

Patients' Choice Act

Q&As

1. Isn't this a new tax on health care, as you make health care premiums part of taxable income?

Our bill changes how health care is taxed, but it is revenue neutral and not a tax increase. By bringing long overdue reforms to our discriminatory tax code, millions of families will end with more money in their pockets and better health care.

The current system effectively subsidizes *corporations* rather than *patients*, and subsidizes health *insurance* instead of health *care*. Under the status quo, Americans working for Wall Street conglomerates rake in more than \$200 billion in tax breaks for their health benefits, but Americans struggling to buy health care on their own do not see a penny for the same plans. Furthermore, the current system discriminates against low-income Americans: wealthy Americans receive \$2,680 in tax breaks for health care while the poorest Americans get only \$102.

Americans happy with their employer-sponsored health benefits should be able to keep what they have, but they, not the government, should make that decision. The tax break should go directly to each individual with a healthcare plan. This will give hardworking Americans the control and the *freedom* to *decide* how best to spend their hard earned dollars when it comes to providing superior healthcare to their families.

This plan rejects the notion that we should accept tax discrimination in our health care system, which favors the wealthy at the expense of the self-employed, the unemployed, and small businesses. The Patients' Choice Act [PCA] ends the discrimination that has forced millions of Americans to accept second-rate health care, and replaces the exclusion with a universal tax credit, bringing much needed equity to our tax code. Additionally, the Patients' Choice Act restores the idea of portability to health coverage: if you move or change jobs – you won't lose your health care. These commonsense reforms ensure a vast majority of Americans will enjoy a considerable reduction in their tax liabilities, while also reclaiming ownership of their health care decisions.

The tax exclusion for employer-provided health coverage hides the true cost of insurance from those covered by it, undermines the health care market, and contributes to more expensive care and more costly insurance.

2. Why create a tax credit (\$5,710) that costs less than the average cost of insurance for a family of four? How are individuals and families supposed to make up the difference?

The Patient's Choice Act will equalize treatment of wages and health coverage under the tax code, which economists say will effectively increase workers' wages so all Americans can obtain affordable and efficient health coverage. A leading health care economist from the Massachusetts Institute of Technology who testified at the Senate Finance Committee in May 2009, John Gruber, has stated that "the costs of health insurance are

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fully shifted to wages.”¹ Redirecting tax benefits from corporations directly to patients will increase wages for hardworking Americans.

As a result of biases in the current tax code, Americans who receive their health benefits from their employer pay roughly one-third of the total health coverage costs, while their employer pays roughly two-thirds. For example, the average family’s annual health insurance plan cost about \$13,000 last year, with an employer paying about \$8,600, while the employee only paid about \$4,200 in annual premiums. Under the Patients’ Choice Act, all Americans would receive a tax credit – over \$5,700 for families – which can only be used to pay for health insurance or medical expenses. Individuals and families will be able to use any overages to pay for preventive care, which can be rolled over at the end of the year.

Economists from across the political spectrum – including President Obama’s own economic advisors – have argued that the current tax treatment of health benefits is one key driver of our out-of-control health care costs. Jason Furman, the President’s deputy economic advisor argued that replacing the tax exclusion with tax credits would reduce health spending without harming health outcomes: “Replacing the current tax preference for insurance with an income-related, refundable tax credit has the potential to expand coverage and reduce inefficient spending at no net federal cost.”²

3. Isn't this the McCain plan? How is this bill different?

One cornerstone of the Patients’ Choice Act is our elimination of the discriminatory distortions in the tax code, so all Americans are able to purchase health insurance that is portable and affordable. The goal is to make individuals and families the owners of their health coverage, not the companies for which they work. So, to some extent, this particular element is similar to proposals outlined by Senator McCain during his presidential campaign.

But our plan today differs from Senator McCain’s campaign proposals in several key ways. First, Senator McCain’s plan was expensive, costing the taxpayers hundreds of billions of dollars over a projected budget window. At a time when one out of three federal dollars already goes to health care costs and our economy is in recession, we do not need to spend a dime more of taxpayer money on health care. Our bill is revenue neutral and budget neutral.

Second, Senator McCain’s plan relied on federal subsidies of high risk pools to get all Americans covered. While our plan allows states to utilize high risk pools or a reinsurance tool, we believe the more innovative concept in our bill is a risk readjustment mechanism for insurers and states to develop creative solutions for

¹ Cited in Ezekiel J. Emanuel, MD, PhD and Victor R. Fuchs, PhD, “Who Really Pays for Health Care Costs,” *Journal of the American Medical Association*, March 5, 2008, <http://jama.ama-assn.org/cgi/content/extract/299/9/1057>

² Furman, Jason, “Health Reform Through Tax Reform: A Primer,” *Health Affairs*, May/June 2008, <http://content.healthaffairs.org/cgi/content/abstract/27/3/622>.

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patients and consumers in their states. In general, rather than design a single federal solution, our bill looks to states as the laboratories of policy and promotes state-based health exchanges, where consumers can navigate a real health care market, with added protections for lower-income Americans and those with preexisting conditions. We empower states to expand risk pools and increase coverage to consumers through an auto-enrollment mechanism at state and medical points of service.

Third, we also address several other areas which were simply outside the scope of Senator McCain's plan, but which are key to building sustainable, comprehensive reform:

- Our plan emphasizes prevention and wellness, with increased accountability for federal programs, incentives that reward results, and educational outreach driven by sound science.
- We modernize Medicaid, putting it on a sound financial path, removing the stigma from Medicaid and giving Medicaid patients real choice for the first time –roughly doubling the number of providers which needy families on Medicaid can access.
- Our proposal gives states options for health courts and expert review panels to reduce medical liability junk lawsuits and reduce the need for “defensive medicine”
- We create a new public-private enterprise which will give all patients, consumers, and researchers substantially increased transparency on price and quality

4. Doesn't this undermine existing employer-based health care, and push workers into the private market to fight big insurance companies on their own?

No. Americans who like their employer-sponsored health benefits will be able to keep what they have. But individual Americans should make that decision – instead of falling victim to arbitrary tax rules or staying in a job only because they can't afford to lose their health insurance. Tax breaks should go directly to every individual with a health insurance plan. This will give hardworking Americans the control and the freedom to choose how best to spend their hard earned dollars when it comes to choosing health care for their families.

Many Americans rely on the companies they work for to make health insurance decisions. But what if they move cities, change jobs – or worse – lose their job? All Americans should have the security of knowing they would not lose their health insurance or have their benefits change. Our current employer-based system came about not by design, but as the accidental result of historical events. During the Second World War, when the Federal Government imposed wage and price controls, employers sought to attract workers from a tight labor pool by offering modest health coverage, and excluding the costs from wages. When these employers sought endorsement of the practice from the Internal Revenue Service [IRS], the IRS approved. After the war, when the IRS tried to rescind this decision, Congress wrote it into law. The exclusion, which

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this year totals an estimated \$151.8 billion, has made employer-provided coverage the most common form of health insurance.

Although the employer-based tax health benefit helped expand health coverage during and after the war, it has evolved into an expensive, inflexible, and unfair subsidy, and is out of step with today's diverse, and rapidly changing workplace. It also contributes to the insecurities felt by those who have employer-based health insurance, because they fear sacrificing coverage if they lose or change jobs.

The Patients' Choice Act will give individuals the power and the resources to take ownership of their health coverage. There are significant protections for individuals, who cannot be refused coverage based on age or health from an insurance company participating in state exchanges. A consumer-driven health care model ensures that all Americans – regardless of income, age, or health – are in the best position to secure the health benefits they want and get the care they need.

5. How do the state exchanges work? How are the state-based health exchanges in your bill different from the Massachusetts connector model?

State-based exchanges facilitate the purchase of private health insurance based on price and quality. A large variety of plans, including a plan you can tailor to fit your individual or family circumstances, will be available. To encourage enrollment, States may develop automatic enrollment procedures to ensure that every individual seeking health coverage has the opportunity to enroll in a plan (though individuals may opt-out from health coverage). Any health insurance plan licensed in the state may participate in the Exchange, though plan participation is not mandatory. Participating insurers must offer at least the same standard health benefits made available to Members of Congress and are prohibited from discriminating based on prior medical history or existing conditions and must provide annual open enrollment periods to enroll newly eligible individuals.

Individuals are guaranteed access to a health insurance plan through the Exchange. To avoid cherry-picking of patients by insurance companies, exchanges can utilize mechanisms to protect enrollees from the imposition of excessive premiums, to reduce adverse selection, and to share risk. Options include an independent risk adjustment mechanisms, health security pools and reinsurance mechanisms.

Whether an individual uses an insurance broker, an internet comparison page, or calls a toll free number, individuals are provided the information needed to choose a plan tailored to their individuals needs. Once a plan is selected, the insurance company will claim the portion of the Medi-Choice rebate necessary to pay the premium. Some plans will be entirely covered by the rebate while others will require a monthly payment in addition to the rebate. For the first time, coverage will be available without regard to employment status. Individuals will also enjoy the benefits of being able to shop across state lines for insurance products – through the use of interstate compacts and multi-state pooling arrangements.

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There are significant differences between the state-based exchanges described above and the Massachusetts connector model are as follows:

- The connector requires an individual mandate to purchase health insurance, with a penalty for opting out. The exchange has no such mandate, and no opt-out penalty.
- Insurance plan participation in a connector is mandatory, forcing all plans into one system. Plan participation in an exchange is optional – encouraging competition among insurers by allowing plans the benefit of a large pool of consumers and patients armed with a tax rebate to purchase health insurance, so long as they abide by certain requirements – such as guaranteed access and minimum benefit standards.
- Under a connector model, all individuals must purchase coverage through the connector. The exchange continues to allow individuals to purchase insurance outside the exchange. Individuals are able to use their tax credit to purchase insurance that is offered outside the exchange, so long as the plan is licensed in the state.

The Massachusetts Connector offers many lessons in health care reform, but too many of the lessons are not positive (for example, Boston now ranks as one of the most expensive cities in the nation to buy health insurance and the state's overall health costs have increased by 42% since the reform legislation was enacted in 2006). States and Governors can build smarter, more efficient solutions for all Americans by utilizing state-based exchanges.

6. How does auto-enrollment work? If I were uninsured and was auto-enrolled when I went to the DMV, what plan would I be forced into? Also, why would I want to spend more time at the DMV filling out confusing forms?

Some in Congress think the Federal Government should create a mandate requiring everyone to have health insurance. This would make it illegal for individuals to not have coverage. We strongly disagree. We believe a better option is to let states design a system and select a tool which works best for them. Our plan allows states to utilize a simple auto-enrollment mechanism to help people enroll in health insurance plans when they go to a hospital, or a doctor's office, or an emergency room. States could also use their DMVs or state income tax forms as vehicles for auto-enrollment. Our plan does not dictate details, but lets states choose the best vehicles for auto-enrollment.

Auto-enrollment is not an individual mandate. With a new tax credit for most people under age 65, our plan essentially creates a bank account for a health insurance policy for each individual. The tax credits cannot be used to purchase anything other than health insurance, or pay for medical and preventative services. With an auto-enrollment mechanism, individuals could choose to select a plan and write the check themselves, or, the tax credit can be "automatically" designated to a high deductible private plan if the covered individual does not opt out. The credit would cover the full cost of the policy so there would be no fines or penalties. But individuals and the market would quickly catch on.

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Numerous studies show that auto-enrollment mechanisms can help create a “positive default” action. And by simply helping more people enroll in health plans (which they will be able to afford with the tax credit), we can help millions of Americans currently without insurance have real health coverage for the first time. And, because about 25-45% of bankruptcies are currently a result of high medical bills, our plan can help give all Americans real health security, protecting families from unforeseen catastrophic events which might not only endanger their health, but might also jeopardize their financial stability.

Under our plan, we let states design solutions that work best for them. So states would decide what points of medical service or state government would be used to enroll uninsured people, as well as what specific kind of plan uninsured people would be enrolled in. But no patient in any state would be forced into a plan. We believe in patient choice and our plan gives all American patients more, better choices.

Under our bill, state exchanges must also provide for “choice counseling” to help individual patients choose the plan that best fits their needs and budget. So, whether at a doctor’s office or a state government office, states could design a system where patients have the information they need to make the best decision for themselves. For patients who make no decisions, they would simply be automatically enrolled in a low-cost, high-deductible catastrophic health care plan.

7. What does this plan do to ensure coverage for those with preexisting conditions and the chronically ill? Why would a private insurance company offer coverage to these 'uninsurable' individuals? Isn't this why we need a public option, to cover those that private insurers refuse?

Our plan uses guaranteed issue of health coverage for any patient in a state exchange – even those with preexisting conditions and the chronically ill. Insurers participating in state exchanges would be required offer coverage to any individual, regardless of age or health status.

Private insurance companies currently have no economic motivation to offer coverage to patients with preexisting conditions or the chronically ill. Under our plan however, insurers are not only required to offer coverage, but they would have financial incentives to better manage patient care, resulting in better health outcomes and lower costs. Health insurance coverage will slowly shift from paying when you are sick, to helping you and your doctor manage your wellness and focus on prevention.

A public option is a bad deal for the American public. From what we have learned from the experience of several European countries, such a system would underpay doctors and hospitals, reduce the number of talented professionals in the medical field, and eventually lead to rationing of care. Furthermore, a respected independent policy research group, the Lewin Group, found that a so-called “public option” would lead to the collapse of the private insurance market, as about 120 million Americans would lose their current private health care coverage. The resulting government-run plan would be

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bureaucratic, costly, and deny patients their ability to see the doctor they want and get the care they need.

8. There are an estimated 45 million Americans without health insurance. How many more Americans will be covered under your plan?

Many people estimate there are 45 million Americans without health insurance. Under our plan, with the creation of a tax credits and state exchanges, as well as the utilization of auto-enrollment provisions, all uninsured Americans could be covered. Our plan is comprehensive, offering the possibility of health coverage to every single American, regardless of their health status, whether or not they pay taxes, whether or not they work, and whether or not they currently have health insurance. Under our plan, Americans would have money in their pocket specifically allocated for the purchase of health insurance and medical care. There would no longer be any reason for any American to not have health care and coverage. For example, the estimated 10.7 individuals and families eligible for Medicaid or SCHIP would have more money in their pocket, roughly double their access to care, and could choose the coverage they need.

Under our plan, the 10.1 million people currently living at 300% of the poverty level without health insurance would have more money in their pocket to buy the care and coverage they need. Under our plan, even the 5 million young, healthy adults would have more money in their pocket and could opt for HSA plans, rolling over their health care dollars and paying for prevention and wellness. Our plan brings the possibility of universal coverage within sight, but relies on individuals not bureaucrats, enabling all Americans to choose the care and coverage they need, with the affordability and access they want.

9. When individuals venture into the market alone, the concept of risk pooling breaks down. Shouldn't we seek to bring more Americans under a larger blanket of coverage, so the health risks will average out among the population? Without relatively healthier counterparts, what incentive will an insurance company have to insure a relatively sick individual at a reasonable price?

It is true that under our current system, a single patient venturing into the individual market does not have the benefit of spreading risk (and costs) in a broader risk pool. This is a problem that our bill resolves. Under our plan, individual patients will be able to buy innovative health insurance products in a state exchange and benefit from the broader risk pool of the exchange. Unlike a large nationalized, government-run plan where everyone is covered by the government, under our plan, individual patients have financial incentives to buy the coverage they need. This means that patients can see the doctors they want and get the medicines they need, but they won't be over insured. To give states even more creative tools to address the issue of risk pooling, our plan also lets states choose to create high risk pools or reinsurance mechanisms to ensure the needs of their patients are met.

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Under our plan, states will create real marketplaces where both healthy and sicker patients can purchase innovative, well-designed insurance products to meet their needs. Because our plan includes a risk adjustment mechanism – removing the incentive for “cherry-picking” – we help equalize the risk across companies which cover relatively healthy and sick patients.

10. This seems like too drastic of a reform - why can't I just keep what I have, and focus reforms on extending coverage to the uninsured?

Under our plan, if you like the health coverage you have, you can keep it. If you have health insurance through your employer, nothing will change. For most Americans, the tax credit they will receive will cover the premiums for employer-provided health benefits they currently receive, as well as the marginal tax liability on the cost of health insurance provided by the employers which will be counted as wages. But employees who like their employer-provided health benefits get to keep it. Employers will still be able to count health insurance provided to their employees as a tax-free, business cost write off, just like they write off wages now.

For the millions of Americans who don't currently have the benefit of employer-based health coverage, their situation dramatically improves for the better. Currently, Americans who are unemployed or self-employed have minimal purchasing power for health insurance. And many Americans who work part-time also have little purchasing power and no tax benefits for purchasing health coverage. Our bill changes this. Under our plan, every American will have a tax credit to purchase a health insurance policy which meets their needs. Families working in a small-business, or individuals working part time – every American receives real purchasing power to get the care and coverage they need. Families will have a tax credit worth over \$5,700, and individuals will have a tax credit worth about \$2,300.

11. Won't an emphasis on competition and market forces favor the wealthy, the healthy, and big insurance companies?

No, because we are changing the paradigm of how insurance companies maximize profits under the current system. Under the status quo, insurance companies increase profits by covering healthier and younger groups of people and minimizing the number of claims paid. This is an unsustainable model. Through State Exchanges, health insurance companies would be rewarded by covering the uninsurable. Instead of managing claims payment, plans will have a direct role in managing wellness.

The lack of health insurance is a serious problem for some Americans. But it is mainly the result of rapidly rising health care costs, which are themselves a problem for every American. Our plan provides real solutions for both groups.

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12. Why mess with a program like Medicare where satisfaction among seniors remains relatively positive? Should these government-run health care programs be used as the model for the rest of our health care system?

It is true many seniors are satisfied with Medicare. But financial problems can be seen on the horizon. We already lose over \$50 billion in fraud, waste, and abuse each year. Costs are increasing as the baby boomers are aging and more people are living longer. Americans not on Medicare see the average cost of their premiums artificially higher by about \$1,500 each year, due to the cost shift from Medicaid and Medicare. And, in recent days, the Medicare Trustees Report noted for the fourth year in a row that the long-term financial sustainability of Medicare is in jeopardy as early as 2017.

But financing isn't the only problem with Medicare. New Medicare beneficiaries (those just turning 65) are having trouble finding a physician that will take Medicare. Seniors that relocate closer to their families are having a similar problem. Long-term care services covered by Medicare encourage high rates of re-hospitalization among seniors with multiple chronic conditions. A lack of coordination with long-term care services provided by Medicaid can be confusing for families caring for aging loved ones during already emotionally-trying times.

True health care reform has to leave us with a sustainable system, not a new expansion of government that will collapse on itself. The "public option" or "Medicare for all" is based on the same old ideas and failed strategy of assuming that increasing government spending will fix health care. These plans are particularly dangerous in light of our short and long-term economic outlook because the costs of government health programs have been chronically underestimated, and the cost-shifting that occurs hurts beneficiaries when and where they choose to seek care.

13. How do you force private insurance companies to cover everyone without a public option or a mandate?

States will have the flexibility they need to guarantee affordable insurance is available to everyone – including those with chronic conditions or disease. Plans offered on the exchange will not be able to turn anyone away. However, some plans may end up with healthier pools than others. To encourage reasonable risk sharing among plans, states will be able to establish an independent panel to implement risk adjustment among health plans. High risk pools and reinsurance will also be available to states. Competition among providers and the need to have a balanced portfolio will encourage insurers offer coverage to high risk populations.

14. How is the Healthcare Services Commission, which sets standards and measure effectiveness, different from the Obama Administration's Institute of Comparative Effectiveness, which you often criticize as being a vehicle for rationing care?

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The Institute for Comparative Effectiveness, which was established as part of the recent 'stimulus' legislation, is built upon the notion that the federal government will dictate to doctors and health care providers how health care will be delivered. Other countries have similar agencies – in England it is called the National Institute of Comparative Effectiveness [NICE]. For those who propose it in America, it will serve as a mechanism for rationing healthcare.

Our proposal repeals the provisions of the 'stimulus' bill which created the Institute, replacing it with the Health Care Services Commission. We believe that greater transparency, and knowledge of price and quality data is critical for the functioning of a vibrant health care market, but the PCA rejects the notion that these standards should be set by a bureaucracy in Washington. Rather than the heavy hand of government, uniform and reliable measures of reporting quality and price information should be designed by the stakeholders in health care, with input from the general public. The PCA creates a Healthcare Services Commission that relies on a public/private partnership to enhance the quality, appropriateness and effectiveness of health care services through the publication and enforcement of quality and price information.

15. You seem to make a lot of promises about universal health care, as well as investments in prevention and health IT. How much will your plan cost the American taxpayer?

The Patient's Choice Act is budget neutral. We anticipate a cost estimate will demonstrate revenue-neutrality as well, meaning net taxes will decline, or remain at their current level, costing the American taxpayers no additional money. The legislation will redirect tax dollars, leveling the playing field so every American has access to affordable health insurance. Official cost estimates have been requested from the nonpartisan Congressional Budget Office and the Joint Committee on Taxation.