently have and enjoy, conservative health reforms should also encourage policies that promote greater personal ownership of health insurance. One key reform would allow individuals who maintain continuous coverage to purchase an individual health insurance plan of their choosing, eliminating the requirement that such individuals first exhaust COBRA coverage before accessing an individual plan. These and other similar reforms will encourage Americans to purchase coverage they can take with them from job to job.

#### **CROSS-STATE INSURANCE PURCHASING:**

Because health insurance is regulated at the state level, many health insurance markets face two major problems. First, in many states, one or a handful of insurers control most of the market for coverage, and these oligopolies tend to raise premiums. Obamacare has not helped this trend, and in fact may have worsened it. According to the *New York Times*, more than half of all counties in the United States have only one or two health plans participating in their states’ insurance exchanges.<sup>77</sup>

Second, benefit mandates imposed by state legislatures force individuals to purchase more insurance coverage than they may need or want. According to the Council for Affordable Health

According to the *New York Times*, more than half of all counties in the United States have only one or two health plans participating in their states’ insurance exchanges.

create anticompetitive risks, have raised costs, and limited mobility of medical providers, all for unclear benefits to health care quality.<sup>75</sup> At a time when health costs remain high and access for vulnerable populations limited, states should act in both these key areas, initiating reforms that have the potential to reduce costs while simultaneously increasing access to needed care.

#### **BETTER ACCESS FOR INDIVIDUALS**

**CHANGING EMPLOYERS:** The fact that so many Americans currently receive health

74. Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission before the Illinois Task Force on Health Planning Reform, September 15, 2008, <http://www.justice.gov/atr/public/comments/237351.pdf>, pp. 1-2.

75. Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, July 2004, [http://www.justice.gov/atr/public/health\\_care/204694.pdf](http://www.justice.gov/atr/public/health_care/204694.pdf), pp. 25-28.

76. According to the U.S. Census Bureau, in 2012 170.9 million Americans were covered by employer-based insurance, compared with 30.6 million Americans

covered by direct-purchase insurance (including various forms of supplemental coverage). Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Census Bureau, September 2013, <http://www.census.gov/prod/2013pubs/p60-245.pdf>, Table C-1, p. 67.

77. Reed Abelson, Katie Thomas, and Jo Craven McGinty, “Health Care Law Fails to Lower Prices for Rural Areas,” *New York Times* October 24, 2013, <http://www.nytimes.com/2013/10/24/business/health-law-fails-to-keep-prices-low-in-rural-areas.html>.

Insurance, states have imposed an average of 44 benefit mandates, each of which raises health costs.<sup>78</sup> Individually, the mandates may not appear to raise premiums by a significant amount, but estimates suggest that collectively, benefit mandates impose hundreds of dollars in added costs to consumers every year.<sup>79</sup>

Such a measure would give power from insurance company cartels back to consumers, make health insurance portable across state lines, and reduce the growth of premiums.

**O**ne solution to both these problems rests in Congress enacting legislation allowing consumers to purchase health insurance across state lines. Consumers purchasing insurance across state lines would receive clear disclosures that their health coverage would be regulated by another state with respect to benefit mandates, solvency standards, and other similar requirements. By using its constitutional authority to regulate interstate commerce, Congress could give consumers the power—a power they currently lack—to buy the health insurance plan that best meets their needs, regardless of the state in which that plan is offered. Such a measure would give power from insurance company cartels back to consumers, make health insurance portable across state lines, and reduce the growth of premiums.

**POOLING MECHANISMS:** In addition to allowing the purchase of health insurance across

state lines, Congress should also provide clear protections, similar to those provided in the Employee Retirement Income Security Act of 1974 (ERISA), for organizations that wish to establish multi-state insurance pools. These organizations could be churches, fraternal organizations, trade groups for small businesses, alumni groups, or any other type of group with a common interest. These groups should be permitted to band together and purchase health insurance for their members, providing coverage that fits members' distinct needs while potentially reducing administrative costs. Just as importantly, coverage obtained through these pools, unlike employer coverage, would be portable: Individuals would have and own their personal health policy, and would not need to change plans when they change jobs.

**LAWSUIT REFORM:** In many states, medical liability problems present several problems for patients. First, defensive medicine practices—doctors performing unnecessary tests due to fear of litigation—raise health costs, according to some estimates by more than \$100 billion annually.<sup>80</sup> Second, the seeming randomness of the legal system—in which some frivolous claims receive large awards, but some legitimate claims are dismissed—frustrates patients. Finally, at a time when America already faces expected physician shortages, the legal climate discourages prospective doctors from pursuing medicine as a career choice.<sup>81</sup> A recent study found that physicians spend more than 10% of their careers with an outstanding malpractice claim lingering over their practice.<sup>82</sup> More than three in five physicians claim they or one of their colleagues may retire in the next three years due

78. CAHI found a total of 2,271 benefit mandates enacted in 50 states and the District of Columbia. Council for Affordable Health Insurance, "Health Insurance Mandates in the States 2012: Executive Summary," April 9, 2013, [http://www.cahi.org/cahi\\_contents/resources/pdf/MandatesintheStates2012Execsumm.pdf](http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2012Execsumm.pdf).

79. One study found that benefit mandates raise premiums by an average of \$0.75 per month, or \$9 per year. A state with the national average of 44 benefit mandates would therefore have raised premiums by an average of \$396 annually. See Michael J. New, "The Effect of State Regulations on Health Insurance Premiums: A Revised Analysis," Heritage Foundation *Center for Data Analysis Report* No. 06-04, July 25, 2006, <http://www.heritage.org/research/reports/2006/07/the-effect-of-state-regulations-on-health-insurance-premiums-a-revised-analysis>, p. 5.

80. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care," March 2003, <http://aspe.hhs.gov/daltcp/reports/mediab.pdf>, p. 16.

81. Association of American Medical Colleges, "Recent Studies on Physician Shortages."

82. Seth A. Seabury, *et al.*, "On Average, Physicians Spend Nearly 11 Percent of their 40-Year Careers with an Open, Unresolved Malpractice Claim," *Health Affairs* January 2014, <http://content.healthaffairs.org/content/32/1/111.full.pdf+html>.

to frustration with the health care system—a fact likely exacerbated by an overly litigious culture.<sup>83</sup>

**E**nacting lawsuit reforms—including a cap on non-economic damages, restrictions on attorney contingency fees, discouraging frivolous lawsuits, and other common-sense changes—would reduce health care costs. Because nearly half of all health spending is controlled by government, largely through the Medicaid and Medicare programs, Congress should take the lead in enacting lawsuit reforms in instances where the federal government is a payer of health services.<sup>84</sup> If enacted, these changes could have a salutary effect on America's physicians, just as the passage of tort reform in Texas encouraged more doctors to move to that state.<sup>85</sup>

**FREEDOM FOR SENIORS TO CHOOSE:** The doctor-patient relationship is the foundation on which our health care system should be based. Unfortunately, government requirements often impede the ability for patients to choose the best option for their own care. For instance, one law dictates that senior citizens may not make their own financial arrangements with their doctors if those arrangements contradict Medicare's payment rates; any physician who does so is prohibited from receiving any reimbursements from Medicare for two years.<sup>86</sup>

Congress should restore the doctor-patient relationship by repealing this onerous requirement. It should also restore the ability of Medicare patients to buy procedures on their own, provided seniors receive full disclosure from their physicians and medical providers for the costs of their care. The *Wall Street Journal* reported that the number of doctors dropping

out of Medicare nearly tripled between 2009 and 2012.<sup>87</sup> Senior citizens should not have access to the physician of their own choosing—or to procedures their doctors recommend for them—violated due to arbitrary restraints imposed by federal bureaucrats.

|| The doctor-patient relationship is the foundation on which our health care system should be based.

Taken together, this package of reforms would accomplish the objectives the American people are looking for in their health care system—the objectives President Obama said his legislation would bring, but which Obamacare has not delivered. Enacting policies that get the incentives right can reduce costs, even while protecting the most vulnerable and enhancing portability and choice for consumers.

The American people deserve true health reform—one that puts patients and doctors first, not government bureaucrats. After repealing Obamacare, enacting America Next's plan would point America's health system in the right direction.

83. Deloitte Center for Health Solutions, "Deloitte 2013 Survey of U.S. Physicians," March 18, 2013, [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us\\_chs\\_2013SurveyofUSPhysicians\\_031813.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_2013SurveyofUSPhysicians_031813.pdf), p. 3.

84. Gigi A. Cuckler, *et al.*, "National Health Expenditure Projections."

85. Joseph Nixon, "Why Doctors Are Heading for Texas," *Wall Street Journal* May 17, 2008, <http://online.wsj.com/news/articles/SB121097874071799863>.

86. Section 4507 of the Balanced Budget Act of 1997, P.L. 105-33.

87. Melinda Beck, "More Doctors Steer Clear of Medicare," *Wall Street Journal* July 30, 2013, <http://online.wsj.com/news/articles/SB10001424127887323971204578626151017241898>.

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