DETMER HEALTHCARE PLAN

Adapted from the Heritage Foundation's Health Care Choices Proposal

Lower Costs, More Personal Choices, Better Access

The main goal of this plan is to mitigate the damages of Obamacare and chart a new course for health care reform—one that is patient-centered and market-based. By replacing the Obamacare spending with a block grant to the states and restoring state authority over some critical regulatory matters, states will have new tools to ameliorate much of the market dislocation that has plagued Obamacare and to lower costs, increase choices, and improve access. There are several likely actions the states will take in response. First, states will likely reassess the essential-benefit, medical-loss-ratio, risk-rating, and the single-risk-pool requirements. Careful not to recreate Obamacare's overreach, the states will likely take a fresh approach to these rules to strike the right balance. If done correctly, states could reduce premiums while still ensuring access. Second, free from Obamacare's flawed subsidy scheme, states would be able to implement their own assistance programs. States can structure their programs in ways that avoid the mistakes of Obamacare, including the problem of individuals with costly conditions migrating from other coverage into the individual market, which has been a major driver of Obamacare's premium increases. Third, states will likely take a more aggressive approach to risk mitigation or "Pre-existing Conditions". Unlike the waiver process, which is unpredictable and ad hoc, this proposal would provide states with certainty and authority to design risk-mitigation programs that best fit their citizens' needs. For example, a state may decide to re-open its high-risk pool or develop a more comprehensive reinsurance mechanism. These efforts would help to bring greater stability to premiums in the market. Fourth, states can redesign existing programs. States will likely reassess how best to provide care and coverage to those currently locked out of the health care market and allow insurers to develop more innovative approaches to reaching those populations to make coverage more attractive and affordable. Finally, the block grant will end the all-or-nothing proposition on Medicaid expansion. Today, states must expand their Medicaid programs up to 138 percent of the FPL in order to receive additional federal Medicaid funding. The block grant would allow states to receive federal dollars and design state-specific programs outside the Medicaid straightjacket of

federal rules to assist those in need while preserving the Medicaid program for those traditionally eligible for the program: poor women and children, the disabled, and the elderly who depend on long-term care services.

Step 1: Eliminate Obamacare spending schemes

Repeal and replace the $1.6 Trillion taxpayers will spend in federal financing for the exchange premium subsidies, the exchange cost-sharing subsidies, and the funding of the ACA's Medicaid expansion.

Step 2: Provide Block Grants to the States

Provide states with a fixed allotment of federal funding. The funding would be based on current state ACA funding and would be gradually rebalanced based on each state's number of low-income residents, bringing greater equity between the states. The states would adhere to the following guidelines in using their allotments:

- **Low income**: At least half of a state's grant funding would be used to provide coverage for low-income populations.
- **Private coverage**: At least half of a state's grant funding would be used to support the people's purchase of private coverage.
- **Risk Mitigation**: State grant funds could be used to offset the costs of individuals with expensive medical conditions through reinsurance programs or other, similar mechanisms.
- **Mental Health Coverage**: State grant funds can also be applied as a stop-gap to supplement traditional health plans that offer zero coverage for mental health screenings and treatment.
- **Premium support:** Individuals who are subsidized by a state grant program, and individuals currently on Medicaid and Children's Health Insurance Program (CHIP), would be able to direct their share of funding to the private coverage of their choosing.
- **Pro-life protections**: By making the grant program an amendment to the existing federal CHIP statute, the current pro-life protections that prohibit taxpayer funding of abortion in CHIP would also apply to the new grant program.

- **Optional use**: States could also incentivize insurers to offer discounts to individuals who maintain continuous coverage, or to young adults in general, who have been fleeing the market altogether.

Step 3: Extend new regulatory flexibility to States

Requires the repeal of certain costly and constrictive federal regulations, returning state regulatory authority over such matters bringing about more affordable options by:

- **The Repeal of the federal single-risk-pool requirement**. The ACA requires that in the individual and small-group markets, insurers must set their rates based on the cost of all of their customers in each of those market segments—as opposed to basing rates on the claims cost of the different groups of customers purchasing different plan designs. This federal restriction prevents variation on product price. Repealing this requirement would enable states to target more assistance directly to those with expensive medical conditions while reducing the cost of coverage for other enrollees, so that fewer of them would need subsidies to afford a plan.
- **The Repeal of federal essential health-benefit requirements**. The ACA requires insurance plans in the individual and small-group market to cover the 10 categories of federal benefits. This federal requirement pre-empted previous state benefit requirements and in most states increased the cost of coverage. Analysis found that this federal requirement has increased premiums between 5 percent and 11 percent, depending on the state.
- **The Repeal of the federal medical-loss-ratio requirement**. The ACA sets the minimum share of premium income that an insurer must spend on claims costs. This federal requirement perversely discourages insurers from spending money to limit claim payments. It also creates a barrier to new insurers entering the market and to existing insurers expanding into new markets, because it does not account for the higher administrative costs associated with the initial years of such expansions.

- **The Repeal of the federal age-rating limitation**.
  The ACA limits age variation of premiums for adults to a maximum ratio of three-to-one. Meaning, for the same plan, an insurer is not permitted to charge a 64-year-old a rate that is more than three times the rate for a 19-year-old. Analysis has found that this federal requirement lowered premiums by 10 percent to 15 percent for those between 50 and 64 years of age, but increased premiums for younger adults by about one-third.