



The Patients' Choice Act

Questions and Answers

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 up 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, advanceable, and refundable tax credit brings much needed equity to our tax code. Additionally, the PCA 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 Patients' Choice Act would effectively increase workers' wages. Higher take-home pay combined with the new tax subsidies would enable individuals to obtain more affordable and efficient health coverage. A leading health care economist from the Massachusetts Institute of Technology, John Gruber, stated that "the costs of health insurance are fully shifted to wages."¹ Redirecting tax benefits from corporations directly to patients will increase wages for hardworking Americans.

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>

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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. So a family's plan that costs \$15,000, the employer covers \$10,000, while the employee only pays \$5,000 in annual premiums. Under the Patients' Choice Act, employees would be provided an advanceable, refundable tax credit - \$5,710 for families - that will more than pay for an employee's part of their current health care premiums. Employees will be able to use the overages to pay for preventive care, and can be rolled over annually.

Economists from across the political spectrum - including President Obama's own economic advisors have made the case that the current tax treatment of health benefits is a root 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. Mr. Furman wrote: "Replacing the current tax preference for insurance with an income-related, refundable tax credit has the potential to expand coverage and reduce inefficient spending at no net federal cost."²

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

The centerpiece of this proposal is eliminating the discriminatory distortions in the tax code so that 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; and to this extent, it is similar to Senator McCain's proposal.

Among the some significant and transformative components of the PCA:

- Promotion of state based exchanges to help consumers navigate the health care market, with added protections for lower-income Americans and those with preexisting conditions;
- Emphasis on prevention and wellness, with increased accountability for federal programs, incentives that reward results, and educational outreach driven by sound science;
- Expansion of coverage through auto-enrollment at state and medical points of service; and,
- Numerous other reforms, including a long-overdue modernization of Medicaid, medical malpractice reforms, increased transparency on price and quality, and more.

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?

Americans who enjoy their employer-sponsored health benefits will be able to keep what they have, but they should make that decision instead of the government. Tax breaks should go directly to every individual with a health insurance 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 choosing healthcare for their families.

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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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 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 economy. 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 position to own and secure their health coverage.

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 will have 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

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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 regardless of employment. 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.

The main 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. The exchange has no such mandate.
- Insurance plan participation in a connector is mandatory, forcing all plans into one system. Plan participation in an exchange is optional – encouraging competition by allowing plans the benefit of a large pool of shoppers 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 disagree. Our plan uses 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. Numerous studies show that auto-enrollment mechanisms help create a "positive default" action. Under our plan, when patients without coverage came to the hospital or DMV, they would be automatically enrolled in a high-deductible health plan. By simply helping more people enroll in health plans they can afford, we can help cover the millions of Americans who are currently without insurance. Also, because currently about 20% of bankruptcies are a result of medical bills, our plan helps protect average Americans from unforeseen catastrophic events which might not only endanger their health, but also jeopardize their financial security.

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

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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, states would offer “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. Such a system would underpay doctors and hospitals, leading to rationing of care. Furthermore, a respected independent think tank, the Lewin Group, found that a so-called “public option” would mean about 120 million Americans would lose their current private health care coverage. The resulting government-run plan would be bureaucratic, costly, and deny patients seeing the doctor they want and getting the care they need.

8. There are an estimated 46 million Americans without health insurance. How many more Americans will be covered under your plan?

Our plan is comprehensive, offering coverage to every single American, whether they currently have health insurance or not. Under our plan, the estimated 10.7 million individuals and families eligible for Medicaid or SCHIP would have more money in their pocket, roughly double their access to care, and can 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, the 5 million young, healthy adults would be auto-enrolled in low cost plans, and other remaining segments of the uninsured crowd would have better choices for coverage that is more affordable.

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

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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, single patients can buy innovative health insurance products in the 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.

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, you can keep the coverage you have if you choose. If you are covered through your employer, nothing will change. Your \$5,700 tax credit more than meets the employee contribution you currently pay and the amount your company paid (in most cases two-thirds of the total cost of your insurance plan) will be converted to wages because the business can still write that off as a business expense. This allows you to continue your health coverage through your employer if you like the coverage you receive because your purchasing power doesn't change.

For those who don't have the option of employer based coverage things change for the better. Currently, those that were unemployed or self-employed have minimal purchasing power when it comes to health insurance. Under this bill, these families will now have a tax credit worth of \$5,700 to purchase a health insurance policy that meets their needs.

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 most beneficiaries are satisfied with Medicare. But Medicare is already starting to show some strain. Recently, the Medicare Trustees Report shows that the long-term sustainability of Medicare is in jeopardy as early as 2017. And 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?

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 shares the belief 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.

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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 Patients' 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.