A FRAMEWORK FOR PERSONALIZED, AFFORDABLE CARE

REPUBLICAN STUDY COMMITTEE
HEALTH CARE PLAN
PART ONE

RSC

A FRAMEWORK FOR PERSONALIZED, AFFORDABLE CARE

REPUBLICAN STUDY COMMITTEE
HEALTH CARE PLAN
PART ONE

RSC
THE REPUBLICAN STUDY COMMITTEE

"THE REPUBLICAN PARTY WILL SOON BE THE PARTY OF HEALTH CARE. YOU WATCH."

President Donald J. Trump, March 23, 2019

Fellow Americans,

The birth of our great nation was inspired by the bold declaration that our individual, God-given liberties should be protected from government overreach and intrusion. As conservatives, that same conviction still informs our actions and policy proposals in every area. Health care is no exception, and the current system is in urgent need of reform.

We approach this challenge today with a review of the sobering facts. The first half of this report shows that millions of Americans have experienced substantially increased costs and a reduced quality of care as a result of the Affordable Care Act. Sadly, too many people with pre-existing conditions, chronic health issues and other challenges are suffering and need real relief.

Beyond the raw statistics are countless personal stories. We share some of those here to acknowledge the fear and uncertainty that can accompany an unexpected diagnosis, irregular test result, childhood illness, or a frantic visit to an emergency room. Every family has its own stories, and health care is an intensely personal issue.

In response to this dilemma, the Left insists that Congress should double-down on the failed current system, or shift to a government run, one-size-fits-all system. Because Americans deserve better, the second half of this report presents a carefully designed framework—based on nearly a year of intensive research and discussions with experts and stakeholders—that can dramatically improve access to quality, affordability, and choice in the American health care system.

It is a plan that: **PROTECTS** the vulnerable – especially those with pre-existing conditions; **EMPOWERS** individuals with greater control over their health care choices and dollars; and **PERSONALIZES** health care to meet individual needs and reduce premiums, deductibles, and the overall cost of health care.

While we anticipate thoughtful debate, even amongst ourselves, about some of the specific details that will emerge from this framework, we find it to be a strong step toward a health care system that can refocus on care. We present this conservative framework as an alternative to more, destructive government interference. We present these solutions to put Americans back in control of their health care decisions. And we submit this as the roadmap that can ensure the Republican Party is the party of health care. **PROTECT, EMPOWER, AND PERSONALIZE.** This is what we support, and this is what we aim to do.

Sincerely,

Rep. Mike Johnson
RSC CHAIRMAN

Rep. Roger Marshall, M.D.
RSC HEALTH CARE TASK FORCE CHAIRMAN

Rep. Phil Roe, M.D.
RSC HEALTH CARE TASK FORCE VICE CHAIRMAN

Rep. Debbie Lesko

Rep. Larry Buchshon, M.D.

Rep. Mike Kelly

Rep. Mark Green, M.D.

Rep. John Joyce, M.D.

Rep. David Rouzer

Rep. Chip Roy

TABLE OF
CONTENTS

PAGE NUMBER

08 **01 INTRODUCTION**

12 **02 THE STATUS QUO UNDER THE ACA**

Main Components of the ACA 14
- i. Regulatory Architecture
- ii. Low-Income Subsidies
- iii. Medicaid Expansion

The ACA: Failing the People it was Designed to Protect 19

The ACA's Failed Medicaid Expansion 30

The Disaster of Single-Payer 34

38 **03 THE RSC HEALTH CARE PLAN**

A Fresh Start 40

Health Insurance Portability 41
- i. Enhanced Portability Protections
- ii. Guaranteed Coverage Pools
- iii. Tax Benefit Equality
- iv. Unleashing Health Savings Accounts

Protecting Medicaid's Vulnerable Populations 51

Expanding Access to Innovative Care 52
- i. Expanding Direct Primary Care
- ii. Health Care Sharing Ministries
- iii. Association Health Plans
- iv. Health Status Insurance
- v. Short-Term, Limited-Duration Plans
- vi. Telemedicine
- vii. Certificate of Need Laws

57 **04 CONCLUSION**

60 **05 SUPPLEMENTAL MATERIALS**

FAQ'S 60

Contrast Document 66

INTRODUCTION

INTRODUCTION

America's health care system has suffered from serious problems for decades. The antiquated laws that predated the Patient Protection and Affordable Care Act of 2010 (also known as "Obamacare" or the "ACA") needed revision, but the ACA has made the situation worse by dramatically increasing costs and reducing both the quality of care and the number of available choices in the health care market. This is a crisis for many Americans that grows with each passing day as more and more patients lose their preferred doctors, or are forced to forgo coverage entirely due to its enormous costs. The current trajectory is simply unsustainable.

Congress has an obligation to fix this mess. The Republican Study Committee (RSC), as the largest caucus of conservatives and the group known as the "intellectual arsenal" of conservativism in the House, aims to meet this obligation by offering bold, thoughtful solutions to ensure Americans have access to the personalized, quality care they deserve. We believe cost-effective health insurance can and should be available to all Americans, including those with pre-existing conditions. Our goal is a thriving health care market that promotes individual choice, quality care and affordable options.

Many of our Democrat colleagues, meanwhile, are moving in the opposite direction. They offer the American people only two bleak options: double-down on the status quo or mandate government-run, one-size-fits-all health care. Their idea of "Medicare for All" would ensure an unprecedented expansion of the federal government instead of personalized, affordable options. It would also cost American taxpayers an estimated $32 trillion in new taxes to artificially control premium increases, and would inevitably lead to long wait times and a reduced quality of care.

If government-run health care were the answer, the Veteran's Health Administration (VHA) would serve as the gold standard. Of course, it does not. Because of its flaws, many veterans have suffered and some have even lost their lives waiting on care they desperately needed. Does anyone really believe Washington bureaucrats could be trusted to manage the individual care of hundreds of millions of Americans? The people of this country deserve so much better.

RSC MEMBERS REFUSE TO IGNORE THE CURRENT CRISIS AND WILL NEVER AGREE TO TURN AMERICAN HEALTH CARE OVER TO BIG GOVERNMENT.

Our RSC Health Care Plan introduces reforms that can: achieve a vibrant market with protections for all, including those with pre-existing conditions; encourage continuous coverage through true insurance portability; and ensure an appropriate and sustainable safety net for our most vulnerable citizens. A second report detailing additional policy recommendations will follow at a future date, and include additional recommendations to further reduce the costs of health care and increase transparency, competition and innovation technologies. This will include recommendations on policies like transparency, competition, and reducing barriers to technological innovation.

RSC members refuse to ignore the current crisis and will never agree to turn American health care over to big government. Instead, we will advance these practical solutions to repair our broken health care system. If Congress will adopt the reforms outlined in this plan, we can achieve a personalized and sustainable health care system for current and future generations.

THE AFFORDABLE CARE ACT

THE STATUS QUO
UNDER THE ACA

MAIN COMPONENTS OF THE ACA

As it was designed, the inaptly named "Affordable Care Act" has resulted in an unprecedented level of federal intervention in the individual insurance marketplace. Signed into law on March 23, 2010, the legislation itself includes thousands of pages of text and hundreds of complicated provisions. Implementing the law has necessitated tens of thousands of additional pages of rules—and trillions of dollars in new spending and taxes. The law is distinguished by three primary features: 1) its regulatory architecture; 2) subsidies for low-income households; and 3) Medicaid expansion. The supposed goal was to expand, subsidize, and guarantee coverage in the individual health insurance marketplace—a unique and relatively small part of the broader American health care system.

For decades now, the vast majority of Americans (generally, more than 80 percent of the population),[1] have obtained health insurance in one of two ways: approximately half of the insured have received their insurance through their employer, and the rest have relied on one of several federally-financed programs, such as Medicare, Medicaid and the VA. In the private market, employer-sponsored health insurance plans have outnumbered individual plans by around eight to one over the past decade.[2] This imbalance is primarily due to decades of misguided federal laws and regulations that have stunted the development of a viable individual marketplace.

Prior to the enactment of the ACA, it is true that an important but relatively small number of Americans faced great challenges in the individual health care market because, for various reasons, they waited to purchase insurance until after developing a health condition. This group included approximately two to four million people under the age of 65.[3] While the plight of these Americans needed to be addressed, the Obama administration's short-sighted approach to the dilemma has upended the nation's entire health insurance system and now jeopardizes care and access for everyone.

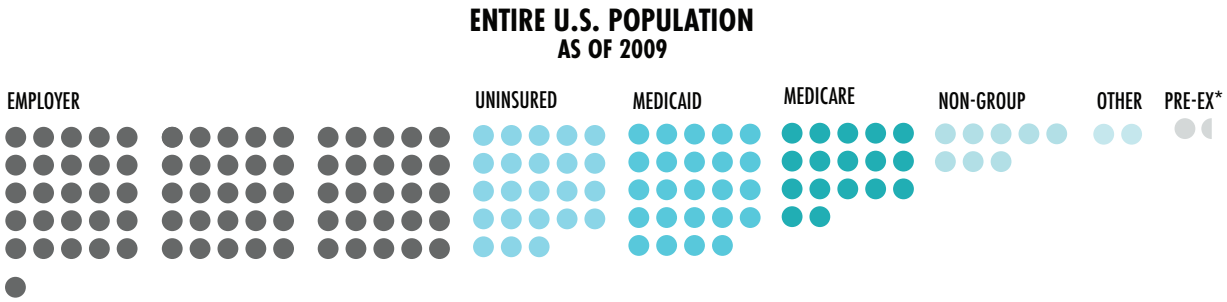
[1] "Health Insurance Coverage of the Total Population." *The Henry J. Kaiser Family Foundation*, 2 Jan. 2019, https://www.kff.org/other/state-indicator/total-population/?-dataView=0¤tTimeframe&sortModel=[{"colId":"Location","sort":"asc"}].

[2] Id.

[3] Capretta, Jim and Tom Miller. "How to Cover Pre-Existing Conditions." *National Affairs,* Summer 2010. https://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions.

HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION IN 2009+

EACH DOT REPRESENTS 2 MILLION PEOPLE



*The number of individuals in the individual market that, leading up to Obamacare's enactment, may have faced difficulty purchasing insurance due to an existing health condition was around 2 – 4 million individuals. See, James Capretta and Tom Miller "How to Cover Pre-Existing Conditions." National Affairs, Summer 2010. https://www.nationalaffairs.com/publications/detail/how-to-cover-pre-existing-conditions.

+Non-Pre-Ex groups information derived from:
"Health Insurance Coverage of the Total Population." The Henry J. Kaiser Family Foundation, 2 Jan. 2019, https://www.kff.org/other/state-indicator/total-population

Regulatory Architecture

While some of its regulatory provisions apply to the employer-sponsored marketplace, the ACA's flawed regulatory framework focuses mainly on restricting the features and mandating the availability of individual market plans—regardless of whether a person had insurance prior to developing a medical condition.[4] To that end, its core provisions require individual market plans to have: 1) guaranteed issue; 2) community rating; 3) minimum actuarial value; and 4) so-called "essential health benefits."[5, 6]

Generally, the ACA's guaranteed issue requirement mandates insurance carriers offer their health insurance plans to any individual without limitation or exclusion for any pre-existing condition. Its community rating restriction bars insurers from adjusting insurance premiums based on the health risks presented by the applicant. Actuarial value requirements mandate carriers pay a heightened percentage of benefit costs that are tied to four levels (or, metal tiers) of coverage.[7] The ACA's essential health benefits requirement prohibits carriers from offering individual marketplace plans that do not contain ten codified categories of services, even when the consumer needs and prefers less.[8, 9]

These regulations were intended to work in tandem with the ACA's "individual mandate," which required all Americans to hold insurance policies or face a limited monetary penalty each year.

[4] 42 U.S. Code § 18001
[5] Fernandez, Bernadette. "Federal Requirements on Private Health." *Congressional Research Service.* 28 Aug. 2018. https://fas.org/sgp/crs/misc/R45146.pdf
[6] 42 U.S. Code § 18022
[7] "Understanding Marketplace Health Insurance Categories." *Healthcare.gov,* https://www.health care.gov/choose-a-plan/plans-categories/.
[8] "Essential Health Benefits - Health care.gov Glossary." *Health care.gov,* https://www.health care.gov/glossary/essential-health-benefits/.; Fernandez, Bernadette. "Federal Requirements on Private Health." 2018. https://fas.org/sgp/crs/misc/R45146.
[9] The Affordable Care Act also mandates plans to include two additional benefits: 1) birth control coverage; and 2) breastfeeding coverage. See, "Find out What Marketplace Health Insurance Plans Cover." Healthcare.gov, https://www.health care.gov/coverage/what-marketplace-plans-cover/.

The individual mandate was intended to keep healthy individuals who are typically low-utilizers of insurance in the market to offset the costs of high-utilizers of insurance.[10] Unfortunately, because the ACA created a perverse incentive for people to forgo insurance until they developed an illness, costs across the board rose dramatically, which required higher premiums on the existing plans in the individual market exchanges. Not surprisingly, the premium spikes further repelled healthy individuals.

The ACA's essential health benefits requirements and actuarial value provisions have further contributed to premium inflation. The essential health benefits requirement stripped states of the ability to decide the minimum features of plans within their borders and eliminated the ability for consumers to choose plans personalized to their needs without unnecessary expense.[11] Indeed, before the ACA, thousands of state-level laws existed setting forth minimum benefits.[12] The ACA's actuarial value provision prohibits access to plans with an actuarial value of less than 60 percent and set up tiers of plans on the ACA exchanges at 60, 70, 80, and 90 percent.[13] Other related ACA regulations included out-of-pocket maximums and prohibitions on annual and lifetime limits.

Furthermore, the ACA imposes a "medical loss ratio" requirement on insurance carriers which prevents them from spending more than 20 percent of their revenue generated by premiums from the exchange plans (15 percent in the employer market) to cover their overhead costs (e.g., marketing, salaries, agent commissions, administrative expenses) or profits. The ACA also prohibits insurers from allowing profits from one market to offset losses in another.

While those regulations provide the core of the ACA individual market restrictions, ACA regulations in the employer market have also been significantly disruptive. For example, similar to the individual mandate, the ACA also created an employer mandate, which requires businesses with more than 50 full-time employees to provide health insurance to at least 95 percent of employees and their dependents up to the age of 26. Full-time employees are defined as those who work over 30 hours per week. Furthermore, the coverage provided to each employee must be "affordable," such that the employee's share of the monthly premiums for the lowest-cost, self-only coverage option is less than 9.86 percent of household income.[14] Employer plans must also meet the minimum actuarial value threshold of 60 percent, as well as out-of-pocket maximums and prohibitions on annual and lifetime limits. If employers do not provide coverage that meets these conditions, they can be fined thousands of dollars per employee.

---

[10] The individual mandates' penalty was reduced to zero, effectively nullifying it, in H.R.1 - An Act to provide for reconciliation pursuant to titles II and V of the concurrent resolution on the budget for fiscal year 2018, more commonly known as the "Tax Cuts and Jobs Act."

[11] Uberoi, Namrata. " The Patient Protection and Affordable Care Act's Essential Health Benefits (EHB)." *Congressional Research Service*. 2015. https://fas.org/sgp/crs/misc/R44163.pdf

[12] According to the National Conference of State Legislatures, "Adding up these laws, there are more than 1,900 such statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over a 30+ year period."
"State Insurance Mandates and the ACA Essential Benefits Provisions." *National Conference of State Legislatures,* 12 Apr. 2018, http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx.

[13] According to the U.S. Centers for Medicare & Medicaid Services, "actuarial value" refers to "the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, one would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy." See, "Actuarial Value - Health care.gov Glossary." *Healthcare.gov*, https://www.health care.gov/glossary/actuarial-value/.

[14] "If You'd like to Change to a Marketplace Plan." *Healthcare.gov*, https://www.healthcare.gov/have-job-based-coverage/change-to-marketplace-plan/.

Low-Income Subsidies

The ACA provides premium assistance subsidies in the form of advanceable tax credits to help pay for the health insurance premiums of low-income individuals on the ACA exchanges. Almost nine out of ten enrollees in the ACA exchange markets are eligible for premium subsidies.[15] The federal government is expected to provide nearly $700 billion in these premium assistance subsidies over the next ten years.

Generally, to qualify for the ACA exchange subsidies, individuals must have a household income between 100 to 400 percent of the federal poverty level (FPL) and cannot be eligible for certain other health insurance coverage.[16] The subsidies are structured so that an individual does not have to pay more than a certain percentage of their income toward their premiums, with the federal government paying the remainder of the premium price. The percentage of their income a person must contribute increases the closer their income gets to 400 percent FPL. While the subsidy is technically a tax credit, it is advanceable so the individual can receive it monthly to offset their premiums. Because this premium structure lacks a consumer-driven incentive to contain premiums, steep increases in premium costs have resulted since the ACA's enactment.

THE PREMIUM SUBSIDIES FOR LOW-INCOME INDIVIDUALS WERE AN EXPENSIVE CONSEQUENCE OF THE ACA'S REGULATORY FRAMEWORK AND THE INDIVIDUAL MANDATE. THIS WAS SIMPLE MATH FROM THE BEGINNING.

The premium subsidies for low-income individuals were an expensive consequence of the ACA's regulatory framework and the individual mandate. This was simple math from the beginning. Since the ACA required every American without public or employer-based coverage to obtain and maintain health insurance regardless of their income level or desire to purchase a plan, and the ACA's regulations would inevitably result in increased premiums in the individual marketplace, the ACA had to provide for premium subsidies.

Further, in its attempt to make the services provided by an insurance plan less expensive for lower-income individuals, the ACA also created cost-sharing subsidies for individuals whose income falls between 100 and 250 percent FPL. The cost-sharing subsidies are only for people enrolled in a "silver" tier health plan. Initially, insurers were required to front the costs of reducing out-of-pocket expenses, and the federal government promised to later reimburse those cost-sharing reduction (CSR) payments to the insurers. However, in October 2017, a federal court ruled those reimbursement payments unconstitutional and canceled them because Congress never appropriated the necessary funding.

Despite the lack of federal reimbursement payments, the ACA still requires insurers to reduce the cost-sharing expenses for eligible silver plan holders. To cover their losses, insurers simply raised the premiums of their silver plans knowing that the federal government would be forced to pay for the premium increases through the provision of premium tax credit subsidies.

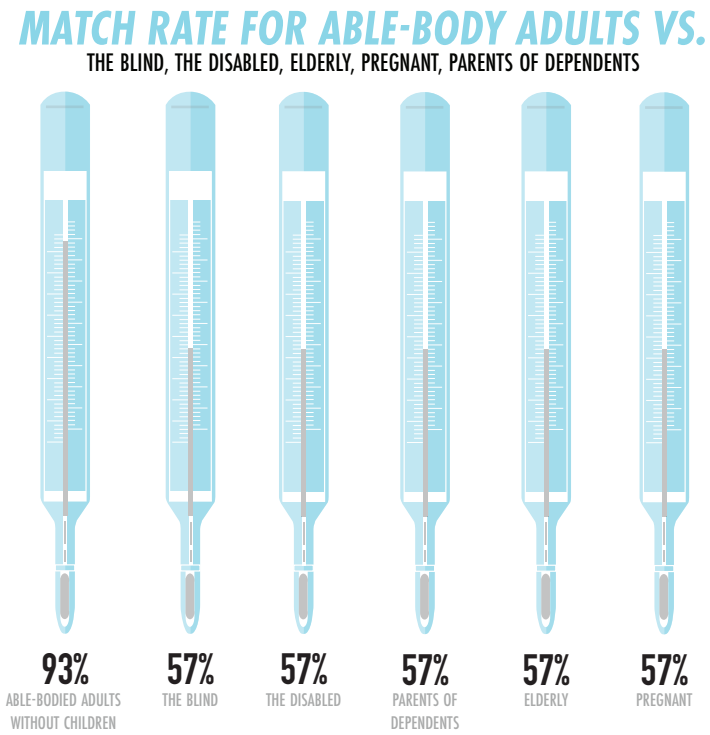
---

[15] Moffit, Robert E. "Why Obamacare Must Be Dismantled." *The Heritage Foundation,* 26 Oct. 2017 https://www.heritage.org/health-care-reform/commentary/why-obamacare-must-be-dismantled.

[16] Fernandez, Bernadette. "Health Insurance Premium Tax Credits and Cost-Sharing Subsidies." *Congressional Research Service*, 24 Apr. 2018, https://www.crs.gov/Reports/R44425?source=search&guid=74bd753bd4874e15b473230977e4cbdb&index=0.

Medicaid Expansion

Created by law in 1965, the original intent of Medicaid was to provide a safety net for the poorest and sickest Americans. Medicaid functions through a federal-state framework where each state administers its own Medicaid program, and the federal government provides the majority of funding. States are required to finance a portion of their Medicaid program pursuant to a match rate determined by the statutory Federal Medical Assistance Percentage (FMAP) formula. While a state's FMAP reimbursement rate is based on that state's per capita income relative to U.S. per capita income, the law requires the federal government to reimburse at least 50 percent of state Medicaid expenses to a maximum of 83 percent. The remaining percentage is not reimbursed and thus borne by the state.[17] The 50 percent floor results in a number of wealthy states receiving more than their fair share of federal funding.[18] The Congressional Budget Office estimates that if there was no floor to the FMAP calculation, mandatory spending would be reduced by $394 billion between 2021 and 2028.[19]



"OPTIONS FOR REDUCING THE DEFICIT: 2019 TO 2028." *Congressional Budget Office,* Dec. 2018, p. 58, https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf#page=54.

Medicaid was originally designed to finance the health care needs of poor children, pregnant women, persons with disabilities, adults with dependent children, and the elderly. Before the ACA expansion of Medicaid, eligibility was contingent upon meeting both income and categorical (*i.e.*, pregnant, disabled, elderly, etc.) standards, the details of which are largely controlled at the state level.[20] Accordingly, for half a century after its creation, Medicaid was a program reserved for those vulnerable populations.[21]

The ACA changed this model when it allowed states to expand Medicaid eligibility to cover healthy, able-bodied adults without dependents with incomes up to 138 percent of FPL.[22] [23] The ACA's Medicaid

[17] "Matching Rates." *MACPAC*, https://www.macpac.gov/subtopic/matching-rates/.

[18] Fourteen states are projected to have an FMAP that would fall below the 50 percent statutory floor. See, "FY 2020 FMAP Projections." FY 2020 FMAP Projections | Federal Funds Information for States, https://www.ffis.org/node/4765.

[19] "Options for Reducing the Federal Deficit: 2019-2028." *Congressional Budget Office*, Dec. 2018, p. 55, https://www.cbo.gov/system/files/2019-06/54667-budgetoptions-2.pdf#page=65.

[20] "Medicaid: An Overview." *CRS.gov, Congressional Research Service,* 24 June 2019, p2., https://fas.org/sgp/crs/misc/R43357.pdf#page=6.

[21] Antos, Joseph. "The Structure of Medicaid. The Economics of Medicaid: Assessing the Costs and Consequences." *Mercatus Center at George Mason University*, 2014, p. 11-12.

[22] Originally, Obamacare mandated states to expand their Medicaid programs, but this was held to be unconstitutional by the United States Supreme Court. National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

[23] Blahous, Charles P. "Medicaid under the Affordable Care Act. The Economics of Medicaid: Assessing the Costs and Consequences." *Mercatus Center at George Mason University,* 2014, pp. 83.

expansion was initially financed entirely by federal taxpayers at a 100 percent FMAP. The federal share phased down to 95 percent beginning in 2017 and will decrease to 90 percent by 2020, where it will remain indefinitely.[24]

Medicaid's overall FMAP reimbursement structure incentivizes states to utilize a financing gimmick known as "provider taxes" to draw more federal funds without increasing net state expenditures. As a report by the Mercatus Center has explained, "Under provider tax schemes, health care providers are given increased Medicaid payments in exchange for paying higher taxes. Such arrangements increase states' Medicaid expenditures—but only on paper. They do not require additional funding from the states' tax base. They do, however, spur the federal government to reimburse its statutorily required share of the artificial spending increase."[25] Republicans are not the only ones to point out the issue with provider taxes. As the report notes, "Provider taxes were discussed as part of the high-profile deficit reduction negotiations between the Obama administration and congressional Republicans and Democrats in 2011, with Vice President Joe Biden reportedly referring to them as a 'scam' that should be eliminated."[26]

THE ACA: FAILING THE PEOPLE IT WAS DESIGNED TO PROTECT

When the ACA was being proposed, its sponsors made big promises. "If you like your plan, you can keep your plan, and if you like your doctor, you can keep your doctor," they assured the American people. "You will even see a reduction in premiums by an average of $2,500 or more!"[27] Of course, this is not what has happened, and PolitiFact even named that first promise 2013's "Lie of the Year."[28] These broken promises became apparent and infamous soon after the ACA was signed into law. Such broken promises illustrate how the ACA has failed to improve—and in many ways harmed—America's health care system. Moreover, these broken promises have caused even greater struggles for millions of Americans, including those with pre-existing conditions. While Democrats argue that keeping the ACA will guarantee that no one is denied health insurance because of their medical history, that guarantee is illusory. As history has proven, the ACA has not fulfilled its promise to guarantee plan retainment, affordability, quality of care or availability of doctors. Indeed, its result has been quite the contrary.

Perhaps the most glaring failure of the "Affordable Care Act" is that it has not made health care more affordable. Under the ACA, average premiums for health insurance in the individual market more than doubled nationwide between 2013 and 2017, and even tripled in some states.[29] For many working-class Americans, this drove the price of health insurance premiums to prohibitively high levels. Many other Americans simply had their plans stripped away. In fact, in the wake of the ACA's enactment, approximately 4.7 million Americans received notices that their health insurance plan was being canceled.[30]

---

[24] "Overview of the ACA Medicaid Expansion." *Congressional Research Service*, 3 Dec. 2018, https://fas.org/sgp/crs/misc/IF10399.pdf.

[25] Blase, Brian. "Medicaid Provider Taxes: The Gimmick That Exposes Flaws with Medicaid's Financing." *Mercatus Center, George Mason University*, 16 Feb. 2016, https://www.mercatus.org/publications/health care/medicaid-provider-taxes-gimmick-exposes-flaws-medicaid's-financing.

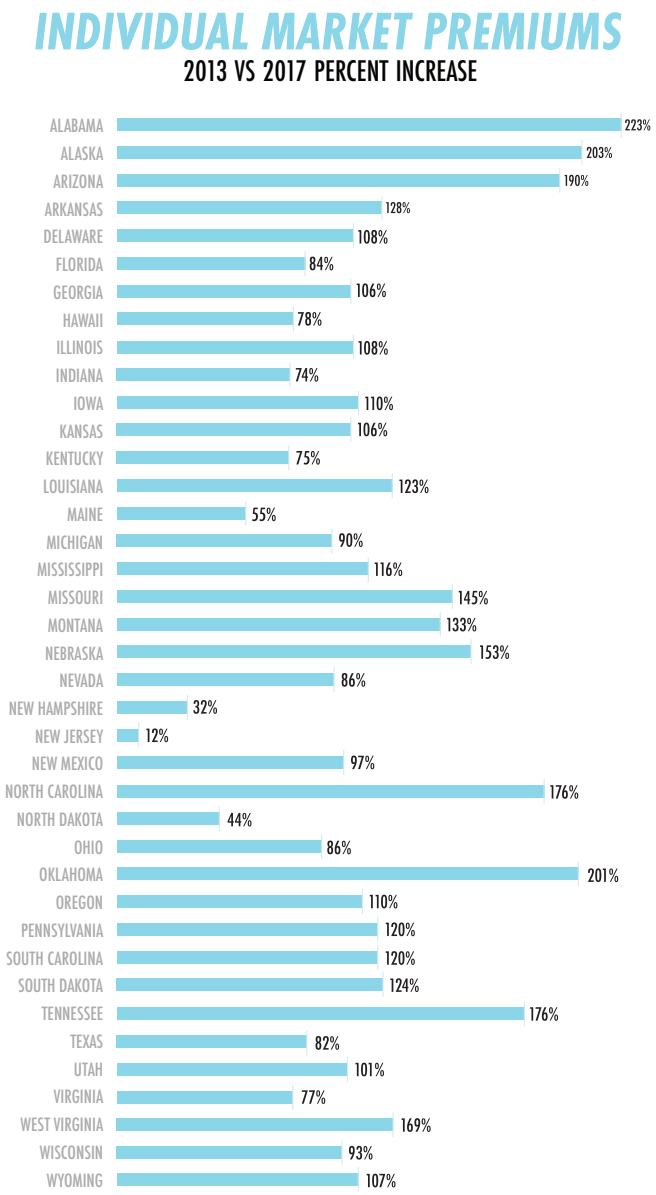
[26] Id. Pg. 4

[27] "Obama: 20 Promises for $2,500." *$2,500*, 22 Mar. 2010, http://freedomeden.blogspot.com/2010/03/obama-20-promises-for-2500.html.

[28] Holan, Angie D. "Lie of the Year: 'If You like Your Health Care Plan, You Can Keep It'." *PolitiFact,* 12 Dec. 2013, https://www.politifact.com/truth-o-meter/article/2013/dec/12/lie-year-if-you-like-your-health-care-plan-keep-it/.

[29] Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 23 May 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

[30] "Policy Notifications and Current Status, by State." *Yahoo! Finance, The Associated Press,* 26 Dec. 2013, https://finance.yahoo.com/news/policy-notifications-current-status-state-204701379.html.



Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 23 May 2017, https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.

The ACA's major flaw, in this respect, is a systemic one rising from the interaction of its regulatory provisions. Preceding the implementation of the ACA, carriers in the individual market could deny and upcharge applicants to reflect any increased health risks presented by the applicant. This process, known as underwriting, is a core tenet of any functioning insurance market. As a result, preceding the ACA, people had an incentive to purchase insurance before developing a health condition that would increase the costs of their coverage.

Conversely, the ACA's regulatory framework—namely its inflexible guaranteed issue and community rating provisions—incentivizes people in the individual market to act irresponsibly and to delay purchasing health insurance until after they develop a disease or illness. In other words, there is neither a carrot nor a stick for proactively and responsibly purchasing and maintaining insurance under the ACA. Applicants cannot later be turned down or required to wait, and they cannot later be required to pay a higher premium. Not surprisingly, under the ACA, a high percentage of individual market participants consists of those people who simply waited until they got sick to seek coverage. This unsustainable model has driven costs to exorbitant levels.

Health insurance premiums for individual coverage on the ACA exchanges more than doubled between 2013 and 2017, and continued to rise in 2018.[31] As pointed out by Michael Tanner of the Cato Institute, "A study by McKinsey and Company for the Department of Health and Human Services found that as much as 76 percent of premium increases since 2010 can be traced to the ACA's regulations."[32] While overall premiums did not increase for 2019, this was not a result of the ACA working, but rather is attributable to the handful of states that received permission to deviate from certain ACA regulations and thus experienced premium decreases significant enough to lower the average nationwide.[33]

[31] Haislmaier, Edmund, and Doug Badger. "How Obamacare Raised Premiums." *The Heritage Foundation*, 5 Mar. 2018, https://www.heritage.org/health-care-reform/report/how-obamacare-raised-premiums.

[32] Tanner, Michael. "Obamacare Is Still with Us, and Getting Worse." *Cato Institute,* 9 May 2018, https://www.cato.org/publications/commentary/obamacare-still-us-getting-worse.

[33] Badger, Doug. "Obamacare Caused Premiums to Spike. Here's How States Are Lowering Them Again." *The Heritage Foundation*, 10 Sept. 2019, https://www.heritage.org/health-care-reform/commentary/obamacare-caused-premiums-spike-heres-how-states-are-lowering-them.

While policy experts often discuss the failures of the ACA from an empirical standpoint, it is more important to understand the dire effects the law has had upon the lives of individuals and families. The stories are common and often heartbreaking. One example is what happened to Coach Jim White, a high school coach from Alabama. His canceled plan and skyrocketing costs under the ACA threatened his survival and pushed his family to the brink. Coach White tells his own story in Figure 1.

PERSONAL STORY OF COACH WHITE

Like many Americans in 2013, my wife and I received a letter from our insurance company telling us our plan had been canceled due to Obamacare. Our plan had a premium of around $400 per month with a $3,500 per person deductible before Obamacare. We were then offered an Obamacare compliant plan with a premium of $1,381 per month (nearly a 250% increase), with a $5,500 per person deductible.

If we paid a years' worth of premiums and our full deductible, this plan would have required us to pay over $20,000 before insurance kicked in. It effectively was not insurance. We looked at the Obamacare exchange plans but none of them included our doctors and they were all similarly expensive.

We were fortunate enough to find a non-Obamacare option called a health sharing ministry plan that had a similar cost to the coverage we had before Obamacare. For several years this met our needs, but then I was diagnosis, with life threatening colon cancer. To make matters worse, a few days before my diagnoses I lost my job at a private Christian school.

We discovered that the best hospital for my cancer was in Houston and they agreed to accept me as a patient, but they would not accept our health sharing ministry plan because it was not insurance. The treatment was going to cost ten of thousands of dollars, money we just did not have. My son set up a GoFundMe page and we were able to raise the funds I needed for my treatment due to the generosity of our family, friends, and community.

Thankfully, the treatment was successful, and I am still cancer free today. However, Obamacare created a health care crisis for me. It stripped away my coverage before I developed a pre-existing condition and then made getting coverage unaffordable after I developed one. I know I am very fortunate and others in a similar situation may have had a different outcome.

People like me got left behind by Obamacare. We deserve better.

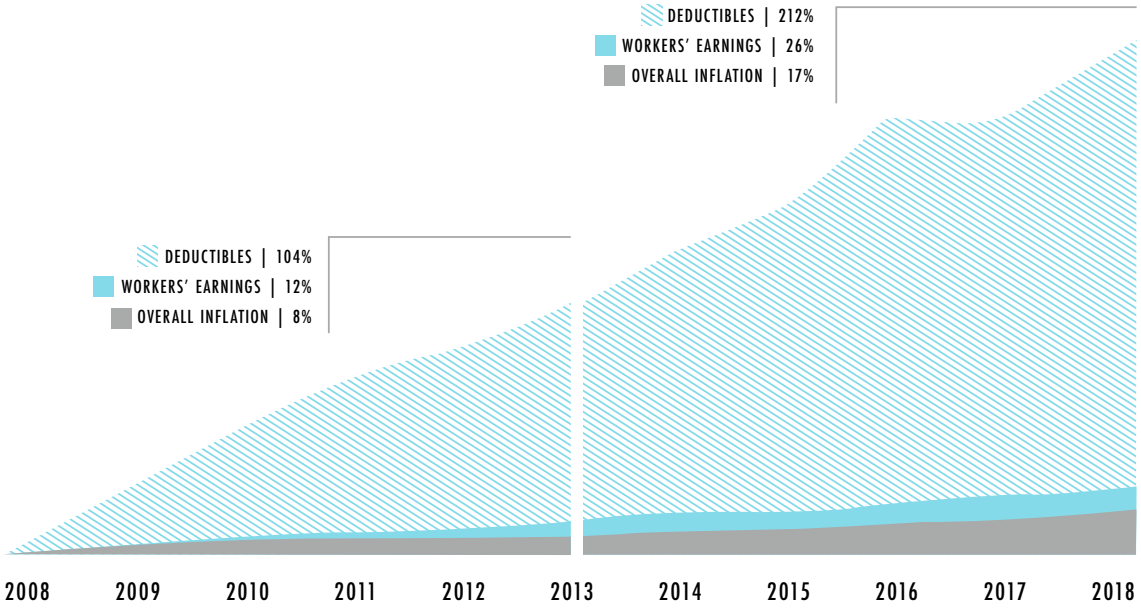
Figure 1.
Coach Jim White, Alabama

While the ACA's effects on the individual marketplace typically garner the lion's share of attention, the employer marketplace—where half of all Americans get their health insurance—has suffered greatly as well. For instance, employer-sponsored family plans have experienced a 49 percent increase in premiums between 2010 and 2019.[34] In fact, according to the 2019 Kaiser Family Foundation annual survey, average family premiums in the employer market eclipsed $20,000 this year for the first time in

[34] "2019 Employer Health Benefits Survey." *The Henry J. Kaiser Family Foundation,* 25 Sept. 2019, https://www.kff.org/report-section/ehbs-2019-summary-of-findings/.

American history.[35] Also disheartening for American families is the growth rate at which premiums have far outpaced wage growth and inflation. Since 2008, average family premiums for employer-sponsored coverage have increased 55 percent, twice as fast as wage growth (26 percent) and three times as fast as inflation growth (17 percent).[36]

SINCE 2008, GENERAL ANNUAL DEDUCTIBLES
FOR COVERED WORKERS HAVE INCREASED EIGHT TIMES AS FAST AS WAGES



NOTE: Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

SOURCE: KFF and KFF/HERT Employer Health Benefits Surveys. Consumer Price Index, U.S. City Average of Annual Inflation (April to April); Seasonally Adjusted Dara from the Current Employment Statistics Survey (April to April).

The other major cost-related impediment to accessing care under the ACA has been the dramatic increase in deductibles. While often attracting less attention than the law's impact on premiums, this failure of the ACA is perhaps just as dangerous for individuals with health conditions. Though a person with a health condition technically can get access to a plan and may even receive federal subsidies to help pay for it, they may be faced with an insurmountable deductible that forces them to forgo seeking medical care. In 2019, the average medical deductible for an individual bronze plan is $5,977.[37] Moreover, the portion of Americans under 65 who carry a high deductible plan has increased from 33.9 percent in 2013 to 43.7 percent in 2017.[38]

---

[35] Id.

[36] Palosky, Craig. "Premiums for Employer-Sponsored Family Health Coverage Rise 5% to Average $19,616; Single Premiums Rise 3% to $6,896." *The Henry J. Kaiser Family Foundation,* 3 Oct. 2018, https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/.

[37] This deductible amount is for bronze plans with separate medical and prescription drug deductibles. Average deductibles for bronze plans with combined medical and prescription drug deductibles is $6,258 for 2019. "Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2019." *The Henry J. Kaiser Family Foundation,* 7 Oct. 2019, https://www.kff.org/health-reform/fact-sheet/cost-sharing-for-plans-offered-in-the-federal-marketplace-for-2019/.

[38] Tozzi, John and Zachary Tracer. "Sky-High Deductibles Broke the U.S. Health Insurance System." *Bloomberg,* 26 June 2018, https://www.bloomberg.com/news/features/2018-06-26/sky-high-deductibles-broke-the-u-s-health-insurance-system.

The ACA has resulted in many families feeling like they have been painted into a corner. Such was the case with the Daverts, a family of a mother with brittle bone disease, a father with cerebral palsy, and twins with brittle bone disease. The mother, Melissa Davert, tells their story in Figure 2.

What makes the increase in deductibles even more significant, particularly for working-class individuals and families, is how little financial maneuverability most American families have to absorb increased and unexpected costs. In 2016, only half of single person households had $2,000 in savings available for such costs. Family households fair only slightly better, with just six in ten possessing such savings. Among millennials, the picture is even more bleak, with six out of ten reporting they do not have enough savings to absorb a $1,000 emergency expense.[39]

Therefore, it should come as no surprise that according to a National Public Radio survey, one in five Americans have postponed, delayed, or canceled some kind of health care services in the preceding three months, such as a doctor's appointment or medical procedure because of cost.[40] Again, among millennials, the effects are more pronounced. About one-third of people under age 35 reported that they had been deterred by costs from obtaining needed health care, compared with only 8 percent of people 65 and older.[41]

The increases in deductibles under the ACA are not limited to the individual marketplace and are actually more extreme in the employer marketplace. Given the fact that employer-sponsored coverage is by far the most common type of insurance in America (the ratio of employer-sponsored coverage to the individual marketplace is currently nine to one), the relative significance is greatly expanded. Between 2008 and 2018, the average annual deductible for single employer-sponsored coverage more than quadrupled.[42] Since 2013, the increase is 53 percent. Over the same period, this increase in deductibles grew eight times as fast as the growth of wages.[43]

The ACA's regulatory structure has not only caused insurers to raise their costs, it has also perpetuated a reduction in the quality of the health coverage provided by exchange plans. Because they are forced to charge all individuals the same premium regardless of their health risks, the ACA has created a system that punishes insurers for offering high-quality care to the sick, which economists find results in inadequate coverage for all Exchange enrollees. Michael Cannon of the Cato Institute has explained this perverse effect as follows:

---

[39] Leonhardt, Megan. "60 Percent of Millennials Don't Have Enough Money to Cover a $1,000 Emergency." *CNBC,* 20 Dec. 2018, https://www.cnbc.com/2018/12/19/60-percent-of-millennials-cant-cover-a-1000-dollar-emergency.html.

[40] Hensley, Scott. "Poll: Young People More Likely to Defer Health Care Because Of Cost." *NPR*, 7 Dec. 2018, https://www.npr.org/sections/health-shots/2018/12/07/674567886/poll-young-people-most-likely-to-defer-health-care-because-of-cost.

[41] Id.

[42] Levey, Noam N. "Health Insurance Deductibles Soar, Leaving Americans with Unaffordable Bills." *Los Angeles Times,* 2 May 2019, https://www.latimes.com/politics/la-na-pol-health-insurance-medical-bills-20190502-story.html.; Hamel, Liz, et al. "Kaiser Family Foundation / LA Times Survey Of Adults With Employer-Sponsored Health Insurance." Kaiser Family Foundation, Kaiser Family Foundation, May 2019, http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance.

[43] Palosky, Craig. "Premiums for Employer-Sponsored Family Health Coverage Rise 5% to Average $19,616; Single Premiums Rise 3% to $6,896." *The Henry J. Kaiser Family Foundation,* 3 Oct. 2018, https://www.kff.org/health-costs/press-release/employer-sponsored-family-coverage-premiums-rise-5-percent-in-2018/.

I live with my husband and twin children, in Michigan. We have unique health challenges. My children and I have brittle bone disease and my husband has cerebral palsy. For a time, we received health insurance through my employer, but I had to take disability leave due to my condition. We received insurance through COBRA for two years, until I was eligible for coverage on Medicare. However, since Medicare did not provide coverage for our children, we were required to purchase a private health insurance plan for them. The plan had an expensive premium, but it covered my children's specific health care needs, and it had a relatively low out of pocket family maximum of $2,500 per year.

We were doing well with little complaint until Obamacare. In the Fall of 2013, we learned that the private plan we'd purchased for our children was going to be canceled, because it didn't meet Obamacare's requirements. The Obama Administration promised to protect people like us with pre-existing conditions and assured us we could keep our plan if we liked it, but that was not the case.

We immediately started looking for a new plan through the federal exchange. The least expensive plan that was accepted by our children's doctors included a $5,100 out of pocket maximum for each child. Suddenly, because our children's health care needs are significant, we were looking at out-of-pocket medical bills of up to $10,200 per year. Even worse, it mandated we pay for things we did not want or need, like abortion coverage. Often ignored is the fact that under Obamacare people with disabilities were (and are) the ones who absorb the costs through higher out of pocket maximum limits. Thankfully at the time our children remained fairly healthy and had supplemental insurance through the state of Michigan, which covered out-of-pocket costs relating only to their disability and their monthly insurance premiums, or this would've been financially catastrophic for us.

Two years ago, our children were forced to accept Medicare, because premiums for all the private plans they were eligible for skyrocketed and were totally unaffordable. To summarize, they were stripped of their original private plan due to Obamacare, then they lost those plans because they were eventually cancelled or the premiums were unaffordable, and now they are forced to take government-sponsored insurance with a huge out-of-pocket medical cost liability and awful prescription coverage.

With our children about to finish college, we have a new obstacle. They recently turned 21 years old and aged out of their state-funded supplemental insurance plan. My children don't want to sign up for Medicaid, because they'll be forced to stay at home and not work, or risk losing coverage if they do work. Our kids, just like any other 21-year-old, want to get a job and go to work to save up for a car and a home someday.

Since our income is limited to disability and my husband's part-time job, it's difficult to pay our medical bills. We sit down as a family every year to re-analyze the insurance plan we purchase. We must guess which kind of catastrophic problem we think the kids might have that year and pick a plan that might cover what we might need.

We feel people like us with disabilities and pre-existing conditions have been forgotten and left behind by the current system. We need a system that prioritizes our personal health care needs and provides everyone with affordable options, while enabling those who can to work.

> To illustrate, suppose insurers expect the average Multiple Sclerosis (MS) patient to file $61,000 in claims and Obamacare requires insurers to charge those patients a premium far below that amount—say, $10,000. If each MS patient brings an insurer $10,000 in premiums but costs them $61,000 in claims, then each MS patient an insurer attracts represents a $51,000 loss. Since MS patients care a lot about the quality of their coverage, they will find and enroll in whichever health plans offer the best MS coverage. The better the MS coverage an insurer offers, the more money the insurer loses.[44]

As a consequence, insurers have routinely implemented reductions in the quality of coverage to avoid attracting too many chronic illness patients—which ultimately require premium increases that repel others without immediate health care needs. As a consequence, the ACA has resulted in substantial reductions in the quality of care and access to medical tests and treatments, and better hospitals, doctors and treatment facilities.

For instance, the ACA exchange plans have increasingly excluded top-tier hospitals and doctors from their networks. Since 2015, nearly three-quarters of all exchange insurance plans suffered from reduced networks.[45] Individuals with chronic illnesses have been increasingly deprived of the choice to seek out the best doctors available to treat their conditions. Instead of paying for better quality physicians, insurers have narrowed their networks of doctors to certain providers who will accept lower payments and potentially provide a lower quality of care. Additionally, because networks are narrowed and patients are funneled only to specific doctors, the overall quality of service also goes down because many doctors become overwhelmed with their patient volumes. This so-called "race-to-the-bottom" and the narrowing of networks is a growing crisis. Although the sponsors of the ACA promised to reduce the cost of health care and improve its quality—the result has been exactly the opposite of what was promised.

Narrowed networks force real families to make difficult choices. A recent volume of the Minnesota Journal of Law, Science & Technology highlighted the struggles the Blanker family faced while seeking care for their daughter in the Seattle, Washington area. At five-months-old, Gabriella was diagnosed with a rare genetic defect that caused her skull bones to fuse. Without proper treatment, it would be life-threatening. Her family had purchased an insurance plan off the Washington State exchange, only to find out later that the Seattle Children's Hospital, which was the best place for her to seek care, was out-of-network with their plan. They had two options: either seek care at in-network hospitals that offered lower quality care, or purchase a more expensive individual plan for Gabriella that had Seattle Children's Hospital in-network. Thankfully, the Blanker family had the means to afford the more expensive plan so Gabriella could get the best care available. However, that is not an option everyone would be able to take. As the Journal summarized, "For the unlucky few with a serious illness, narrow networks may challenge their ability to access medically necessary, and even life-saving care."[46]

---

[44] Cannon, Michael F. "Is Obamacare Harming Quality? (Part 1)." *Cato Institute,* 4 Jan. 2018, https://www.cato.org/publications/commentary/obamacare-harming-quality-part-1.

[45] Haislmaier, Edmund. "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink." *The Heritage Foundation*, 25 Jan. 2018, https://www.heritage.org/health-care-reform/report/2018-obamacare-health-insurance-exchanges-competition-and-choice-continue.

[46] Blake, Valarie "Narrow Networks, the Very Sick, and the Patient Protection and Affordable Care Act: Recalling the Purpose of Health Insurance and Reform", 16 Minn. J.L. Sci. & Tech. 63 (2015).

The ACA has also contributed to the infamous problem of "surprise billing," when a hospital sends a bill to a patient following their care and demands payment for the difference between what the provider charged and what the insurer paid. This often occurs when a provider, such as an anesthesiologist, is not in the patient's network and the patient unknowingly receives care from the provider. Because the ACA has narrowed networks to as little as one or two facilities per region, patients have little option in their choice of where they receive their care. The greater the migration of providers from in-network to out-of-network, the more likely it is that patients unknowingly receive costly care from an out-of-network provider.

dditionally, due to health care provider shortages, hospitals are often forced to resort to staffing services to fill positions that have not yet been hired – such as anesthesiologists, physicians or radiologists.[47,48] By narrowing networks and causing a lack of choice and competition, the ACA has created a perfect storm for the incidences of surprise billing.[49,50,51]

The stark rise in premiums and deductibles is not just due to the overregulation of the insurance market itself. Rather, the ACA structurally altered the entire health care marketplace. Through perverse incentives, including various market-distorting subsidies and the promotion of accountable care organizations with enhanced reimbursements, the ACA has led to a resurgence in hospital consolidations not seen since the late 1990s.[52] This increased hospital market concentration has led to increases in the price of hospital services,[53] as larger systems have greater leverage. As one would expect, these artificially incentivized costs "are passed on to health care consumers in the form of higher premiums, lower benefits, and lower wages."[54]

The ACA's heavy-handed approach has directly fueled the precipitous decline in independent physician practices, with a majority of physicians now becoming employees, typically of large hospital systems.[55] The push towards vertical integration was intentional. In a letter published by the Annals of Internal Medicine in 2010, three Obama administration health care advisers boasted, "The economic forces put in motion by the Act are likely to lead to the vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups."[56] While this letter

[47] Haeder, Simon F, et al. "Surprise Billing: No Surprise in View Of Network Complexity." *Health Affairs,* 5 June 2019, https://www.healthaffairs.org/do/10.1377/hblog20190603.704918/full/.

[48] Feder, Shira. "'Disgusting': Study Shows Hospitals Sending More and More Surprise Bills." *The Daily Beast,* 12 Aug. 2019, https://www.thedailybeast.com/surprise-medical-bills-new-study-says-40-percent-of-patients-socked-with-unexpected-bills.

[49] Id.

[50] Emergency services reached an all-time high due to the implementation of Obamacare. See, Rui P, Kang K. "National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables."

[51] Johnson, Steven Ross. "ACA Has Not Reduced ED Visits, Study Finds." *Modern Health care*, Modern Health care, 19 Apr. 2019, https://www.modernhealth care.com/safety-quality/aca-has-not-reduced-ed-visits-study-finds.

[52] Fuchs, Victor R. "Managed Care and Merger Mania." *The Journal of the American Medical Association*, 19 Mar. 1997, https://jamanetwork.com/journals/jama/article-abstract/414706.

[53] "The Impact of Hospital Consolidation on Medical Costs." *NCCI Holdings Inc.,* 11 July 2018, https://www.ncci.com/Articles/Pages/II_Insights_QEB_Impact-of-Hospital-Consolidation-on-Medical-Costs.aspx.

[54] "The Impact of Hospital Consolidation." *Robert Wood Johnson Foundation,* 1 June 2012, https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html.

[55] Kacik, Alex. "For the First Time Ever, Less than Half of Physicians Are Independent." *Modern Healthcare,* 31 May 2017, https://www.modernhealthcare.com/article/20170531/NEWS/170539971/for-the-first-time-ever-less-than-half-of-physicians-are-independent.

[56] Tuccille, J.D. "How Formerly Independent Doctors Were Pushed Out of Business." *Reason Foundation*, 28 Aug. 2018, https://reason.com/2018/08/28/your-formerly-independent-doctors-didnt/.

was revised after a public outcry, there is little doubt that vertical and horizontal integration was a core tenet of the ACA.[57] This push may make sense if these larger systems provided better, more cost-effective care. Yet, not only are prices higher in these larger, integrated systems, but quality suffers too.[58] [59]

The ACA has also pushed major insurers to flee the market, leaving many Americans over the years with a Hobson's choice to "shop" for insurance in a market with only one available option. In some locations, insurers have completely abandoned ship, leaving entire communities without a single available exchange plan.[60] While there have been no new instances of this zero-option dilemma in 2019, more than two-thirds of communities in the United States currently have just two insurance carriers or less, and more than one-third have just one carrier from which to "choose."[61] The story of Pamela in Nebraska is a perfect example of how average Americans are stripped of affordable options under the ACA. Since 2014, she has had six plans stripped from her, and now faces exorbitant premiums. Today, only one insurance carrier operates in Nebraska's 93 counties.[62] Pamela tells her story in Figure 3.

The ACA has also hurt Americans, particularly those earning lower incomes, by reducing their job prospects. The culprit is the ACA's employer mandate, which has drawn criticism from liberal and conservative groups alike.[63] As one would expect, the mandate's requirement that employers with at least 50 full-time employees (FTE) provide all of those employees health insurance has compelled many small businesses to undertake negative hiring and employment decisions to avoid breaching the 50 FTE threshold. The left-leaning Urban Institute has even admitted that "[e]liminating it will remove labor market distortions that have troubled employer groups, and which would harm some workers."[64]

The extent to which the employer mandate has inhibited job creation in the United States is well documented. According to a paper published by the Becker Friedman Institute for Research in Economics at the University of Chicago, "roughly 250,000 positions...are absent from [small] businesses because of the ACA..."[65] From a broader perspective, the Congressional Budget Office estimated that the ACA generally would cause a reduction in full-time-equivalent employment of about 2.3 million by 2021.[66] Even during the post-Great Recession economic recovery, "[t]he implementation of the employer

[57] Kocher, Robert, MD and Nancy-Ann M. JD, DeParle Ezekiel J. Emanuel. "The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges." *Annals of Internal Medicine, American College of Physicians*, 19 Oct. 2010, https://annals.org/aim/fullarticle/746295/affordable-care-act-future-clinical-medicine-opportunities-challenges.

[58] Short, Marah Noel, and James A. Baker III. "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality." *Institute for Public Policy*, Rice University, 2019, https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938.

[59] M, Gaynor and Town R. The Impact of Hospital Consolidation. *Robert Wood Johnson Foundation*, 1 June 2012, https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html.

[60] Centers for Medicare & Medicaid Services, "County by County Analysis of Current Projected Insurer Participation in Health Insurance Exchanges", June 13, 2017. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-06-13.html.

[61] U.S. Center for Medicare & Medicaid Services, "County by County Plan Year 2019 Insurer Participation in Health Insurance Exchanges," October 26, 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2019-County-Coverage-Map.pdf.

[62] Id.

[63] Levey, Noem. "Almost No One Wants the Obamacare Employer Mandate Now: Here's Why." *Los Angeles Times,* Los Angeles Times, 29 July 2014, https://www.latimes.com/business/la-fi-obamacare-employer-mandate-20140729-story.html.

[64] "Why Not Just Eliminate the Employer Mandate?" *Urban Institute*, 1 Feb. 2019, https://www.rwjf.org/en/library/research/2014/05/why-not-just-eliminate-the-employer-mandate-.html.

[65] Mulligan, Casey. "The Employer Penalty, Voluntary Compliance, and the Size Distribution of Firms: Evidence from a Survey of Small Businesses*." *University of Chicago.* Becker Friedman Institute, Nov. 2017, https://bfi.uchicago.edu/wp-content/uploads/WP_2017-07.pdf.

[66] "Labor Market Effects of the Affordable Care Act: Updated Estimates." *Congressional Budget Office*, Feb. 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixC.pdf#page=11.

penalty in January 2015 coincides with a sudden slowdown in the...recovery in aggregate work hours per capita, with 2016 national employment about 800,000 below the trend before the implementation of the employer penalty."[67]

PERSONAL STORY OF **PAMELA**

On the surface, I should be an ardent Obamacare supporter. Before it became the law of the land, I was denied coverage because of a pre-existing condition. I have regularly purchased my insurance through the exchange, and I received government subsidies to help pay my premiums, keeping my costs relatively in check compared to many others.

However, my situation has been far from rosy. I have been forced to find new insurance nearly every year as Obamacare wreaked havoc on the health care market in Nebraska. Since 2014, I have had six different insurance plans.

Additionally, it has been a struggle finding a plan that would allow me to keep my doctors, especially my doctor I have regularly used across the state border in Colorado.

Unfortunately, none of that compares to the situation I have been faced with this last year. My husband and I sold a rental property we had used for years as a second income and it caused me to no longer qualify for the government subsidies. While I always knew Obamacare was expensive, I was forced to fully confront exactly how outrageously expensive plans had become.

Instead of paying several hundred a month in premiums, my plan was now going to cost $4,300 per month in premiums without the subsidy. How could anyone possibly afford this?

Nebraska is down to one insurance carrier, so I had very few options. Thankfully, the Trump administration made changes to short-term health insurance plans, which allowed me to purchase a one-year plan for roughly $4,500 for the year.

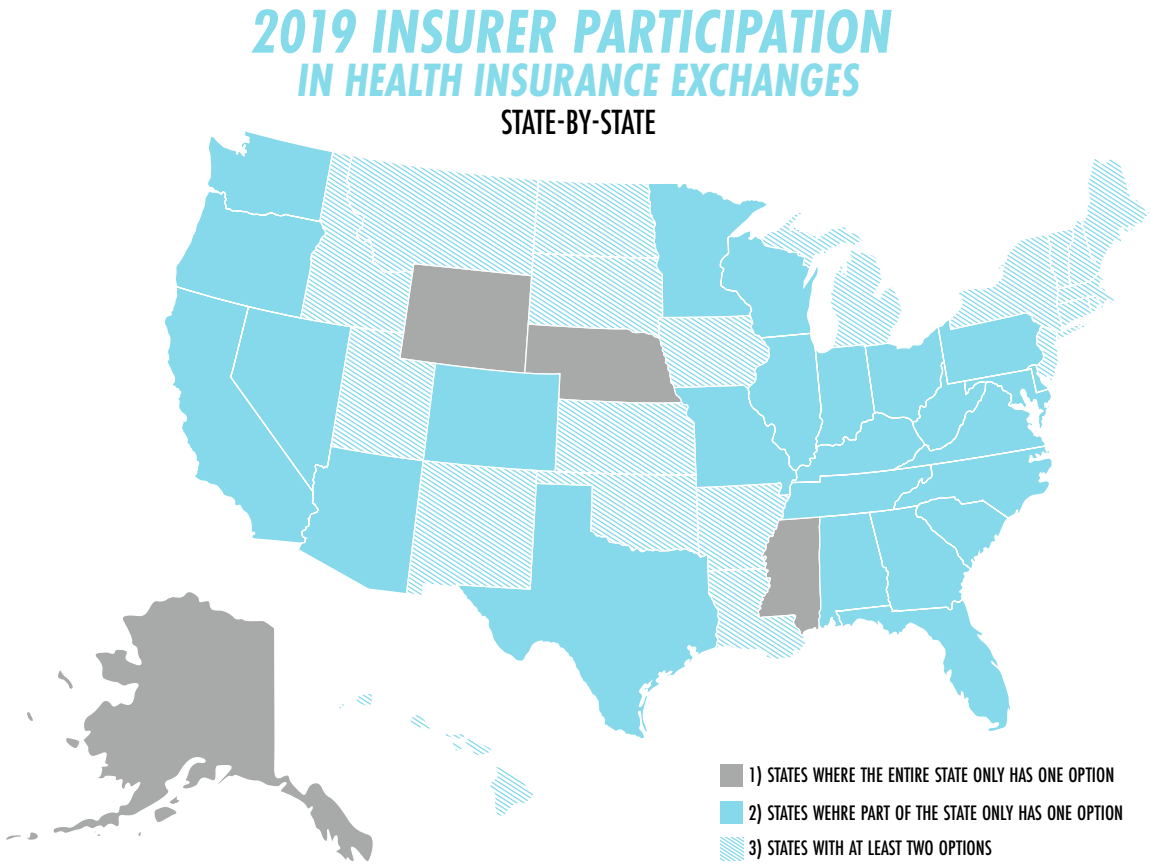
While it does not include preventative care or anything out of network, meaning I will no longer be able to see my doctor in Colorado, it does provide an affordable short-term safety net. For the time being I will have to delay much of my preventative care until a better option comes forward.

People like me need a system that is affordable- that allows us to see our doctors- and fits our own unique personal needs.

Figure 3. Pamela Nesbraska

Furthermore, hundreds of thousands more Americans saw reductions in their hours as a consequence of the employer mandate. A June 2016 paper sponsored by the Upjohn Institute concluded that half a million retail, hospitality, and food service workers were pushed into part-time employment after employers were forced to

[67] Id.



All state-based Exchange data is self-reported from the Exchanges to CMS
Federally- facilitated Exchange data reflected on this map is point in time as of 09/28/18

cut the hours of their employees.[68] Goldman Sachs also determined that "a few hundred thousand workers might be working part-time involuntarily as a result of the Affordable Care Act."[69]

Overall, "businesses... reported that, because of the ACA, they hire fewer workers or at least fewer full-time workers...Employers with 30-49 FTEs are also disproportionately likely to report that they hire less or have shorter work schedules because of the ACA."[70] The most common small-employer employment practice change (25 percent of the full sample) was that weekly hours were being reduced. This should come as no surprise because, and as the University of Chicago paper points out, "[b]usinesses not offering ESI that would otherwise be large can sharply reduce their costs by cutting their employment below the threshold."[71]

[68] Dillender, Marcus. "Early Evidence on the Effects of the Affordable Care Act on Part-Time Employment." *Upjohn Institute*, Sept. 2019, https://research.upjohn.org/projects/251/.
[69] Robb, Greg. "Obamacare Has Led to Rise in Involuntary Part-Time Employment, Goldman Sachs Finds." *MarketWatch.com*, MarketWatch, 8 June 2016, https://www.marketwatch.com/story/obamacare-has-led-to-rise-in-involuntary-part-time-employment-goldman-sachs-finds-2016-06-08.
[70] Mulligan, Casey. "The Employer Penalty, Voluntary Compliance, and the Size Distribution of Firms: Evidence from a Survey of Small Businesses*." *University of Chicago*, Becker Friedman Institute, Nov. 2017, https://bfi.uchicago.edu/wp-content/uploads/WP_2017-07.pdf.
[71] Id.

Some employers even made the difficult decision to drop their employer-sponsored coverage entirely and cut their FTEs below 50. Indeed, the University of Chicago paper's findings are consistent "with the hypothesis that a number of businesses that would have been close to, but above 50 FTEs are induced by the ACA to both (a) drop ESI – doing so permits their employees to receive exchange subsidies – and (b) reduce their employment in order to avoid the employer penalty."[72] This left workers forced to navigate the ACA exchanges to find coverage, which was often more expensive and of lower quality than the health care they had previously received or would have received from their employer.

THE ACA'S FAILED MEDICAID EXPANSION

In 2009, Edward Miller, Johns Hopkins Medicine's then-dean and CEO, cautioned against the immense strain that the ACA's expansion could place on existing Medicaid providers.[73] His prophetic and nonpartisan comments echoed the concerns many analysts had then and now. He stated, "We... endorse efforts to improve the quality and reduce the cost of health care. But we also understand all too well the impact a dramatic expansion of Medicaid will have on us and our state—and likely the country as a whole. A flood of new patients will be seeking health services, many of whom have never seen a doctor on more than a sporadic basis. Some will also have multiple and costly chronic conditions. And almost all of them will come from poor or disadvantaged backgrounds."

Ten years and over $300 billion later,[74] it is clear that the continued existence of the ACA's Medicaid expansion is unsustainable and unwarranted.[75,76] In addition to costing the federal government nearly another trillion dollars over the next ten years,[77] the expansion has been shown to inflict a host of negative consequences related to care, including for Medicaid's most vulnerable populations, and numerous harmful private market distortions.[78] By expanding Medicaid to able-bodied individuals without dependents, it has forced pre-expansion Medicaid groups—such as poor pregnant women, blind and disabled people, children, and the elderly—to compete for care with the expansion population. Despite the program's exorbitant costs, expansion is not improving health outcomes for new enrollees. Research also indicates that a majority of coverage gains under the expansion come from a corresponding reduction in private market insurance and that the expansion is causing increases in private health care costs.

As a result of the ACA's Medicaid expansion, provider availability has suffered among Medicaid's traditional, vulnerable populations. As pointed out by the Kaiser Family Foundation, studies draw a connection between longer wait times for appointments and greater difficulty in booking appointments with specialists. Overall, they demonstrate that expansion states had an increase in reports of medical

[72] Id.

[73] Miller, Edward. "Health Reform Could Harm Medicaid Patients." *The Wall Street Journal.* 5 Dec. 2009, https://www.wsj.com/articles/SB10001424052748703939404574567981549184844.

[74] "Expenditure Reports From MBES/CBES." *Medicaid.gov*, https://www.medicaid.gov/medicaid/finance/state-expenditure-reporting/expenditure-reports/index.html.

[75] Rudowitz, Robin, et al. "Medicaid Financing: The Basics." *The Henry J. Kaiser Family Foundation,* 21 Mar. 2019, https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/view/print/.

[76] According to CMS, data for the expansion adult population is still limited. Thus, there is still uncertainty about the health care costs of expansion adult.

[77] Fiscal years 2020-2029.

[78] "Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's May 2019 Projections." *CBO.gov*, The Congressional Budget Office, 2 May 2019, https://www.cbo.gov/system/files/2019-05/51298-2019-05-healthinsurance.pdf#page=3.

care being delayed because of wait times for appointments.[79] Community health centers, hubs for treating millions in medically underserved communities, in particular, reported that they were significantly more likely to have "increased wait times for appointments, possibly reflecting greater increases in demand for services associated with larger gains in coverage among health center patients in these states." Looking at the availability of pediatric specialty care, one study found that Medicaid patients in expansion states were less successful in obtaining appointments than patients in non-expansion states.

Simultaneously, the ACA failed to address the existing issue of lengthy Medicaid waiting lists pervasive in expansion and non-expansion states. As one March 2018 study explains since the ACA took effect, tragically, at least 21,904 individuals on Medicaid waiting lists have died in expansion states.[80] According to the Kaiser Foundation data available from 2017, the Waiting List Enrollment for Medicaid Home and Community Based Services Waivers totaled 707,378 individuals,[81] including:

- 472,997 individuals with intellectual or developmental disabilities;
- 189,187 aged, or aged and disabled, individuals;
- 11,409 individuals who are physically disabled;
- 28,952 children with disabilities;
- 1,357 individuals who suffer from mental health-related disabilities; and
- 3,395 individuals with traumatic brain injury/spinal cord injury.

As the 2017 Kaiser report aptly points out, "these are the individuals Medicaid was intended to help." While waiting lists predated the ACA, they have grown dramatically following the ACA's expansion.[82] In fact, since 2010, waiting lists have increased by 38.4 percent.[83] These waiting lists are not merely an inconvenience for the vulnerable populations on them, but rather the difference between a life without pain and one of agony. This plight was experienced by Lindsay Overman and her daughter Skylar, as explained in Figure 4.[84]

It is also no secret that Medicaid, despite its destructive impact on federal and states budgets, may in fact result in health outcomes that are demonstrably worse for Medicaid recipients than for people who are completely uninsured. A well-known national study conducted by the University of Virginia examined outcomes for nearly one million people undergoing major surgical operations over a four-year period and determined Medicaid recipients are 13 percent more likely to die in the hospital after surgery than the uninsured, and 97 percent more likely to die than people with private insurance. Scott Gottlieb, the former FDA Administrator, stated bluntly in a Wall Street Journal piece, "Medicaid is worse than no coverage at all."[85] He also pointed to a sampling of research finding poor health

[79] Miller, Sarah, and Laura R Wherry. "Health and Access to Care during the First 2 Years of the ACA Medicaid Expansions: NEJM." *New England Journal of Medicine*, 9 Mar. 2017, https://www.nejm.org/doi/full/10.1056/NEJMsa1612890.

[80] Horton, Nicholas. "WAITING FOR HELP: The Medicaid Waiting List Crisis." *The Foundation for Government Accountability*, 6 Mar. 2018, https://thefga.org/wp-content/uploads/2018/03/WAITING-FOR-HELP-The-Medicaid-Waiting-List-Crisis-07302018.pdf#page=2.

[81] Horton, Nicholas. "WAITING FOR HELP: The Medicaid Waiting List Crisis." *The Foundation for Government Accountability*, 6 Mar. 2018, https://thefga.org/wp-content/uploads/2018/03/WAITING-FOR-HELP-The-Medicaid-Waiting-List-Crisis-07302018.pdf#page=2.

[82] Jacobs, Christopher "Since Obamacare, Waiting Lists For Disabled Care Grew 40 Percent." *The Federalist*, 24 Sept. 2019, https://thefederalist.com/2019/09/24/since-obamacare-waiting-lists-for-care-for-disabled-people-have-grown-40-percent/.

[83] Id.

[84] "Skylar's Story: Waiting for Care." The Foundation for Government Accountability, 8 Oct. 2017, https://thefga.org/success-story/skylars-story-waiting-care/.

[85] Gottlieb, Scott. "Medicaid Is Worse Than No Coverage at All." *The Wall Street Journal*, 10 Mar. 2011, https://www.wsj.com/articles/SB10001424052748704758904576188280858303612.

outcomes for patients seeking care for head and neck cancer, heart procedures, and lung transplants. Moreover, while the ACA expansion was supposed to reduce the number of emergency room visits, studies have actually shown such visits have increased under the expansion.[86] [87]

PERSONAL STORY OF **LINDSEY OVERMAN**

Lindsey Overman and her family live in Arkansas. Her daughter Skylar was diagnosed with a rare condition called Schizencephaly in utero. There is no corrective procedure for Skylar's condition, so the family focuses on treating her symptoms and everything that comes with her diagnosis.

According to Lindsey, "We go to the doctor sometimes 3 or 4 times a month. We try to prolong her life and give her the best life possible. She has a wonderful school and has a one-on-one nurse. But she relies on us for care for everything."

The Medicaid program is supposed to provide health care to the truly needy, but that is not the Overmans' experience. Skylar has been on the Medicaid waiting list for over 10 years. The ACA encouraged states like Arkansas to expand Medicaid to prioritize abled-bodied adults over those with disabilities like Skylar. There are thousands of people on the Medicaid waiting list in Arkansas and over 80 people have died while waiting for services since the expansion.

"What's frustrating on the Medicaid waiting list, is we've always been a number," Lindsey has said. "I've seen people get services because they cheated the system. It's easier for me, as I would receive more services if I quit my job and stayed at home and allowed the state to pay for things. But I work really hard and I am very determined to have a great life. I want to provide for my family more so than what the state is going to provide."

After 10 years on the waiting list, the family finally found out Skylar was accepted, but then learned she would not end up being approved for services. The Overman family and patients like Skylar need a health care system that protects the truly vulnerable, without discouraging people like Lindsey from working to provide for their families.

Figure 4.
Lindsey Overman, Arkansas

Medicaid is also notorious for high levels of fraud, waste, and abuse. For every federally-funded dollar that Medicaid pays out, nearly 10 percent is done so improperly.[88] In FY 2018, Medicaid covered about 75 million individuals and cost $629 billion, of which $393 billion came from the federal government. This means that in FY 2018, the federal government made approximately $36 billion in Medicaid payments in error. This mismanagement, exacerbated by the ACA expansion, translates into wasted resources that could be directed to better care for Medicaid's vulnerable populations. Louisiana, which expanded in 2016, is illustrative of the program's failures. "Since Louisiana expanded Medicaid in July

[86] Sharma, Aabha I., et al. "Emergency Department Visits and Hospitalizations for the Uninsured in Illinois Before and After Affordable Care Act Insurance Expansion." *Springer Link.* 12 Nov. 2016, https://link.springer.com/article/10.1007/s10900-016-0293-4.

[87] Ladhania, Rahul, et al. "The Effect of Medicaid Expansion on the Nature of New Enrollees' Emergency Department Use." *Medical Care Research and Review,* May 2019, doi:10.1177/1077558719848270.

[88] "HIGH-RISK SERIES Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas." *United States Government Accountability Office*, Mar. 2019, https://www.gao.gov/assets/700/697245.pdf#page=257.

2016, at least 5,534 Louisiana residents with disabilities have died—yes, died—while on waiting lists for Medicaid to care for their personal needs," according to Chris Jacobs of the Juniper Research Group.[89] Meanwhile, out of "100 Medicaid recipients studied by the [Louisiana Legislative Auditor], 93...did not qualify for benefits for at least one month they received them, [and] had an average—repeat, average—household income of $67,742. Fourteen of the recipients reported income of over $100,000."[90]

Additionally, Medicaid's expansion has been responsible for several health insurance market distortions, namely "crowding out" of private insurance and increasing costs in the private market. Given the disparity of care between private insurance and Medicaid, pushing individuals out of employer-sponsored care and into Medicaid (*i.e.*, "crowding out") could have devastating consequences. While proponents of the Medicaid expansion typically rely heavily on how it extended insurance to millions of Americans, a 2018 study published by the Manhattan Institute points out that "57% of the increase in publicly subsidized insurance between 2007 and 2017 was offset by a decline in unsubsidized private insurance."[91] As the Kaiser Family Foundation points out, these declines occur when "employers alter their offering of coverage in response to the expansion of Medicaid."[92]

Moreover, states that expanded Medicaid experienced an average increase of $177 per person in private-sector health care costs. This is caused by increased "cost-shifting," where providers offset increased losses from taking on more Medicaid patients post-expansion. Even before the ACA, it was estimated that an average family paid an additional $1,800 on their private health insurance premiums per year because of the cost-shifting phenomenon.[93]

THE DISASTER OF SINGLE-PAYER

Clearly, the status quo is not working for the American people. The ACA has failed to make health insurance more affordable and has reduced the quality and accessibility of care. However, rather than focusing on reforms that would provide personalized and affordable care, many Democrats are using the ACA's failures as a springboard for instituting a mandatory one-size-fits-all, government-run health care system that would eliminate all private forms of health insurance. This proposal is often referred to as a "single-payer" system.

Under such a government-run system, the federal government would act as the sole-financier of health care services for every American. Far from free, Americans would pay for their one-size-fits-all health insurance by paying twice as many taxes and swallowing lower-quality care and long wait times. In other words, the federal government would be the nation's sole health insurer with thousands of faceless, unaccountable Washington bureaucrats playing gatekeeper between patients and the health

[89] Jacobs, Chris. "The Inconvenient Truths of Louisiana's Medicaid Expansion." *Lafayette Daily Advertiser,* 17 May 2019, https://www.theadvertiser.com/story/opinion/2019/05/17/inconvenient-truths-louisianas-medicaid-expansion/3693606002/.

[90] Pope, Chris. "HOW TO INCREASE HEALTH INSURANCE COVERAGE BY REDUCING ACA CROWD-OUT." *Manhattan Institute* , Jan. 2018, https://media4.manhattan-institute.org/sites/default/files/R-CP-0118.pdf.

[91] Pope, Chris. "HOW TO INCREASE HEALTH INSURANCE COVERAGE BY REDUCING ACA CROWD-OUT." *Manhattan Institute* , Jan. 2018, https://media4.manhattan-institute.org/sites/default/files/R-CP-0118.pdf.

[92] Antonisse, Larisa, et al. "The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review." T*he Henry J. Kaiser Family Foundation,* 15 Aug. 2019, https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/.

[93] Roy, Avik. "How Ohio's Medicaid Expansion Will Increase Health Insurance Premiums for Everyone Else." *Forbes Magazine*, 10 June 2013, https://www.forbes.com/sites/theapothecary/2013/02/08/how-ohios-medicaid-expansion-will-increase-health-insurance-premiums-for-everyone-else/#7a8e5c5319d7.

care services they need. Such a system would be a disaster for the American people, especially for those with chronic health conditions.

We can see the degradation in health care quality that stems from a one-size-fits-all, government-run health care system in the countries all over the world that have adopted it. For instance, in England, there are a record-setting 4.2 million patients on its National Health Service waiting lists.[94] Moreover, 19 percent of cancer patients will wait over two months after referral for their first urgent cancer treatment.[95] In Canada, the median waiting period in 2016 for a referral from a general physician appointment to see a specialist was 9.4 weeks.[96] This is on top of the median wait of 10.6 weeks that elapses between a specialist visit and first treatment.[97] Together, this means that the median wait after an initial doctor appointment to start treatment is around 4.5 months.[98]

This system could also create an exodus of quality medical professionals from the health care field and a reduction in services offered by providers and hospitals. According to the Journal of the American Medical Association, due to reduced payment rates, a single-payer system could result in 1.5 million job losses in the hospital sector.[99] [100]Meanwhile, rural health centers, already struggling to keep their doors open, could be forced to close and leave those area residents without care.[101] To offset revenue losses, services that had previously yielded smaller profit margins, like mental health, could be abandoned.[102]

We can also see the disfunction of a government-run health care system in our own country with the U.S. Veterans Health Administration (VHA), which provides health care to 9 million military veterans each year.[103] In 2014, it was revealed that at least 40 veterans seeking treatment with the Phoenix Veterans Affairs Health Care system died while waiting for appointments, and managers attempting to protect their performance bonuses purposefully hid a secret list of 1,400 – 1,600 sick veterans who had been waiting months for a doctor's appointment.[104] This is the type of care and management that comes from a health care system run by bureaucrats. According to a 2015 VHA report entitled, "Review of Alleged Mismanagement at the Health Eligibility Center," as of September 2014, enrollment processing had a backlog of 867,000 health care applications, and of this backlog 307,000 applications (35 percent) belonged to applicants determined to be deceased by the Social Security Administration.[105]

---

[94] Atlas, Scott. "The Conservative Case for Health Care." *The Washington Times,* 22 May 2019, https://www.washingtontimes.com/news/2019/may/22/the-conservative-case-for-health-care/.
[95] Id.
[96] Barua, Bacchus, and Feixue Ren. "Waiting Your Turn: Wait Times for Health Care in Canada." *Fraser Institute*, Nov. 2016, https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-wait-times-for-health-care-in-canada-2016.pdf.
[97] Id.
[98] Id.
[99] "The Implications of 'Medicare for All' for US Hospitals." *Bahm Alliance*, 6 Apr. 2019, https://bahm-alliance.org/publications/5058/.
[100] Jacobs, Chris. "CASE AGAINST SINGLE PAYER: How Medicare for All Will Wreck Americas Health Care System and Its... Economy." Republic Book Publisher, 2019, p. 76.
[101] Abelson, Reed. "Hospitals Stand to Lose Billions Under 'Medicare for All'." *The New York Times,* 21 Apr. 2019, https://www.nytimes.com/2019/04/21/health/medicare-for-all-hospitals.html.
[102] Id.
[103] Veterans Health Administration." *VA.gov, Veterans Health Administration,* 29 Apr. 2008, https://www.va.gov/health/#targetText=The%20Veterans%20Health%20Administration%20is,million%20enrolled%20Veterans%20each%20year.
[104] Bronstein, Scott, and Drew Griffin. "A Fatal Wait: Veterans Languish and Die on a VA Hospital's Secret List." *CNN*, Cable News Network, 24 Apr. 2014, https://www.cnn.com/2014/04/23/health/veterans-dying-health-care-delays/.
[105] "Review of Alleged Mismanagement at the Health Eligibility Center." *The Department of Veterans Affairs,* 2 Sept. 2015, https://www.va.gov/oig/pubs/VAOIG-14-01792-510.pdf.

For those who survive the waitlists, the toll of the VHA health care system can still be too much to bear. Former corporal in the 12th Marine Regiment, Jonathan LaForce, has written about the devastating struggles veterans face under the VHA's government-run model, recounting "reports of vets who threw themselves out the upper windows of VA hospitals because of some moronic bureaucrat" and how one veteran "doused himself in gasoline in front of the clinic, lit himself on fire, and died."[106]

Not only would Americans be stuck with worse health care under a one-size-fits-all, government-run-system, it would come at enormous costs to taxpayers. One "lower bound" estimate conducted by the Mercatus Center concluded that such a plan would cost $32.6 trillion over the first 10 years.[107] This cost estimate is verified by a nearly identical estimate from the Urban Institute.[108] Even *doubling* federal individual and corporate income taxes would fail to finance the enormous proposal. The Mercatus Center paper warns, "it is likely that the actual cost of [a single-payer system] would be substantially greater than these estimates" because they assume the federal government would reimburse providers at Medicare rates. This assumption, however, is unrealistic, with government-run health care advocates already abandoning Medicare rates and supporting higher provider payments.[109] This exact scenario has already played out in the state of Washington.[110] Accordingly, Americans can expect that a one-size-fits-all, government-run system to not only raise federal spending and taxes but total national health care spending. In other words, the promise that Americans would pay less overall is a fallacy—not to mention the accompanying reductions in the quality and timeliness of health care.

If you like your plan, you will definitely not be able to keep it under a one-size-fits-all system of health care. Instead, what would be required is the complete elimination of employer-sponsored health insurance, resulting in roughly 160 million people losing their current health insurance coverage. The ACA has resulted in a few million people losing their coverage, but a complete government-run system would force nearly 200 million people off their employer-coverage as soon as it is implemented.[111] A one-size-fits-all system would also include the total takeover of thousands of privately-owned health care providers. Additionally, seniors would be required to leave Medicare, a program they have paid into their entire lives, and would be moved into a new program where every American would compete for their benefits[112].

The RSC rejects this system, which would threaten the care of hundreds of millions of people, jeopardize the country's economy, and result in Washington bureaucrats taking over the American health care system. Instead, we are proposing real solutions.

---

[106] LaForce, Jonathan. "We Have A Single-Payer System, And It's Killing Veterans Like Me." *The Federalist,* 21 Aug. 2017, https://thefederalist.com/2017/08/16/america-already-single-payer-system-killing-veterans-like/.

[107] Blahous, Charles. "The Costs of a National Single-Payer Health care System." *Mercatus Center George Mason University,* July 2018, https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

[108] Holahan, John, et al. "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending." *Urban Institute,* 1 Feb. 2017, https://www.urban.org/research/publication/sanders-single-payer-health-care-plan-effect-national-health-expenditures-and-federal-and-private-spending.

[109] Blahous, Charles. "The Costs of Medicare for All Are Rising Already." Economics21, 26 Aug. 2019, https://economics21.org/medicare-for-all-costs-rising-already.

[110] Id.

[111] Jacobs, Chris. "CASE AGAINST SINGLE PAYER: How Medicare for All Will Wreck Americas Health Care System and Its... Economy." Republic Book Publisher, 2019, p. 7.

[112] Id at, p. 27.

THE RSC HEALTH CARE PLAN

THE RSC
HEALTH CARE PLAN

A FRESH START

From the beginning, many advocates of the ACA sought to weaponize the issue of "pre-existing conditions" as a means to get their new law passed. The result has been that a vulnerable population of Americans has been used as political pawns. To extend insurance to individuals with pre-existing conditions, the ACA imposed a new regulatory scheme consisting of onerous mandates and laws that forced all Americans into insurance plans they did not need and could not afford. The RSC has always understood this is the wrong approach, and now a decade of increases in insurance costs and the overall reductions in the quality of available care under the ACA have proven the point.

In stark contrast to the failed ACA experiment and reckless calls for a one-size-fits-all, government-run system, the RSC offers a sustainable solution that would still provide protections for those Americans with pre-existing conditions without sacrificing the quality of care. The RSC plan envisions an individual marketplace in which the government no longer makes health care decisions for each American, but rather each individual is empowered with greater control over their own health care choices and resources. Moreover, while the ACA has disincentivized the purchase of insurance, the RSC plan is designed to reward responsibility, reduce barriers to continuously maintaining insurance, and provide a wider array of affordable options.

To accomplish these goals, it is necessary to transform the individual marketplace's current regulatory structure, unwind the ACA's Washington-centric approach, and largely return regulatory authority to the individual states.[113] As explained in the following section, protections pertaining to guaranteed issue and the prohibition on coverage exclusions would be retailored under the RSC plan to reward continuous coverage and promote portability in the individual marketplace. Additionally, in order to provide Americans with health insurance options that fit their individualized needs and do not add unnecessary expenses, the RSC plan would undo the ACA's regulations on essential health benefits, annual and lifetime limits, preventive care cost-sharing, dependent coverage, and actuarial value. Each state would again be allowed to dictate the minimum attributes and cost-sharing parameters of plans to best meet the needs of their own citizens. The ACA's medical loss ratio, along with its competition-killing and premium-increasing effects, would be eliminated as well. In no case, however, would carriers be able to rescind, increase rates, or refuse to renew one's health insurance simply because a person developed a condition after enrollment. [114]

Additionally, states—and not the federal government—would be solely empowered under the RSC plan to establish restraints on the extent to which carriers could incorporate the health risks of individuals into premiums. Thus, the RSC plan would eliminate the ACA's community rating, age banding, and single risk pool requirements. However, under the RSC plan, individuals with high risk medical conditions would have affordable access to state-run Guaranteed Coverage Pools under which their health care costs would be subsidized with federal grants and further contained by any state-enacted premium-setting restrictions.

Separately, the RSC plan would ensure states receive federal grants designed to assist the states in flexibly providing low-income individuals with access to affordable coverage. Funding for these grants would be derived from repackaging the ACA's premium subsidies and Medicaid expansion funding. Details regarding the RSC plan's Guaranteed Coverage Pool funding and low-income grants are provided further below.

The cumulative effect of these changes would result in Americans being provided with more insurance choices that are personalized to their needs and available at affordable rates. In this way, the RSC plan is designed to facilitate the acquisition and continuity of coverage. These two elements are critical to the RSC's holistic approach to neutralizing the issue of pre-existing conditions. People must be able to get and keep coverage before developing an adverse health condition.

HEALTH INSURANCE PORTABILITY

Enhancing portability of coverage is the cornerstone of the RSC's approach to neutralizing the issue of pre-existing conditions. What is portability? The term refers to the ability of an insured individual to carry their insurance coverage protections with them. Enhancing portability is critical for purposes of preventing breaks in coverage, during which time an individual could develop a medical condition posing an impediment to obtaining health insurance. In this way, continuous coverage can be a *de facto*

[113] Although the ACA regulations enumerated in this section would be eliminated at the federal level under the RSC plan, as has always been the case, states would retain the ability to reinstate them within their borders, and the RSC plan would do nothing to preempt this authority. Indeed, 11 states have preemptively codified Obamacare's individual regulatory scheme or are considering doing so. See, Corlette, Sabrina, and Emily Curran. "Can States Fill the Gap If the Federal Government Overturns Preexisting-Condition Protections?" *Commonwealth Fund*, 7 May 2019, https://www.commonwealthfund.org/blog/2019/can-states-fill-gap-preexisting-condition-protections.

[114] Short-term, limited duration plans, would continue, as is the case under ACA, to be renewable upon agreement of both the insured individual and carrier.

safeguard against pre-existing conditions, so long as the operative legal backdrop ensures that coverage protections are portable. Indeed, this is precisely the legal framework and peace of mind that the RSC plan provides.

Enhanced Portability Protections

Before the enactment of the ACA, individuals were afforded some degree of portability in the private health insurance arena, but this was primarily focused within the employer-sponsored market. Federal law generally prevented an employer that sponsored health insurance from precluding any employee's participation in the plan because of an existing health condition. This guaranteed coverage requirement was subject to an optional, temporary period during which a pre-existing condition could be excluded from coverage, but that would be reduced month-for-month for periods of prior coverage.[115] This rule applied whether the individual was entering the employer marketplace from the individual market or coming from another employer. The ACA later barred the temporary exclusion period.[116] It also implemented the employer mandate applicable to employers with 50 or more full-time employees. The RSC plan does not propose reversing the ACA's ban on exclusion periods in the employer market but our plan would eliminate the ACA's job-killing employer mandate.

BECAUSE CHANGES IN INDIVIDUAL CIRCUMSTANCES CAN HAPPEN UNEXPECTEDLY, THE RSC PLAN WOULD GIVE INDIVIDUALS THE FLEXIBILITY TO MOVE THROUGH THE PRIVATE MARKET.

Pre-ACA federal law sought to facilitate the transition from the employer marketplace to the individual marketplace by providing certain portability protections to eligible individuals, such as guaranteed issue and a prohibition on pre-existing condition exclusions.[117] These portability protections were dictated by the Health Insurance Portability and Accountability Act (HIPAA). Eligibility was contingent upon the individual: 1) possessing credible health insurance coverage for at least 18 months without a break of 63 days; 2) exhausting any COBRA (or other continuation) coverage;[118] and 3) having no eligibility for coverage under any employment-based plan, Medicare or Medicaid. A state could fulfill its duty to provide these portability protections by either requiring individual market carriers to supply them to eligible individuals (this was the federal default), or by instituting an alternative mechanism, such as a high-risk pool for eligible individuals.[119]

This pre-ACA framework, however, left a gap in portability. While it largely provided portability for coverage going into a job, from job to job, and from a job to the individual marketplace, it did not reward individuals who maintained insurance with any portability protections when they moved within the individual marketplace. In other words, if a person sought to change carriers within the individual marketplace, he or she could be denied coverage based on their health status. The ACA ignored the opportunity to simply bridge that portability gap for individuals who have responsibly maintained insurance, and instead created a system that disincentivized individuals from purchasing insurance. This inevitably resulted in the reduced quality of care and cost-prohibitive premiums and deductibles that Americans are experiencing today.

[115] Under HIPAA, the exclusion period could be as long as 12 months, reduced for each month of creditable coverage.

[116] Under the ACA, employers are still allowed to require new employees to work for up to 90 days prior to becoming eligible to participate in the employer plan.

[117] HIPAA's provisions requiring guaranteed issue and prohibiting pre-existing condition exclusions for HIPAA-eligible individuals could alternatively be satisfied by implementation of, among other things, a qualified high-risk pool.

[118] COBRA Fact Sheet." *Centers for Medicare & Medicaid Services*, 20 May 2019, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html.

[119] Id.

The RSC plan proposes to bridge the portability gap that was left by HIPAA in the individual marketplace by providing enhanced portability protections for individuals as they move between and within the employer and individual marketplaces. Why would somebody move from an individual plan to individual plan? Perhaps that person has relocated to a new state which offers different plans, or perhaps a carrier no longer offers plans in a particular market. Because changes in individual circumstances can happen unexpectedly, the RSC plan would give individuals the flexibility to move through the private market.

First, under the RSC plan, movement into the individual marketplace from the employer marketplace would be facilitated by ensuring that individuals do not need to exhaust COBRA (or other continuation) coverage before entering the individual market with portability protections. Employer-sponsored plans are often far broader and more expensive than people need or can afford on their own. Consequently, people are routinely forced into having a lapse in continuous coverage because their COBRA plan is not a viable option. While the RSC plan would eliminate the need to exhaust COBRA, individuals would still have access to this coverage pursuant to their own choice, and employers would still have to provide it as an option.

Second, whether a person is moving from an employer plan into the individual marketplace or switching individual plans, they would receive the same coverage protections afforded to a person enrolling in employer-sponsored coverage under pre-ACA HIPAA law. In other words, everyone seeking coverage in the individual marketplace would have guaranteed issue protections and could not be refused a plan based on the enrollee's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.[120]
However, if a person does not have twelve months of continuous coverage,[121] the person could be subject to an exclusion period of up to twelve months for an existing condition. Prior periods of continuous coverage would reduce any exclusion period month-for-month. The 63-day grace period for gaps in coverage would be maintained under the RSC plan. Additionally, as was the case under HIPAA, states would be able to satisfy the RSC plan's portability protections through the implementation of a Guaranteed Coverage Pool providing these same portability protections.

Critically, the parameters of the RSC plan would simply serve as guardrails in the individual marketplace and would not in any way hinder states from shortening continuous coverage requirements, providing limitations on premiums for people with or without prior coverage, or adding any additional protections for people seeking a plan in the individual marketplace.

Lawmakers could also explore ways in which states could be given flexibly in providing these portability protections in the individual marketplace for those with continuous coverage. For instance, prior to the ACA, federal law allowed states to meet group-to-individual market portability protections by requiring carriers to offer eligible individuals access to their two most popular policies or access to a lower-level and higher-level coverage. Some states simply had a designated carrier serve as the guaranteed issue carrier.

---

[120] Haislmaier, Edmund. "Saving the American Dream: The U.S. Needs Commonsense Health Insurance Reforms." *The Heritage Foundation*, 22 June 2012, https://www.heritage.org/health-care-reform/report/saving-the-american-dream-the-us-needs-commonsense-health-insurance.

[121] HIPAA required 18 months of continuous coverage for individuals moving from the employer coverage to the individual marketplace before becoming eligible for portability protections (guaranteed issue and a prohibition on condition exclusions).

To ensure that ample options exist for Americans to possess continuous coverage, short-term, limited-duration plans would count toward periods of continuous coverage under the RSC plan. Additionally, the RSC plan would codify the Department of Health and Human Services' new rule allowing short-term, limited-duration plans to last for a term of one year (and renewable for up to 36 months). Health care sharing ministry plans would also count toward continuous coverage. However, in order to combat a potential adverse selection issue where individuals with portability protections attempt to switch to a plan with more substantial benefits, carriers should be given the flexibility to apply the continuous coverage requirements on a benefit-by-benefit basis. Indeed, this concept existed to some extent prior to the ACA.[122] Without such an option, insurers would be disincentivized from providing quality benefits, a phenomenon that has adversely affected the quality of care under the ACA. Again, this twelve-month period would be reduced month-for-month for periods that the individual possessed a particular benefit. In this way, individuals would be provided with the ability to change plans, but for the sake of a sustainable insurance market, safeguards would be put in place to prevent gaming the system.

Guaranteed Coverage Pools

The RSC plan would provide federal funding for states to supplement the medical costs of eligible high-risk individuals. The RSC plan refers to this mechanism as a Guaranteed Coverage Pool. These federally-funded, state-administered pools would provide premium stability in the individual marketplace, ensure that individuals with high-cost illnesses have access to affordable health coverage, and serve as a means of providing portability protections for individuals who have maintained continuous coverage.

More specifically, under the RSC plan, the federal government would make funding available for states to design and operate their own Guaranteed Coverage Pools. States would not be locked into a particular Guaranteed Coverage Pool mechanism, but rather would be given the freedom to use the federal funds to implement innovative, state-centric designs that would ensure everyone in the state's pool has access to better care than under the ACA. The RSC plan would not require the federal government to operate a Guaranteed Coverage Pool if a state chooses not to do so, but simply would make funding available to states that do.

The RSC plan offers true flexibility to states to operate a Guaranteed Coverage Pool designed by them to best meet their citizens' needs. For instance, states could choose to administer a Guaranteed Coverage Pool resembling a traditional high-risk pool. Prior to the ACA, more than thirty states operated such pools.[123] Alternatively, states would have the flexibility to implement other innovative models to stabilize and reduce premiums within their borders. For instance, they could adopt the invisible high-risk pool model developed in Maine prior to the ACA,[124] or build off of similar reinsurance programs recently implemented in several other states pursuant to ACA waivers.

Under the Maine invisible high-risk pool model, lawmakers designated certain high-risk conditions that would automatically qualify an individual for participation in the invisible high-risk pool. These

[122] "The Health Insurance Portability and Accountability Act (HIPAA) of 1996." *Congressional Research Service*, 24 Jan. 2005, https://www.everycrsreport.com/files/20050124_RL31634_ea1679709ba7307c9b9ff48e98238723ea72163c.pdf#page=10.

[123] "Health Insurance: State High Risk Pools." *Congressional Research Service*, 26 Jan. 2011, https://www.everycrsreport.com/files/20110126_RL31745_fef77533858b8e9826d900b2efc7789381c4604e.pdf.

[124] Allumbaugh, Joel, et al. "Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions." *Health Affairs*, 2 Mar. 2017, https://www.healthaffairs.org/do/10.1377/hblog20170302.059003/full/.

conditions included congestive heart failure, HIV, COPD, kidney failure, and various cancers.[125] [126] Insurers also were given the discretion to cede individuals on a case-by-case basis after reviewing their medical history. Individuals qualifying for federal financing were still able to enroll in private coverage and were even unaware of the fact that their medical costs were largely being paid by such funding. Insurers were required to relinquish nearly all the premiums collected from high-risk individuals to the pool to assist with its financing. This also negated the opportunity for insurers to make a profit from placing individuals in the pool. Maine's pool paid all medical costs for the individual beyond $10,000. With insurers bearing the risk up to this threshold, there was not a financial advantage to excessively designate individuals as high-risk.

Even when implemented in the context of the burdensome regulatory scheme in Maine—which was essentially the ACA—their risk-sharing model has been estimated to have reduced premiums 12 to 15 percent.[127] When coupled with very minor regulatory reforms related to age-banding, mandated benefits, and cost-sharing flexibility, average individual market premiums were cut in half.[128]

More recently, seven states, including Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin, were awarded waivers under Section 1332 of the ACA to deviate from certain ACA mandates and redirect ACA subsidies toward uniquely designed reinsurance programs. While each of these states' programs share similar designs to bring down premiums, and largely reflect the strategy of Maine's original IHRP, they contain unique attributes reflecting the flexibility needed for effective implementation. As Doug Badger of the Heritage Foundation has explained:

> All five have established attachment points (claims thresholds above which the reinsurance fund would begin to pay), ceilings (levels above which the reinsurance fund would no longer defray the claims costs), and coinsurance rates (the percentage of claims the reinsurance fund would pay between the attachment point and the ceiling). North Dakota, for example, proposes a reinsurance fund that would pay 75 percent of claims between $100,000 and $1,000,000. Colorado, by contrast, would set the claims range at $30,000 to $400,000, and would vary coinsurance by rating area (range of 45 percent to 85 percent). The ability of a state to tailor its waiver program to its market (and to vary the program to reflect market variations within the state) is an essential feature.[129]

---

[125] As explained by the Brookings Institution, "High risk" was determined based on having one of eight prior diagnoses (congestive heart failure, HIV, COPD, kidney failure, various cancers), or based on information the insurer collected from applicants through a detailed medical questionnairea detailed medical questionnaire. The questionnaire can be found here: http://www.mgara.org/Health%20Assessment%20Form.pdf. See,
Hall, Mark, and Nicholas Bagley. "Making Sense of 'Invisible Risk Sharing.'" *Brookings Institute,* 5 Mar. 2018, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/04/12/making-sense-of-invisible-risk-sharing/.
"MAINE GUARANTEED ACCESS REINSURANCE ASSOCIATION HEALTH ASSESSMENT FORM INDIVIDUAL INSURANCE PLAN." *MGARA.org,* Maine Guaranteed Access Reinsurance Association, http://www.mgara.org/Health Assessment Form.pdf.

[126] Hall, Mark, and Nicholas Bagley. "Making Sense of 'Invisible Risk Sharing.'" *Brookings Institute,* Brookings Institute, 5 Mar. 2018, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/04/12/making-sense-of-invisible-risk-sharing/.

[127] Gorman, Bela, et al. "The Impact of PL90 on Maine's Health Insurance Markets." *Gorman Actuarial, LLC,* Dec. 2011p.12, https://www.maine.gov/pfr/insurance/publications_reports/archived_reports/pdf/gorman_actuarial_report.pdf#page=12.

[128] Allumbaugh, Joel, et al. Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions. *Health Affairs,* 2 Mar. 2017, https://www.healthaffairs.org/do/10.1377/hblog20170302.059003/full/.

[129] Badger, Doug. "How Health Care Premiums Are Declining in States That Seek Relief from Obamacare's Mandates." *The Heritage Foundation,* Aug. 13, 2019, https://www.heritage.org/sites/default/files/2019-08/IB4990.pdf.

Moreover, according to Badger, "Premiums in those waiver states fell by a median of 7.48 percent, while premiums in the other 44 states and the District of Columbia rose by a median of 3.09 percent. An additional five states (Colorado, Delaware, Montana, North Dakota, Rhode Island) project premium declines ranging from -16 percent to -5.9 percent in 2020 due to waivers." The common lesson learned from these risk-sharing programs is that when states are allowed to innovate, they are able to reduce the cost of insurance without sacrificing the quality of care.

Notably, states were able to accomplish this inspite of the fact that they were all severely restricted in their regulatory flexibility. Maine's IHRP was coupled only with minor reforms related to age-banding, mandated benefits, and cost-sharing flexibility. States carrying out 1332 waivers only waived the ACA's single-risk pool requirement. Thus, it can be expected that, when coupled with the RSC plan's more robust regulatory reforms, premiums would be driven down even further. Consequently, the individual marketplace would become a better, more affordable option for healthier people, including those who were previously uninsured. People would be attracted to and rewarded for obtaining individual marketplace coverage rather than repelled and disincentivized as they are under the ACA.

As noted above, states can satisfy the RSC plan's individual marketplace portability protections through the implementation of a Guaranteed Coverage Pool that provides such protections. Accordingly, the coverage pool would have to: 1) provide immediate access to a plan and prohibit condition exclusions for individuals who have maintained twelve months of continuous coverage; 2) cap any condition exclusion period at twelve months; and 3) reduce any exclusions month-for-month for individuals with less than twelve months continuous coverage. Consequently, everyone with an existing condition who is seeking coverage in the individual market would be provided a pathway to obtaining complete coverage of all their conditions within just twelve months.

States would be free under the RSC plan to enact shorter exclusion periods. Prior to the ACA, the vast majority of states with high-risk pools capped their exclusion period at six months or shorter. Specifically, out of the states operating high-risk pools, two states had no exclusion period, five states had periods of 2 to 3 months, sixteen states had periods of 6 months, and nine states had periods of 9 to12 months.[130]

States would be given the flexibility to set other guardrails on the cost and attributes of a pool's insurance coverage, too. For instance, states could set caps, relative to standard market rates, on the premiums of those high-risk individuals ceded to a Guaranteed Coverage Pool. Notably, the vast majority of states with high risk pools prior to the ACA limited premiums for their high-risk population to a ratio of 1.5:1 of standard market rates.[131] Still, even including states with caps higher than 1.5:1, average premiums for high-risk individuals were 1.38:1 relative to market rates.[132] Moreover, according to the Kaiser Family Foundation, "most pools offered a choice of plan options with different deductibles; in 29 programs, the plan option with the highest enrollment had a deductible of $1,000 or higher..." Compare this to plans under the ACA, where the average deductible for a bronze plan in 2019 is nearly $5,900.[133]

---

[130] Richard Cauchi, "States and High Risk Pools," *National Conference of State Legislatures (NCSL)*, May 17, 2010, http://www.ncsl.org/portals/1/documents/health/HighRiskpoolswebinar51710.pdf.

[131] NASCHIP. "Premium Rate Setting Methodology" Sept. 2012, http://naschip.org/2012/Quick%20Checks/Premium%20Rate%20Setting%20Methology.pdf.

[132] Id.

[133] Luhby, Tami. "Fact Check: Are Obamacare's Deductibles More than $7,000?" *CNN*, 2 Apr. 2019, https://www.cnn.com/2019/04/01/politics/fact-check-obamacare-deductibles/index.html.

Federal funding for Guaranteed Coverage Pools would be delivered to states in the form of a grant derived from repackaging the ACA's individual marketplace subsidies and Medicaid expansion. This reflects the method by which states receive federal funding for their reinsurance pools under 1332 waivers—through repackaging of the ACA subsidy spending. It should be noted that although states would be given maximum flexibility in utilizing Guaranteed Coverage Pool funds to lower costs for high-risk individuals, under the RSC plan, such funding could not be used to subsidize abortion benefits. Lawmakers could funnel funding through the current Children's Health Insurance Program, as proposed in the Graham-Cassidy-Heller-Johnson proposal,[134] to ensure that CHIP's current pro-life protections attach automatically.

Overall, lawmakers must endeavor to determine the appropriate amount of funding that would be needed to bring stability to the individual marketplace to ensure that premiums for high-risk individuals are affordable, without shifting costs over to non-high-risk individuals to the extent they do not wish to purchase insurance. Though the potential $17 billion annual price tag[135] may not seem ideal, it sets up a sustainable path for the individual marketplace and deters our nation from heading toward a government-run, one-size-fits-all health care system that would cost taxpayers more than $30 trillion over the next decade. The RSC plan's reforms will incentivize continuous coverage and provide the opportunity to purchase affordable, personalized plans, which together will drive individuals to obtain coverage before they become sick. Consequently, the RSC plan will operate to neutralize the issue of pre-existing conditions and build a healthier marketplace.

Tax Benefit Equality

A sustainable health care plan which aims to address long-existing systemic problems must also address problems that predated the ACA.[136] One such area in need of reform is the inequitable way in which health insurance expenditures are treated under antiquated tax laws. The RSC plan would remedy relevant tax code flaws to further facilitate personalized, portable, and continuous coverage.

The most notable flaw in the tax code as it relates to health care is the inequitable treatment between employer-sponsored and individually purchased health insurance. A person choosing to purchase health insurance with income from their paycheck is at a significant tax disadvantage versus a person receiving employer-sponsored insurance. When an employer spends money to purchase a plan for an employee, the employer does not have to pay payroll taxes on the benefit nor does the employee pay payroll or other federal and state income taxes on the benefit. On the other hand, if an employee seeks to purchase individual coverage, the funds they would use to do so are subject to each of those forms of taxation. This results in a massive financial disincentive for both the employee and the employer to provide wages for the purchase of individual insurance versus providing employer-sponsored coverage.

The tax-exempt status of employer-sponsored insurance has been called the "original sin" of the U.S. health care system.[137] Though the Internal Revenue Service had generally considered fringe benefits

[134] "Read About Graham-Cassidy-Heller-Johnson." *U.S. Senator Bill Cassidy of Louisiana,* https://www.cassidy.senate.gov/read-about-graham-cassidy-heller-johnson.

[135] Ely, Kathleen E., et al. "The Federal Invisible High Risk Pool: Effect on Premium Rates, Individual Marketplace Enrollment and Use of Federal Funds. Foundation for Government Accountability," 17 Apr. 2017, https://thefga.org/wp-content/uploads/2017/04/The-Federal-Invisible-High-Risk-Pool.pdf.

[136] Graboyes, Robert, and Charles Blahous. "The Pre-Existing Condition: Innovative Solutions to America's Thorniest Health care Challenge." *Mercatus Center at George Mason University,* 29 Sept. 2015, https://www.mercatus.org/publication/pre-existing-condition-innovative-solutions-america-s-thorniest-health care-challenge.

[137] Katebi, Charlie. "With tax reform, Congress missed an opportunity to fix original sin of US health care." *The Hill,* https://thehill.com/opinion/health care/368339-with-tax-reform-congress-missed-an-opportunity-to-fix-original-sin-of-us.

given by employers to be non-taxable, the exclusion of employer-sponsored health insurance premiums was codified by IRS guidance in 1943. Why? It was in response to the Executive Order 9250 issued by Franklin D. Roosevelt three months earlier, which froze wage and salary levels across the United States. This enormous regulation left businesses with only one option to compete for labor, to offer increased fringe benefits. After the IRS reversed its ruling in 1953, Congress then codified this practice into statute in 1954.[138] Congress had no other choice at that time because the entire U.S. economy had spent a decade with employers funneling money into health insurance plans for their employees instead of wages.

This haphazard and overly invasive government interference is why the U.S. has its unique health care system—one in which the government has artificially made it cheaper for employers and employees to lock people into jobs and have employers handle health care negotiations for individuals, instead of increasing wages and giving people increased freedom over their income and health care choices. In other words, it is a major obstacle to moving towards a system focused on portability and personalized coverage.

This system has also greatly contributed to the high-priced health care market we have today. It decreases market efficiency because individuals who do not pay most of their health care costs directly are encouraged, and sometimes effectively forced, to enroll in needlessly expensive health insurance policies that further exacerbate over-utilization. Additionally, it reduces job flexibility by paying people to stay with their present job and not enabling them to switch to a more productive job. Studies have shown this tax treatment has significantly reduced wages,[139] and the Congressional Budget Office has concluded that premiums are higher because of the exclusion.[140]

The RSC plan proposes a more efficient system that would provide equal tax treatment in the employer and individual health insurance markets. Thus, the RSC plan would give individuals the ability to use health savings accounts (HSAs) to pay for premiums in the individual marketplace. The RSC plan would also preserve the existing above-the-line deduction for self-employed individuals.

By allowing individuals to use health savings accounts funds to pay for their health care premiums, the RSC plan allows individuals to take advantage of the triple-tax advantaged status of health savings accounts. First, funds that are deposited in a health savings account are not subject to income tax or payroll taxes (including individual and employer payroll taxes) when they are earned. Once in the account, funds are not subject to taxation for any interest accrued. Nor are funds taxed when they are removed from the health savings account and spent on qualifying medical costs. An individual who utilized their health savings account in this way would no longer be penalized for choosing to shop for a plan on the individual market.[141] This will be akin to the Trump Administration's Health Reimbursement Arrangement (HRA) rule, which the RSC plan supports codification of, except that instead of the funding belonging to the employers, the funds will belong to the individual.[142]

---

[138] "Tax Treatment of Employment-Based Health Insurance" *Congressional Budget Office,* March 1994. https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/1994_03_tax-treatmentofinsurance.pdf.

[139] Baicker, Katherine and Amitabh Chandra. "The Labor Market Effects of Rising Health Insurance Premiums" Feb. 2005. https://www.nber.org/papers/w11160.pdf

[140] "Tax Treatment of Employment-Based Health Insurance" *Congressional Budget Office,* March 1994. https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/1994_03_tax-treatmentofinsurance.pdf.

[141] Cannon, Michael F. "How Expanding Health Savings Accounts Could Cure America's Sick Health Care System." *New York Post,* 21 Sept. 2019, https://nypost.com/2019/09/21/how-expanding-health-savings-accounts-could-cure-americas-sick-health-care-system/.

[142] "Health Reimbursement Arrangements and Other Account-Based Group Health Plans." *Federal Register, A Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department,* 20 June 2019, https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

The benefits to the individual and the individual health insurance marketplace from equalizing tax treatment are vast. First, the inequitable tax treatment of employer-sponsored insurance can cause an employee to forgo valuable wages while being pushed into a plan that exceeds or does not match the needs of the individual. Equalizing tax treatment will pave the way for individuals to negotiate higher pay and pursue more affordable, personalized plans on the individual marketplace. Employees could also push for funds that would have gone toward an excessive employer-sponsored plan to be placed in full into their health savings account, purchase their own affordable plan, and save the remainder tax-free for future medical needs. Moreover, Americans would be given greater control over their own money and their health care choices.

It is also notable that greater control and personalization of health insurance will help combat the issue of health care over-utilization in the United States. If individuals are given greater ability to tailor their health insurance to their needs, they will be more likely to reduce not only unnecessary insurance components but also the extent to which they seek services that they would have accepted under an excessive employer-sponsored plan. This stands in contrast to the current employer market where individuals are often over-insured and can be unaware of the costs of the services they are receiving. Indeed, this "third-party payer" issue is a primary reason for the rapidly escalating health care costs in the United States.[143] Perhaps more importantly, research shows that "reduction in overuse could bend the cost curve while concurrently improving quality."[144]

Health insurance portability would also be enhanced through this approach. Individuals taking advantage of the RSC plan's tax equality to purchase an individual plan would be able to carry their personalized individual coverage benefits regardless of whether they move jobs or become self-employed. This freedom will further facilitate continuous coverage to lock in those benefits and portability protections under the RSC plan and give the individual a true piece of mind. As the Cato Institute has succinctly stated, "Consumers are likely to appreciate the option of purchasing health insurance that doesn't disappear when they get sick and lose their jobs."[145] In this way, tax equality works synergistically with the portability protections of the RSC plan to further neutralize the issue of pre-existing conditions.

Unleashing Health Savings Accounts

Beyond allowing individuals to use health savings accounts to pay health insurance premiums, the RSC plan would enact a significant amount of reforms to expand the accessibility and effectiveness of health savings accounts. In particular, the RSC plan would eliminate the requirement that health savings accounts be tied to a high-deductible plan, increase health savings accounts' maximum contributions, and expand the scope of eligible health care expenditures.

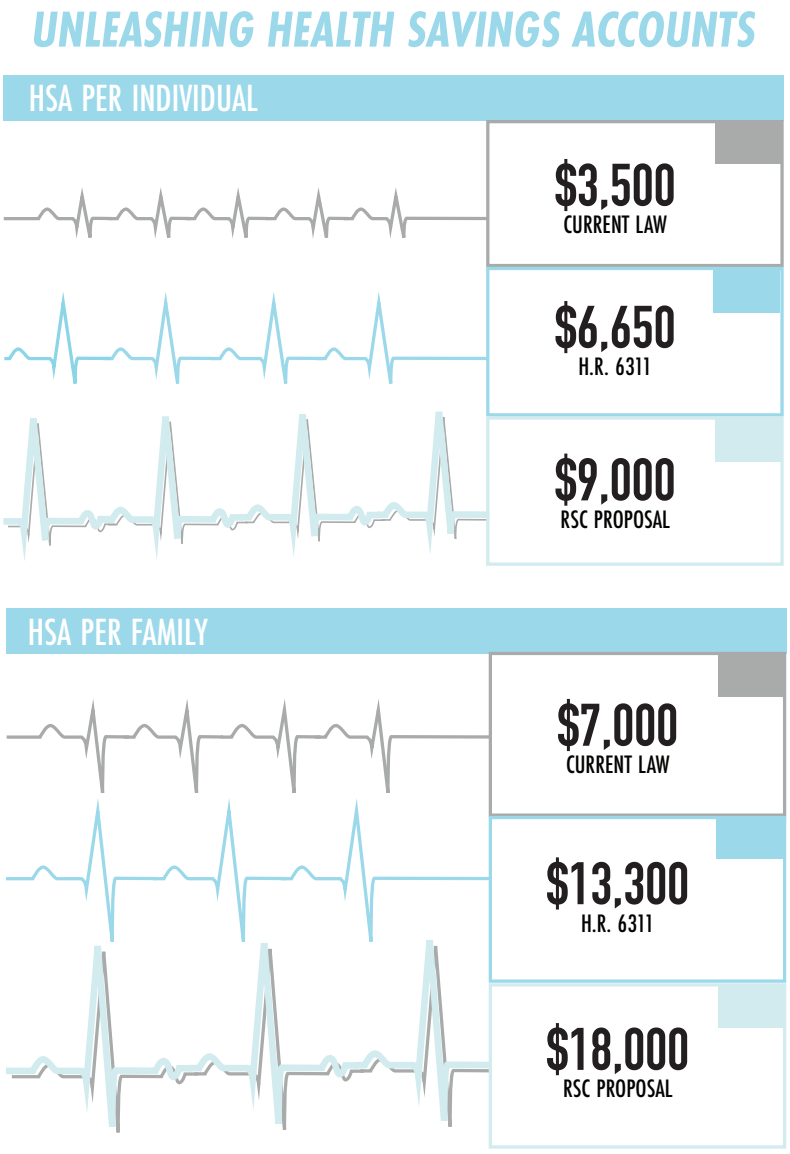
Under current law, health savings accounts plans cannot be used in conjunction with plans that are not a "qualified high-deductible health plan." This unnecessarily hamstrings the ability for millions of Americans to access this important savings tool. Accordingly, the RSC would eliminate this requirement to allow health savings accounts to be utilized even if a person does not have a health insurance plan.

[143] Emanuel, Ezekiel J., and Victor R. Fuchs. "The Perfect Storm of Overutilization." *Louisiana State University Health Sciences Center,* 18 June 2018, https://www.medschool.lsuhsc.edu/emergency_medicine/docs/Overutilization.pdf.

[144] Nassery, Najlla, et al. "Systematic Overuse of Health care Services: a Conceptual Model." *U.S. National Library of Medicine*, Feb. 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5511697/.

[145] Cannon, Michael F. "Cato Handbook for Policymakers." *The CATO Institute,* 2017, https://object.cato.org/sites/cato.org/files/serials/files/cato-handbook-policymakers/2017/2/cato-handbook-for-policymakers-8th-edition.pdf#page=401.

The RSC also plan proposes an increase in how much can be contributed to a health savings account. Under current law, for 2019, $3,500 may be contributed to health savings accounts for an individual, and $7,000 for families.[146] In 2018, the House of Representatives passed legislation to increase the contribution caps to $6,650 for an individual and $13,300 for a family.[147] However, according to the Kaiser Family Foundation, the average annual family premium per enrolled employee for employer-based health insurance in 2017 was $18,687.[148] Because of this, under the RSC plan, contribution limits would be increased even more to $9,000 per individual and $18,000 for families, in line with what the Cato Institute has proposed.[149]



"Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance." The Henry J. Kaiser Family

The RSC plan would also expand health savings accounts so that they could be used for a number of health services and products that currently must be paid for with after-tax dollars. Similar to allowing health savings accounts to pay for insurance premiums, health savings accounts would be able to pay for direct primary care, health care sharing ministries, and other non-traditional health insurance products, such as health status insurance. The RSC plan would allow working seniors, or anyone on Medicare, to have a health savings accounts and continue to contribute to it. Individuals enrolled in other public health insurance programs, such as those with Tricare, Indian Health Service, or Veterans benefits, would also be able to contribute to a health savings accounts. The RSC plan would allow people to contribute to a health savings account even if they or their spouse has a health Flexible Savings Accounts (FSA).

[146] "2019 HSA Contribution Limits." *HSACenter,* 19 Oct. 2018, http://www.hsacenter.com/how-does-an-hsa-work/2019-hsa-contribution-limits/.

[147] "House Passes Two HSA Bills." *National Association of Plan Advisors*, 11 Feb. 2019, https://www.napa-net.org/news-info/daily-news/house-passes-two-hsa-bills.

[148] "Average Annual Family Premium per Enrolled Employee For Employer-Based Health Insurance." *The Henry J. Kaiser Family Foundation,* 9 Aug. 2019, https://www.kff.org/other/state-indicator/family-coverage/?currentTimeframe=0&selectedDistributions=total-annual-premium&sortModel=[{"colId":"Location","sort":"asc"}].

[149] Cannon, Michael F. "CATO Handbook for Policymakers." *The Cato Institute*, 2017 p. 395, https://object.cato.org/sites/cato.org/files/serials/files/cato-handbook-policy-makers/2017/2/cato-handbook-for-policymakers-8th-edition.pdf#page=403.

Furthermore, FSA and HRA balances could be converted into a health savings account, and FSAs could be rolled over year-to-year at the employer's discretion. The plan would allow individuals to have a health savings account and retain access to retail or onsite medical clinics, chronic disease management services, or telemedicine that have been provided at no cost. Spouses who are health savings account-eligible and age 55 or older could deposit their catch-up contributions into one health savings account. It would allow HSAs, HRAs, and FSAs to pay for FDA-approved over-the-counter medicines without a prescription, but not for homeopathic products, dietary supplements, or fitness equipment. Lastly, health savings account funds would be protected in bankruptcy proceedings.

Critically, while the RSC plan would unleash health savings accounts, it would ensure that these accounts are pro-life and do not inadvertently allow a back-door method of subsidizing abortion procedures. Accordingly, the RSC plan would ensure these accounts cannot be linked to a plan that provides abortions, nor would abortions or abortion drugs be an eligible expense.

PROTECTING MEDICAID'S VULNERABLE POPULATIONS

The RSC plan calls on lawmakers to right-size the Medicaid program so that it can remain a sustainable health care safety net for vulnerable populations for generations to come. Total Medicaid spending has been on a runaway trajectory for decades. Federal spending on the program has ballooned from $14 billion in 1980, to $118 billion in 2000, to $375 billion in 2017, to a projected $702 billion in 2029.[150] Medicaid expenditures on the Medicaid expansion population alone are projected to amount to nearly $938 billion over the next ten years.[151] Nonetheless, enrollees often experience poor health outcomes, while the expansion has been accompanied by crowding out of the private market and direct competition with low-income vulnerable populations. The primary blame for Medicaid's runaway costs rests with its open-ended entitlement structure and FMAP reimbursement formula which combine to incentivize states to increase their own spending and rely on provider taxes as a means of forcing larger federal assistance expenditures.

The first step to right-sizing Medicaid under the RSC plan is an immediate moratorium on future Medicaid expansions and the institution of a phase-out of the expansion's enhanced FMAP rate. Through incremental reductions, the FMAP rate for the expansion population would eventually match normal FMAP rates. There is no reason why an able-bodied adult without any dependents should be more heavily subsidized than a poor pregnant woman, elderly person, child, disabled individual, or parent.

Second, the RSC plan would replace Medicaid's current open-ended entitlement structure with separate per capita grants to help them address the health care needs of the traditional Medicaid populations—poor pregnant women, children, the elderly, the disabled, and parents. The federal Children's Health Insurance Program (CHIP), currently funded as a block grant, could also simply be combined with the Medicaid grant for children. Another separate block grant, a "flex-grant," would allow states, subject to work requirements, to otherwise supplement the health needs of their low-income population. The flex-grant would be funded through repackaging funding from the ACA expansion and its exchange

[150] "The Budget and Economic Outlook: 2019 to 2029," *Congressional Budget Office*. January 2019. https://www.cbo.gov/system/files?-file=2019-01/54918-Outlook.pdf.
[151] Wolfe, Christian J., et al. "2017 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID." Centers for Medicare and Medicaid Services, 2017, p. 5, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf#page=10.

subsidies. The flex-grant could be used by states for providing care for low-income individuals through subsidizing the purchase of private health insurance and alternative care delivery mechanisms, increasing overall insurance coverage, and reducing the premiums of Guaranteed Coverage Pool plans. However, under the RSC plan, at least half of a state's flex-grant funding must be dedicated toward supporting low-income individuals' purchase of private plans. Moreover, flex grants would be pro-life such that funding could not be used to provide access to abortion procedures or coverage that provides such procedures.

The amount of flex-grant money allocated to each state should initially reflect the amount of funding historically allocated to each state for Obamacare's premium subsidies and their Medicaid expansion population followed by a gradual phase-out of the disparity between expansion and non-expansion states. Lawmakers may also want to consider allowing states to use a portion of their flex-grant to enhance care provided to their traditional Medicaid populations.

The size of the traditional population grants would be determined by establishing a per capita cap for beneficiaries in each group based on average federal expenditures for a beneficiary in the applicable group. Lawmakers could consider reducing the average federal expenditure calculation for states that but-for the statutory FMAP floor would have historically received a federal reimbursement rate below 50 percent. For a given year, these caps, adjusted annually using chained- Consumer Price Index (CPI), would be multiplied by the number of individuals enrolled in each group to determine the maximum amount of federal funding a state could receive.

This model has a number of benefits over the current flawed approach. The federal government would be allowed to better control the amount of Medicaid funding it provides to states while also providing programmatic flexibility to account for increases (and decreases) in enrollment. The issue of provider taxes would then disappear. Separate grants would also mean that Medicaid's vulnerable populations would not compete with the able-bodied expansion population. States would have greater operational freedom to achieve efficiencies and provide better care. (But, in no instance would grant funding be allowed to pay for an abortion.) Additionally, adjusting the traditional population grants using chained-CPI creates downward pressure on health care costs that have significantly outpaced inflation in recent decades. No longer would states be incentivized to spend more of their state budgets to reap additional federal subsidies.

EXPANDING ACCESS TO INNOVATIVE CARE

Most Americans would agree that the best way to improve access to care is to increase the scope of affordable care options available.[152] Barak Obama himself alluded to this when he was a candidate in the 2008 presidential election when he said, "I believe the problem is not that folks are trying to avoid getting health care. The problem is they cannot afford it."[153] The RSC plan urges lawmakers to explore and promote innovative ways for delivering care to individuals at affordable prices, the following being a representative selection.

[152] "The Freedom and Empowerment Plan: The Prescription for Conservative Consumer-Focused Health Reform." *American Next,* Apr. 2014 p. 5, https://www.americanext.org/wp-content/uploads/2014/04/The-Freedom-and-Empowerment-Plan.pdf#page=5.

[153] "Part 2 of CNN Democratic Presidential Debate." *CNN,* Jan. 21, 2008, http://www.cnn.com/2008/POLITICS/01/21/debate.transcript2/index.html.

Expanding Direct Primary Care

Direct Primary Care is an innovative, affordable, and transparent care delivery system that allows patients to pay a monthly service fee—usually about $60 - $70 per month—directly to a health care provider instead of paying a copay or coinsurance for each visit to a doctor. Under this service model, patients would be allowed to see their doctor for as many times as their monthly service allows. This means that patients can regularly see their doctor for better quality care, often at the price of an average cell phone bill, without having to meet an expensive deductible. The monthly fee covers all primary care services, clinical and laboratory services, consultative services, care coordination, and comprehensive care management.[154] Additionally, most states allow direct primary care practices to dispense generic medications directly from their offices at near-wholesale prices. As Avik Roy has said, "It's like concierge medicine, but for everyone, including the poor."[155]

Often individuals pair their Direct Primary Care with a high-deductible catastrophic plan. This works in a way so that individuals may use their Direct Primary Care services for the small things – such as checkups, preventative care, or small sickness diagnoses, whereas if something serious arises like a surgery, they are still covered by some form of insurance.

Because a patient gains significantly more access to their doctor under a Direct Primary Care model, their doctor is incentivized to ensure patients' needs are addressed efficiently so as not to result in unnecessary visits. Additionally, this model removes third-party payment and its negative incentives from the equation as patients are paying doctors directly for their care. In other words, the Direct Primary Care model encourages patients to actively engage in their care while the physician focuses on providing the patient value-added primary care. The result is mutual accountability.

To provide for greater access to Direct Primary Care, the RSC plan would make Direct Primary Care payments eligible health savings account expenditures. Additionally, the RSC's flex block grant, described above, would allow states to use such funds to give beneficiaries access to Direct Primary Care.

Health Care Sharing Ministries

Health care sharing ministries (HSMs) are faith-based nonprofit organizations whose members share a common set of ethical and religious beliefs and share medical expenses among themselves in accordance with those beliefs. Funds come from monthly share amounts paid by members to other members. This model is based on long held faith based traditions of helping others when in need. HSM's are tailored to those who have specific beliefs, values or faiths, or do not want certain benefits provided. For example, if a group of a particular religious faith does not want something like abortion covered, the group could join an HSM and provide health care dollars to participants without participating in insurance models that cover abortion. Health care sharing ministries are also typically more affordable than traditional health insurance. The RSC plan would ensure that HSM fees are an eligible health

[154] "Direct Primary Care: American Academy of Family Physicians." *American Academy of Family Physicians,* 21 Mar. 2019, https://www.aafp.org/practice-management/payment/dpc.html.

[155] Roy, Avik. "Direct Primary Care: A Big Winner In The Senate GOP Health Care Bill." Forbes, Forbes Magazine, 14 July 2017, https://www.forbes.com/sites/theapothecary/2017/07/09/direct-primary-care-a-big-winner-in-the-senate-gop-health-care-bill/#21c494777e26.

savings account expense. This is similar to President Trump's recent Executive Order under which HSM and direct primary care payments would constitute qualifying medical expenses for purposes of the limited deduction under current law.[156] Additionally, as mentioned above, HSMs would count toward continuous coverage requirements under the RSC plan.

Association Health Plans

The RSC plan urges codification of the reforms promulgated by the Department of Labor that ensure Americans have greater access to Association Health Plans (AHP). Association Health Plans currently work by allowing small businesses to band together by geography or industry to obtain health care coverage as if they were a single large employer. Importantly, AHPs offer benefits comparable to employer-sponsored plans and cannot discriminate against patients with pre-existing conditions.[157] They also "strengthen negotiating power with providers from larger risk pools and [provide] greater economies of scale," according to the Department of Labor.[158] Consequently, these plans are able to offer more affordable, quality health insurance plans.

The Department of Labor rule on AHPs sought to modify how the Department interprets the word "Employer" in ERISA.[159, 160] According to Brian Blase, former White House health care policy advisor, "this [would have] allowed any employers within a state or common metropolitan area to form an AHP regardless of their line of businesses and allowed these AHPS to include sole proprietors."[161] While this rule has stalled in the courts,[162] the Department of Labor is currently appealing that delay.

Health Status Insurance

Traditional health insurance covers your risk of medical expenses in the current year, whereas health status insurance covers your risk that your insurance premiums may rise due to an unforeseen circumstance that may occur in the future.[163] Individuals could maintain their employer plan, or individual plan, and have health status insurance as a backup for something catastrophic or disruptive. This essentially allows an individual to pay for the option to purchase more comprehensive insurance at a later date. According to Chris Jacobs, "[health status policies] function as 'health insurance-insurance,' guarding against a future pre-existing condition that might make an individual uninsurable." [164]

According to the Cato Institute, if an individual does develop a condition that causes them to lose their job, become uninsurable or causes their premiums to rise, health status insurance would cover the risk

---

[156] "Executive Order on Improving Price and Quality Transparency in American Health care to Put Patients First." *The White House,* 24 June 2019, https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-health care-put-patients-first/.

[157] Keith, Katie. "Court Invalidates Rule On Association Health Plans. Health Affairs," 29 Mar. 2019, https://www.healthaffairs.org/do/10.1377/hblog20190329.393236/full/.

[158] "About Association Health Plans." *U.S. Department of Labor,* June 2018, https://www.dol.gov/general/topic/association-health-plans.

[159] "Presidential Executive Order Promoting Health care Choice and Competition Across the United States." *The White House,* The United States Government, 12 Oct. 2017, https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-health care-choice-competition-across-united-states/.

[160] "Health Plans & Benefits: ERISA." *U.S. Department of Labor,* https://www.dol.gov/general/topic/health-plans/erisa.

[161] Blase, Brian. "Health Reform Progress: Beyond Repeal and Replace." The Galen Institute, Sept. 2019, https://galen.org/assets/Health-Reform-Progress-Brian_Blase.pdf#page=7.

[162] Keith, Katie. "Court Invalidates Rule On Association Health Plans." *Health Affairs,* 29 Mar. 2019, https://www.healthaffairs.org/do/10.1377/hblog20190329.393236/full/.

[163] Chochrane, John. "Health Status Insurance." *U.S. Health Policy Gateway,* 3 May 2017, http://ushealthpolicygateway.com/vii-key-policy-issues-regulation-and-reform/p-health-reform/national-health-reform/models-for-health-reform/health-status-insurance/.

[164] Jacobs, Chris. "CASE AGAINST SINGLE PAYER: How Medicare for All Will Wreck Americas Health Care System and Its... Economy." *Republic Book Publishers,* 2019, p. 203.

of premium reclassification, just as medical insurance covers the risk of medical expenses.[165] Before the enactment of the ACA, the United Health group unleashed a "first of its kind" product which allowed for the right to buy an individual health policy at some point in the future, even after one becomes sick.[166] Such health status insurance plans were a cheap and effective way to be certain someone who gets sick with a high-utilizing condition can be insured.

The ACA's burdensome individual marketplace regulations—that effectively reward individuals for remaining uninsured until after they become sick—have resulted in health status insurance becoming obsolete.[167] The RSC health care plan's repeal of these cumbersome ACA regulations would allow individuals to access personalized plans that fits their need, making health status insurance again a potentially viable option for individuals to mitigate against the future risk of illness. Additionally, as mentioned above, the RSC plan would allow health savings account funds to be used to pay for health status insurance.

Last year, the Department of Health and Human Services finalized a rule that not only allows short-term, limited-duration plans to last for a period of 12 months (renewable for up to 36 months), but also allows the purchase of health status insurance to ensure the plan could be renewed.[168] An Obama-era rule limited such plans to just three months. The RSC plan supports this new rule and urges its codification.

Short-Term, Limited-Duration Plans

Short-term, limited-duration plans are exactly what they sound like: health insurance plans meant to be used for short periods of time in-between jobs or during other short lapses of health coverage. Under current law, they are exempt from the ACA's individual marketplace regulations such as guaranteed issue, the prohibition on exclusions, community rating, and guaranteed renewability. However, they are a cost-effective alternative for healthy individuals or individuals who need a plan with minimal coverage for a short period of time.[169]

In addition to urging codification of the Trump administration's rule expanding short-term, limited-duration plans to 12 months, the RSC plan would allow health savings account funds to be used to pay the premiums of these plans. Moreover, as mentioned above, short-term, limited-duration plans would count toward continuous coverage requirements under the RSC plan.

Telemedicine

Access to networks has narrowed under the ACA. However, despite the ACA, access to technology has greatly increased due to sheer technological innovation. Though telemedicine has not yet been universally implemented by the health care provider industry, the RSC believes that regulatory barriers

[165] Cochrane, John H. "Health-Status Insurance: How Markets Can Provide Health Security." *The Cato Institute*, 18 Feb. 2009, https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-633.pdf#page=2.

[166] Abelson, Reed. "UnitedHealth to Insure the Right to Insurance." *The New York Times,* 3 Dec. 2008, https://www.nytimes.com/2008/12/03/business/03insure.html.

[167] Miller, Thomas P. "New STLDP Options: Limited Lifeboats, Not Luxury Liners, for Obamacare Victims." *The American Enterprise Institute*, 8 Aug. 2019, https://www.aei.org/health-policy/new-stldp-options-limited-lifeboats-not-luxury-liners-for-obamacare-victims/.

[168] "Short-Term, Limited-Duration Insurance, Finale Rule." *Centers for Medicare & Medicaid Services*, 2019, https://www.cms.gov/CCIIO/Resources/Files/Downloads/dwnlds/CMS-9924-F-STLDI-Final-Rule.pdf.

[169] Gorman, Anna. "Short-Term Insurance Plans Are Enticing, Low-Cost Alternatives for Healthy People." *The Washington Post,* Dec. 2018, https://www.washingtonpost.com/national/health-science/short-term-insurance-plans-are-enticing-low-cost-alternatives-for-healthy-people/2018/11/30/14e833e8-ece7-11e8-8679-934a2b33be52_story.html?utm_term=.63dd3aa634a6.

should be removed in this area. According to the Heritage Foundation, nationwide use of telemedicine increased by 643 percent from 2011 to 2016.[170] Research and development in this area will help drive affordability of quality health care for rural and underserved areas, and beyond.

As explained by health care policy expert John Goodman, an estimated one-third of all doctor visits do not actually require a physical visit.[171] These include many services, like blood pressure monitoring, taking a patient's temperature, and examining basic skin-related dermatology check-ups. The popularity of telemedicine is only set to increase. The potential for the innovation in the telemedicine service field is vast and could lead to reduced costs and greater efficiency in the health industry.

Unfortunately, many states have passed laws impeding the provision of telemedicine by banning or heavily restricting its progress.[172] Notably, the position of the American Medical Association still calls for doctors to be physically present when rendering medical services. [173]Such policies can stand in the way of administering routine medical assessments for people having difficulty reaching a physician. For instance, rural and underserved areas could get their vitals checked, undergo a simple check-up, or have a consultation with their doctor of choice using their handheld smart-device. Individuals with chronic health conditions requiring frequent visits to the physician would likely benefit the most from advancements in telemedicine. Beyond rural and underserved areas, telemedicine could be utilized as a means for convenient medical care for individuals in populated areas as well.[174] According to the Centers for Disease Control, there were approximately 884 million ambulatory care visits to physician offices.[175] Teladoc has estimated that one-third of the visits could be treated via telehealth, with an average of only $40 per visit.[176]

The RSC is recommending that states work to remove barriers for telemedicine to be able to innovate and become more prevalent. Additionally, under current law, Medicare reimburses for limited telehealth services—and only when a senior lives in a "Health Professional Shortage" area. Moreover, the service must take place in an approved medical facility. The RSC plan would reverse this so Medicare can pay for telehealth services so seniors may receive the health care they need in their own home without entering a physical building if they do not absolutely need to be there.

---

[170] Zawada, Stephanie J. "Telemedicine: The Promise and the Performance." *The Heritage Foundation,* 17 Dec. 2018, https://www.heritage.org/health-care-reform/report/telemedicine-the-promise-and-the-performance.

[171] Goodman, John C. "Standing Between You And All The Benefits Of Telemedicine: The AMA And The Federal Government." *Forbes Magazine,* 9 July 2015, https://www.forbes.com/sites/johngoodman/2015/07/09/standing-between-you-and-all-the-benefits-of-telemedicine-the-ama-and-the-federal-government/#f6797af7d3fd.

[172] Marks, Jacqueline D., et al. "State Telehealth Laws and Medicaid Policies: 50-State Survey Findings." *Manatt*, 10 July 2018, https://www.manatt.com/Insights/Newsletters/Manatt-on-Health/State-Policy-Levers-for-Telehealth-50-State-Surve.

[173] Goodman, John C. "Will Texas Medicine Return To The Middle Ages?" *Forbes Magazine,* 22 May 2015, https://www.forbes.com/sites/johngoodman/2015/05/22/will-texas-medicine-return-to-the-middle-ages/#796d669852bd.

[174] "Telemedicine: Ultimate Guide - Everything You Need to Know." *EVisit,* https://evisit.com/resources/what-is-telemedicine/#2.

[175] "FastStats- Physician Office Visits." *Centers for Disease Control and Prevention*, https://www.cdc.gov/nchs/fastats/physician-visits.htm.

[176] Teladoc Investor Presentation. Teladoc, Sept. 2017, https://s21.q4cdn.com/672268105/files/doc_presentations/2017/09/Teladoc-Investor-Presentation-September-2017.pdf#page=4.

Additionally, the provision of telemedicine services would not disqualify someone from using a health savings account under the RSC plan. Under current regulations, the provision of telehealth services not subject to a deductible under a high deductible health plan can disqualify a person from using a health savings account.[177] However, the RSC plan delinks health savings accounts from the high deductible health plan requirement.

Certificate of Need Laws

Certificate of need laws currently exist in 36 states and the District of Colombia. These laws require health care providers to obtain certificate of need permits from their licensed state health regulatory authorities before they can expand their facilities and services.

Consequently, decisions on the needs of a community are decided by a state regulatory board of bureaucrats. States that have such laws on the books have not reaped the cost reductions originally anticipated. For instance, in 2009, overall health care costs were approximately 11 percent higher in states with certificate of need laws versus those without them— "$7,230 per capita in the former compared to $6,526 in the latter." [178]

By restricting new construction of provider facilities, these programs reduce competition, prevent the market from working on its own, and are subject to political influence. As Dr. Robert Moffit of the Heritage Foundation has pointed out, "Both the Justice Department and the Federal Trade Commission have long identified these laws as anti-competitive. A growing body of professional economic literature confirms this assessment. Certificate of need laws generally do not control costs, nor improve quality, and they restrain provider entry and innovation in health care delivery."[179] For these reasons, the RSC plan urges states to reform or repeal their certificate of need laws.

CONCLUSION

Over the last decade, the ACA has left a long list of broken promises in its wake. Some, such as "if like your plan, you can keep your plan," have been well-documented. But others have gone uncontested and unchallenged despite indisputable evidence to the contrary. In fact, the ACA's most grievous broken promise may also be its most underreported: that the law does not actually guarantee individuals with pre-existing conditions access to affordable and quality health care.

In reality, while the ACA does deliver access to health insurance for all, it does not guarantee affordability, choices, plan retainment, access to quality care, and availability of doctors— all things that are important to the chronically ill.

[177] "Telemedicine—Impact on HSA Eligibility." *New England Employee Benefits Co., Inc.*, 2017, https://www.neebco.com/wp-content/uploads/2017/03/Telemedicine-Impact-on-HSA-Eligibility.pdf.
[178] Bruneau, Jordan. "The Great Health Care CON: Jordan Bruneau." *FEE Freeman Article*, Foundation for Economic Education, 15 Jan. 2014, https://fee.org/articles/the-great-health care-con/.
[179] Moffit, Robert E. PhD. "How State Leaders Can Begin Undoing Obamacare's Damage" *The Heritage Foundation.* 25 Jan. 2018. https://www.heritage.org/health-care-reform/commentary/how-state-leaders-can-begin-undoing-obamacares-damage.

As this report has demonstrated – both through facts and personal stories – under the current system, vulnerable Americans, including those with pre-existing conditions, chronic illness, and serious health issues, have been left behind. Americans like:

The Davert family from Michigan (p. 24), who despite having two children suffering from brittle bone disease, lost their private health insurance and were forced onto Medicare because the ACA premiums and deductibles were unaffordable.

Coach Jim White from Alabama (p. 21), who was unable to afford coverage on the ACA exchange, and was thus forced to turn to a GoFundMe page to pay for life-saving cancer treatments after losing his job at a private school; and

Lindsey Overman from Arkansas (p. 33), who a mother of two working her way through graduate school was powerless to stop able-bodied adults drawing Medicaid benefits away from her disabled daughter, Skylar.

To argue for doubling-down on the status quo is to argue against helping these families and the countless number of other Americans who have fallen through the cracks of the ACA. At the same time, to embrace the Left's "solution" of a government-run, one-size-fits-all ACA replacement proposal is to ignore the fact that individuals have unique health care needs. After all, the best coverage for the Davert family may not be the best coverage for you.

As conservatives, we have joined together to propose another path forward—one that can dramatically improve access to quality, affordability, and choice in the American health care system. We offer a plan that will **PROTECT** the vulnerable, **EMPOWER** patients, and **PERSONALIZE** care. It is a plan that will give Americans, including those with pre-existing conditions, access to coverage options they can actually afford to use, and it will right-size Medicaid so it can remain a sustainable health care safety net for those who truly need it for generations to come.

Our plan will unleash the health insurance market to drive down costs, delivering much-needed relief to Americans – especially those in the middle class – who are burdened by rising premiums and exorbitant deductibles. This plan will also strengthen the overall health insurance system by bringing young and healthy Americans back into the marketplace with personalized coverage, and it will work to increase care among underserved populations and those with chronic conditions by embracing – rather than stifling – innovative solutions such as direct primary care and telemedicine.

PROTECT, EMPOWER, AND PERSONALIZE. This is our plan. This what we aim to do – for the good of our health care system, our nation, and the millions of Americans who for too long have been left behind.

THE SUPPLEMENTALTAL MATERIALS

Q DO YOU HAVE PLANS TO ADDRESS OTHER HEALTH CARE ISSUES NOT COVERED IN THIS REPORT?

A Yes. As we mention in the introduction of the report, this is simply phase one of the RSC Health Care Plan and we expect to release a second report with additional policy details at a later date. Our second report will look specifically at additional policies that will help bend the cost curve on health care. This could include things like health care transparency reform and policies that will lead to thriving competition in the marketplace.

In addition, we understand that the development of innovative healthcare technology has the potential to strengthen the delivery, cost, and outcomes in the America's health care system. To facilitate the development and adoption of new innovative technology, our next report will propose a regulatory environment that invites solutions designed to better assess, monitor, and treat patients. Having any conversation about the future of healthcare in the United States needs to address how technology will play a vital role.

Q HOW DOES THE RSC PLAN PROVIDE PROTECTIONS FOR INDIVIDUALS WITH PRE-EXISTING CONDITIONS?

A The RSC plan is premised on the idea that protecting people with pre-existing conditions is more than just guaranteeing an insurance plan. The RSC plan would provide protections to people with pre-existing conditions and also focus on access to affordability and quality of care.

The RSC takes a holistic approach to neutralizing the issue of pre-existing conditions. It is designed to: 1) provide more affordable insurance options so that people can more easily access a plan they like; 2) enhance the portability of insurance to avoid gaps in coverage by providing guaranteed coverage protections and equal tax benefits in the employer and individual marketplaces; 3) provide states with federal funds and flexibility to establish Guaranteed Coverage Pools that would provide coverage to and effectively lower the medical costs of people with pre-existing conditions; and 4) provide states with "flex-grants" to assist them in providing their low-income populations, including those with pre-existing conditions, with access to insurance coverage. Moreover, the RSC plan would allow states to expand upon these reforms to further enhance individual marketplace rules and increase Guaranteed Coverage Pool availability.

The ACA actually compounded the issue of pre-existing conditions by reducing the incentive for people to obtain coverage prior to getting sick. This resulted in the doubling of health care premiums nationwide between 2013 and 2017 alone, and has raised deductibles so high that insurance has effectively become useless for many Americans. For instance, Bronze plan deductibles for 2019 are around $6,000 on average, an insurmountable obstacle to care for many, especially for those with pre-existing conditions.

The RSC plan would also codify the Department of Labor's recently blocked Association Health Plan (AHP) rule, that allows employers and self-employed individuals in the "same line of business" or in a common area to pool together for purposes of providing participants with pre-existing condition protections applicable to employer-sponsored plans.

Q UNDER THE RSC PLAN, HOW WOULD PREMIUM AND DEDUCTIBLE COSTS BE REDUCED?

A By allowing a greater array of tailored insurance options, continuity of coverage incentives, and federally funded, state administered Guaranteed Benefits Pools, under the RSC plan, individuals and families could expect reductions to both premiums and deductibles.

Additionally, the RSC plan would increase affordable health insurance options in the individual marketplace, and thus attract a healthier pool of people to purchase health insurance. Those participants in the market will further decrease overall costs for everyone.

Federal Guaranteed Coverage Pool funding would also assist states in providing affordable coverage to people with pre-existing conditions. The RSC plan's flex-grants would give states funding to reduce the premiums of low-income populations and provide them with access to insurance coverage.

The RSC plan would allow people to pay for their premiums with tax-free dollars, the same tax treatment afforded to insurance provided by employers. Equalizing tax treatment will also pave the way for individuals to negotiate higher pay and have the ability to pursue more affordable, personalized plans on the individual marketplace. Employees could also push for funds that would have been gone toward an excessive employer-sponsored insurance (ESI) plan to be placed in-full into their Health Savings Account (HSA), purchase their own affordable plan, and save the remainder tax free for future medical needs. Greater control and personalization of health insurance will help combat the issue of health care overutilization in the United States.

The RSC plan also incorporates proposals to facilitate innovation in health care delivery and insurance models. For instance, it would make Direct Primary Care payments, Health Care Sharing Ministry fees, Health Status Insurance, and premiums for Short-term, Limited-duration plans all eligible, tax-free HSA expenses. The RSC plan would also remove regulatory restrictions impeding the use of telemedicine and similar emerging technologies that increase health care access and efficiency.

Q HOW IS THE RSC PLAN'S APPROACH TO EXPANDING PRIVATE INSURANCE DIFFERENT FROM THE AFFORDABLE CARE ACT?

A Despite its intentions, the Affordable Care Act (ACA) has actually reduced the incentive for people to purchase health insurance. While the ACA legally required Americans to obtain insurance, millions simply opted to pay the mandate's penalty rather than purchase a plan featuring skyrocketing premiums, cost-prohibitive deductibles, and a lower quality of care. The approach of the ACA has resulted in continually increasing costs and reduced access to health care.

The RSC plan is specifically designed to do the opposite. The proposals here would increase access to more affordable and useful insurance options, make health insurance more portable, reward individuals who have maintained continuous coverage, and provide protections for people with pre-existing conditions.

Q WOULD THE RSC PLAN PROVIDE SUBSIDIES TO HELP PEOPLE PAY FOR THEIR HEALTH INSURANCE?

A Yes, the RSC plan would provide funding to states to directly subsidize the health care costs of people with pre-existing conditions and people who are low-income. The RSC plan's flex-grants would give states the ability to provide their low-income citizens with access to affordable care in a way that best fits the needs of their state. For instance, states could use flex-grant funding for subsidizing the purchase of private health insurance and alternative care delivery mechanisms, increasing overall insurance coverage, and reducing the premiums of Guaranteed Coverage Pool plans.

The RSC plan's Guaranteed Coverage Pool funding would provide states with resources to directly subsidize the medical costs of individuals with pre-existing conditions and ensure that even those individuals who developed a condition without having insurance have a pathway to gaining coverage of their condition.

Additionally, the RSC plan would reduce the overall cost of health insurance in the individual marketplace to make insurance more affordable for all, even without the benefit of federal subsidy money. Individuals would also be able to pay for their health insurance premiums in the individual marketplace tax-free under the RSC plan.

Q HOW WOULD THE RSC PLAN EXPAND HEALTH SAVINGS ACCOUNTS?

A First and foremost, the RSC plan would increase the HSA contribution limit in order to give Americans greater control over their health care dollars. Under current law for 2019, $3,500 may be contributed to HSAs for an individual, and $7,000 for families. According to the Kaiser Family Foundation, the average annual family premium per enrolled employee for employer-based health insurance in 2017 was $18,687. The RSC plan would dramatically raise HSA contribution limits to $9,000 per individual and $18,000 for families.

Critically, under the RSC plan, individuals would be able to pay for their premiums with pre-tax dollars from their HSAs. This would allow for individuals to effectively own their personalized health care plans so they can take their plan from job to job, enhancing portability. Additionally, similar to allowing HSAs to pay for insurance premiums, the RSC plan would make Direct Primary Care payments, Health Care Sharing Ministry fees, Health Status Insurance, and premiums for Short-term, Limited-duration plans all eligible, tax-free HSA expenses.

The RSC plan would also greatly expand the usefulness of HSAs in a number of other ways. It would allow working seniors, or anyone on Medicare, to have an HSA and continue to contribute to it. Individuals enrolled in other public health insurance programs, such as those with Tricare, Veterans Administration, or Indian Health Service benefits, would also be able to contribute to an HSA. The RSC plan would allow people to contribute to an HSA even if they or their spouse have a health Flexible Savings Accounts (FSAs). Furthermore, FSA and Health Reimbursement Account (HRA) balances could be converted into an HSA, and FSAs could be rolled over year to year at the employee's discretion. The plan would allow individuals to have an HSA and retain access to retail or onsite medical clinics, chronic disease management services, or telemedicine that is provided at no cost. Spouses who are HSA-eligible and age 55 or older could deposit their catch-up contributions into one HSA account. It would allow HSAs, HRAs, and FSAs to pay for FDA-approved over-the-counter medicines without a prescription, but not for homeopathic products, dietary supplements, or fitness equipment. Lastly, HSA funds would be protected in bankruptcy proceedings.

Q UNDER THE RSC PLAN, IF I AM INSURED, COULD MY INSURANCE BE CANCELLED BECAUSE I CONTRACT A SERIOUS DISEASE?

A Under the RSC plan, in no event could your insurance be cancelled by a carrier simply because you develop a condition after enrollment.

Q UNDER THE RSC PLAN, IF I AM INSURED, COULD MY INSURANCE COMPANY RAISE MY INSURANCE PREMIUMS BECAUSE I CONTRACT A SERIOUS DISEASE?

A Under the RSC plan, your insurance carrier could not raise your premiums simply because you develop a condition after enrollment.

Q HOW WOULD THE RSC PLAN GIVE AMERICANS ACCESS TO MORE PERSONALIZED HEALTH CARE PLANS?

A Americans will be able to obtain personalized health care plans in the individual market that fit their needs.

Under the status quo, individuals are forced to pay for health benefits they do not need or wish to have. This one-size-fits all approach contributes to the high cost of ACA plans. Consequently, many forgo insurance because the ACA has made insurance unaffordable.

Under the RSC plan, Americans would also be able to utilize Health Savings Accounts to pay for the premiums of their personalized plans on the individual market tax-free. Increased contribution limits under the RSC plan would better enable people to save for their future health care needs. Additionally, by equalizing the tax treatment between the individual and employer markets, people could more easily maintain personalized coverage as they move between jobs. This notion of portability is a core feature of the RSC plan.

Q WOULD THE RSC PLAN MAKE ANY CHANGES TO MEDICARE?

A The RSC plan would make no changes to Medicare except to facilitate use of telemedicine for the convenience of seniors' care. Indeed, this plan would further protect seniors' access to Medicare by combatting recent efforts to either maintain the status quo or implement a massive, nationwide, one-size-fits all, government-run health care system. Such a system would lead inevitably to increased taxes for seniors, potentially rationed care, and longer wait times for medical treatment.

Additionally, the RSC plan would allow working seniors, or anyone on Medicare, to have a Health Savings Account and continue to contribute to it.

Q : WOULD THE RSC PLAN PLACE A MANDATE ON INDIVIDUALS TO PURCHASE HEALTH INSURANCE?

A Contrary to the design of the ACA, the RSC plan includes no mandate for individuals to purchase health insurance and imposes no penalty if an individual chooses to forgo coverage. However, the RSC plan will lead to more affordable insurance options, provide tax equality between the employer and individual marketplaces, and incentivize individuals to purchase health insurance and maintain continuous coverage.

Q WHAT DOES THE RSC PLAN MEAN FOR PEOPLE CURRENTLY ON MEDICAID?

A The RSC plan would reform Medicaid to prioritize funding for America's vulnerable populations while also providing states with flex-grants to provide health care to their low-income citizens.

Under the RSC plan, vulnerable recipients would receive their benefits from a dedicated and separate funding stream and no longer receive lower priority than able-bodied adults. The RSC plan will help reduce fraud and abuse and ensure that the Medicaid program remains solvent and preserved for those who have legitimate needs.

Q HOW WOULD THE RSC PLAN AFFECT INSURANCE I OBTAIN THROUGH MY EMPLOYER?

A The RSC plan maintains the current law's pre-existing condition protections for employer-sponsored insurance, including prohibitions on denying an employee with a pre-existing condition coverage, excluding their condition from coverage for any length of time, or charging them more for having a pre-existing condition. Additionally, the RSC plan would fully maintain the current law's exclusion of employer-sponsored insurance from taxation.

Under the RSC plan, employers would be allowed to offer HSAs to their employees whether or not those employees are provided with a high-deductible health insurance plan. Employees would be able to receive larger sums of tax-free money in HSAs under the RSC plan. It would more than double HSA contribution limits to $9,000 per individual and $18,000 per family. Additionally, the RSC plan would also expand HSAs so that they could be used for a number of health services and products that currently must be paid for with after-tax dollars.

The RSC plan would remove the ACA's employer mandate which has hurt Americans, particularly low-wage Americans, by reducing their job prospects. The mandate has forced small businesses to make painful hiring and employment decisions to avoid breaching the mandate's 50 full-time employees threshold, after which they would have to pay for their employees' health insurance. The left-leaning Urban Institute has even admitted that "[e]liminating it will remove labor market distortions that have troubled employer groups, and which would harm some workers."

Q DOES THE RSC PLAN ELIMINATE THE HEALTH CARE INSURANCE EXCHANGES?

A The RSC plan does not make a recommendation as to whether or not the ACA exchanges should be eliminated. However, if the reforms recommended by the RSC plan were adopted, the exchanges would serve as little more than an online forum for offering insurance plans.

CONTRAST ARGUMENTS

PRE-EXISTING CONDITIONS: THE ACA VS. RSC'S FRAMEWORK FOR PERSONALIZED, AFFORDABLE CARE

The ACA was meant to protect people with pre-existing conditions, those with chronic health conditions, and the vulnerable. But, how have they fared under the current system? The RSC report details five ways it has left them behind.

CHALLENGES UNDER THE ACA

1) DOES NOT PROTECT PEOPLE WITH PRE-EXISTING CONDITIONS– The current system guarantees individuals can get insurance coverage, but it does so at the expense of affordability, plan retainment, access to quality care, and availability of doctors- all things that are important to those that are chronically ill. Moreover, it exacerbates the issue of pre-existing conditions by disincentivizing people from getting coverage before getting sick. This is an unsustainable system.

2) MAKES HEALTH INSURANCE UNAFFORDABLE– The explosion in the cost of health insurance under the current system has made insurance unaffordable, causing fiscal stress to many individuals who already struggle with the stress of being sick.

3) CAUSES EXPLOSION OF OUT-OF-POCKET COSTS– Under the current system, deductibles have exploded, which has caused many to delay care they may need because they will bear much of the costs. This is especially a problem for those with chronic health conditions who require regular use of medical services.

4) REDUCES ACCESS & QUALITY OF CARE– The current system caused insurance companies to dramatically reduce their networks of hospitals and physicians to control costs, which has made it more difficult for individuals to access the care they need. The best doctors and hospitals may not be available to the people that need them most. The current system also incentivizes insurance companies to provide the sick and vulnerable with the worst coverage legally possible.

5) PRIORITIZES ABLE-BODIED OVER THE VULNERABLE– The Medicaid expansion prioritized able-bodied adults over the truly vulnerable instead of improving the system for the people it was designed to protect. Thousands of individuals with disabilities and significant health needs remain on waiting lists.

IMPROVEMENTS UNDER RSC'S PLAN

1) EXTENDS PRE-EXISTING CONDITIONS PROTECTIONS– It extends to the individual health care market important protections for people with pre-existing conditions that were put in place in the employer health care market. It does this without sacrificing affordability, access to quality care, or availability of doctors. The plan neutralizes the issue of pre-existing conditions by providing greater portability of coverage and breaking down barriers that prevent people from obtaining affordable, personalized options.

2) MAKES HEALTH INSURANCE MORE AFFORDABLE– It reduces regulatory barriers that have caused the current explosion of health insurance costs, which will make health insurance more affordable so individuals can access the care that fits their personal needs.

3) EMPOWERS INDIVIDUALS TO SAVE FOR HEALTH CARE EXPENSES– It expands and reforms Health Savings Accounts to make it easier for people to save for their personal health care needs and pay for the costs of insurance and care.

4) IMPROVES ACCESS & QUALITY OF CARE– It opens up more innovative insurance and care models that will provide greater personalized access to doctors and care providers, and thus l improve competition and choice.

5) PRIORITIZE THOSE IN NEED- It provides a stable and sustainable safety net that truly focuses on the most vulnerable populations.

RSC

THE REPUBLICAN STUDY COMMITTEE