

HEALTH CARE SECURITY

Every American should be able to afford and acquire preventive health care and treatment – regardless of employment, health status, or income level. No one should face bankruptcy because of a catastrophic illness; no one should be denied health coverage because they are branded “uninsurable.” Yet few will be able to afford health care or insurance if rising costs continue to spiral out of control. The only way to ensure that all Americans have access to quality health care is to confront these rising costs and the market distortions that created them. Such an approach will not solve every problem in the complex network of health care delivery and financing; but it *will* correct the most fundamental flaws.

Central to this idea is putting American families and their doctors back in control of their health care needs. Current arrangements remove patients from the decision-making process and hide the true cost of services. In an effort to contain costs, employers have consistently limited choice, flexibility, and coverage options for their employees. Yet health coverage is currently linked to employment by the tax exclusion for employer-sponsored health care. This tax treatment effectively discriminates against workers and families who do not have employer-sponsored health insurance. Compounding the problem, the number of employers providing health insurance has dropped 69 percent since 2000; and this alarming trend is continuing.

Equalizing the tax treatment of health care and coverage will give workers and families much more freedom to acquire a plan that best suits their needs. What’s more, people will no longer live in fear of losing their health care if they lose their job. As the marketplace begins to respond to this new patient centered control, the resulting increase in competition will necessitate an improvement in the quality of services and provide more options to meet the diverse needs of Americans.

The Health Care Marketplace

Changing the Tax Treatment of Health Coverage. To correct this problem, ownership of health insurance must be shifted away from third parties to those who are actually using it. In place of the current Federal tax law creating the market distortion – the tax exclusion for employer-sponsored health insurance – every American (except those enrolled in Medicare or a military health plan) will have the option to receive a refundable tax credit – \$2,500 for individuals and \$5,000 for families – to pay for health coverage. The tax credit is available solely for the purchase of health insurance. A family or individual may apply the credit to an employer-sponsored plan, if available, or to an alternative plan that better suits their needs. Employers continuing to offer insurance continue to claim contributions as a business expense deduction.

The payment will be made directly to the health plan designated by the individual, allowing those who use the health care to choose the insurance product that best suits their needs. Any individual who obtains health coverage that costs less than the credit will receive any leftover amount as a payment from the health plan. Alternatively, those who choose to purchase policies with premiums higher than the credit will assume responsibility for the additional amount themselves. This will encourage individuals to

shop for policies best suited to their needs, at the best prices. *Every American will play a role in restraining health insurance premiums*, and enhancing the quality of health care services.

There are several other advantages to this approach:

- *Broad Availability.* Individuals without income tax liability are still eligible for the credit. Due to the refundable nature of the tax credit, ownership of health insurance is available to every American, regardless of income level. It is also “advanceable,” enabling individuals to purchase coverage at the beginning of a year, rather than waiting for their tax returns.
- *Portability.* Individuals will be able to take their health insurance from job to job. The choice of physician and insurance plan would belong to the employee, not the employer. This is especially important for younger Americans who change jobs more frequently and are more apt to start their own businesses. It is also an important advantage for individuals with pre-existing health conditions, who may feel less free to change jobs for fear of losing health care coverage.
- *A More Responsive Market.* Because current tax law encourages the employer, not the individual, to be the purchaser and owner of health insurance, insurance companies tend to market their products to employers, whose chief concern is keeping operating costs low. Placing those decisions in the hands of individuals and families will encourage insurance companies to offer more variety, higher quality, and more cost-effective plans to meet the needs of their consumers.
- *Greater Opportunity for Small-Business Coverage.* The proposal creates an alternative for small businesses to offer a health care benefit. Currently, unless a business can afford to offer a full-scale health insurance plan, its options are limited in terms of health care benefits it can offer employees. The refundable tax credit model allows employees to take responsibility for purchasing their own health care with the tax credit, but also allows small businesses to make defined contributions to accounts – such as Health Savings Account [HSAs] – to help fund their employees’ health care expenses.
- *Enhanced Health Care Quality.* Health care quality will improve under this proposal due to increased competition among providers. The current market reimburses providers at a specified rate set by health insurance companies almost irrespective of the quality of the care they provide to their patients, or the efficiency with which they deliver the care. With individuals controlling their own health care dollars, providers will be encouraged to compete for business by increasing quality and charging more competitive prices. For providers, increased competition will mean they are less likely to be locked in to prices set by insurance plans, and will have more flexibility to determine the appropriate charges for services based on quality and demand.

Increasing Affordable Options Through Interstate Purchasing. Currently, individuals and families can only purchase health insurance in the States in which they live, and insurance companies are prohibited from marketing policies outside their respective

States. Thus, consumers are prevented from purchasing coverage from another State that might be better suited to their needs, more affordable, or both.

This proposal breaks the lock, allowing each individual to use the refundable tax credit toward the purchase of health insurance in *any* State. This will greatly expand the choices of coverage available to the consumer, and also will encourage broader competition and diversity among insurers, who will be able to sell their policies to individuals and families in every State, as other companies do in other sectors of the economy. After analyzing Federal Employee Health Benefits Program [FEHBP] preferred provider organization [PPO] prices, the Government Accountability Office reports: “We found that FEHBP PPO hospital prices differed by 259 percent and physician prices differed by about 100 percent across metropolitan areas in the United States, after we removed the geographic variation associated with the costs of doing business such as rents and salaries, and differences in the types of services provided.” (Government Accountability Office, *Federal Employee Health Benefits Program: Competition and Other Factors Linked to Wide Variation in Health Care Prices*, August 2005)

The arrangement also will balance State regulation of health insurance. Individuals no longer will have to pay for health benefits mandated by their home States that they do not need; they will be able to choose policies from States whose mandates better fit their personal circumstances. States will then have an incentive to balance their insurance mandates against costs to remain competitive with other States.

Making Price and Quality Data Available to All. For individuals and families to shop for their health care, they must have a better sense of what they are expected to pay – and what they are getting for their money. Making data on the pricing and effectiveness of health care services widely available is critical to the success of an effective health care marketplace. So far, however, the market has been unable to develop a process for defining industry-accepted metrics that measure “quality” and define “price.” The result has been a flurry of reports by trade organizations, specialty groups, and government agencies, each using different terminology and definitions. The lack of uniform standards has prevented effective, “apples-to-apples” comparisons.

The environment resembles what existed in the securities markets before the stock market crash of 1929. Abuse, fraud, and misinformation about the nature of stocks and the rules governing their purchase were rampant. In response, the Securities and Exchange Commission [SEC] was formed with the main purpose of bringing transparency to the market and restoring consumer confidence. With the increasingly rapid transformation of the financial markets and the growing complexity of financial transactions, the private sector began to take a more prominent role in developing accounting guidelines; and eventually the SEC began relying on the private sector to establish the basic standards by which it would be regulated. Since 1973, the SEC has recognized the nongovernment Financial Accounting Standards Board [FASB] as the authoritative standard-setting organization for financial accounting and reporting information. While the SEC has statutory authority to establish financial such standards, it has historically adopted FASB rules. The SEC allows the private sector to establish its own disclosure standards, so long as it demonstrates the ability to fulfill the responsibility in the public interest. The authority to enforce the standards, however, falls solely to the SEC.

Applying this model to the health care industry will allow all stakeholders to come together, without heavy-handed government intervention, to establish uniform and reliable measures by which to report quality and price information. To accomplish this goal, this proposal restructures the current Agency for Healthcare Research and Quality [AHRQ] and removes it from the Department of Health and Human Services. The new agency, renamed the Healthcare Services Commission [HSC], will be governed along the same lines as the Securities and Exchange Commission, and managed by five commissioners chosen from the private sector (with no more than three from the same political party), appointed by the President, and approved by the Senate.

The HSC's purpose – to enhance the quality, appropriateness, and effectiveness of health care services through the publication and enforcement of quality and price information – will be guided by a standard-setting Forum for Quality and Effectiveness in Health Care. The group will play a role similar to that of FASB in establishing accounting principles. The forum will consist entirely of private-sector representation, with the authority to establish and promulgate metrics to report price and quality data. Forum members will represent views from medical providers, insurers, researchers, and consumers, and will serve independently of any other employment.

The forum, designed to keep pace with innovation, will publish, for public comment, a preliminary analysis on standards for reporting price, quality, and effectiveness of health care services. After the comment period, the group will publish a final report containing guidelines for regulating the publication and dissemination of health care information. The HSC will be authorized to enforce these standards.

Protection for Those Who Need It Most. Uninsured individuals with pre-existing health conditions have the most difficult time finding and affording health care coverage. As a result, many individuals with pre-existing conditions often face bankruptcy to pay for health care expenses or, worse, go without treatment. If these individuals are fortunate enough to have group health insurance, their high costs are spread among their coworkers and employers in the form of ever-higher premiums, making coverage expensive for all.

Ensuring that “high-risk” individuals – those with the greatest medical costs – can obtain high-quality coverage is critical to the success of any plan to reform health care. High-risk individuals not only face an insurmountable burden in medical expenses themselves, but that burden is often transferred to taxpayers in the form of uncompensated care expenses from hospitals, or due to the likelihood that these individuals end up on Medicaid after having exhausted their financial resources paying for their medical costs.

This plan strengthens the health care safety net for these individuals. As further explained below, States choosing to let their Medicaid populations participate in the tax credit must spend previously allocated Medicaid funds on a Maintenance of Effort [MOE] program. A State's base MOE amount is equal to the amount the State spent in calendar year 2008 for its State Children's Health Insurance Program and Medicaid for healthy adults and children. The MOE amount increases each year by the same inflation adjustment as the health care tax credit. Each State is to apply these funds to the following:

- *Establishing High Risk Pools.* State health insurance high-risk pools will offer affordable coverage to individuals who would otherwise be denied coverage due

to pre-existing medical conditions, making coverage affordable for those currently deemed “uninsurable.” As part of offering affordable coverage to high-risk individuals, States may offer direct assistance with health insurance premiums and/or cost-sharing for low-income and/or high-cost families.

- *Auto-Enrollment.* Each State is to develop auto-enrollment health insurance procedures (similar to those for dual-eligibles under the Medicare Modernization Act) for previously eligible Medicaid recipients. Under this procedure, any uninsured person seeking medical care could be enrolled in an insurance plan, so that he or she no longer continues without coverage.
- *Setting Reasonable Limits on Premiums.* As part of high-risk pool reform, States will define premium standards such that individuals may be deemed high-risk if their health insurance premiums exceed a certain amount. Covering these individuals in high-risk pools dramatically improves the actuarial health and price of existing group health insurance plans, thereby lowering and stabilizing premiums for the vast majority of Americans with average health profiles.
- *Creating Reinsurance Mechanisms.* The establishment of State reinsurance mechanisms will ensure that high-risk pools are adequately funded, and that individuals receiving coverage through high-risk pools are not subject to prohibitively high premiums.

Relief for Small Businesses. The problem of rising health care costs is especially acute for small businesses, who cannot pool risks of thousands of employees, as large companies do – and therefore cannot afford group coverage for their workers. To correct the problem, this proposal allows the establishment of association health plans [AHPs], giving small businesses a means of offering health coverage to their employees. Under this strategy, small businesses will be able to pool together nationally to offer coverage to their employees. The plans offered would be subject to the same new rules for flexibility (using the tax credit to pay for health insurance at the workplace) and portability (being able to take insurance from job to job) described above.

Encouraging the Adoption of Health Information Technology. Just as individuals must own their own health coverage, so too should own their own health records. By establishing a modern market-driven approach to building a National Health Information Network, the plan will give every American ownership over his or her own medical record, transitioning the health care industry from paper-based medical records to electronic medical records through the creation of Independent Health Record Trusts. With electronic accounts, medical records travel with the individual, allowing timely and more accurate diagnoses and treatments. The Health Record Trusts, modeled on the framework of credit unions, will allow medical information to be managed in the same manner that financial institutions, such as banks and credit card companies, manage financial data – establishing a nationwide health information technology network designed to improve health care quality, reduce medical errors, and ensure that appropriate information is easily accessible.

Medicaid

Modernizing the Benefit. Medicaid, the Federal-State health care entitlement program for qualifying low-income and indigent individuals, is outdated and fiscally unsustainable. Without major reform, Medicaid recipients' access to health care is in jeopardy. The right changes can form a more effective program, and also make the health care safety net stronger and more reliable for the neediest populations.

Allowing States to offer their Medicaid populations the option of using the refundable tax credit to enroll in private insurance, in lieu of traditional Medicaid coverage, will restrain rising health costs and level the playing field for those with Medicaid coverage. The increased number of individuals shopping for health coverage and services will not only restrain prices, but also will increase competition in the marketplace. Additionally, Medicaid recipients – like all other Americans – will be able to purchase more affordable coverage from other States with the refundable tax credit if they find health insurance plans that better suit their needs.

Below are some of the particular benefits of this approach.

Removing the Stigma. Medicaid recipients deserve to choose their own doctors and make their own health care decisions, instead of having the government dictate those decisions for them. But instead of helping the neediest gain access to the same level of care available to those with private insurance, the current Medicaid Program forces both doctors and patients to accept bureaucratically determined standards of care at government-set prices. The result has been a fraying safety net that fails to sustain the most vulnerable; forces the medical community into making the impossible choice of providing care or going bankrupt (more than half of doctors will not take Medicaid recipients); and threatens to overrun State budgets. Additionally, Medicaid often fails to offer vision and dental care and various other services available in private health plans.

Low-income individuals should not be subject to second rate care simply because they receive more assistance from the government. Offering Medicaid beneficiaries the option to enroll in private plans with the refundable tax credit will remove the stigma Medicaid recipients face, and allow them to take advantage of the same range of options available to those with private plans.

State Flexibility. States may choose whether to allow their Medicaid populations participate in the tax credit plan, or to continue their current Medicaid Programs. States that select the latter receive their Federal Medical Assistance Percentage [FMAP] funding in the form of a block grant, adjusted for population growth and indexed to inflation by a blended rate of the consumer price index [CPI] and the medical care component of the CPI. This gives States maximum flexibility to adapt their programs to their specific populations. Any State opting to let its Medicaid population to take part in the tax credit must agree to use its previously allocated Medicaid funds to assist the Medicaid population in enrolling and purchasing health insurance plans. As mentioned above, States can use their MOE funds to supplement the tax credit for low-income and high-risk families if they choose to do so.

Retention of Medicaid for Specific Populations. States' long-term care and disabled

populations do not take part in the tax credit, but continue in the current Medicaid program, with each state receiving a block grant of this portion of its Medicaid funds. This change allows States maximum flexibility to tailor their Medicaid programs to the specific needs of their populations. The long-term care block grant is indexed for inflation by a blended rate of the CPI and the medical care component of the CPI, and adjusted for population growth.

State Children’s Health Insurance Program [SCHIP]. The current SCHIP population becomes eligible for the health care tax credit. This ensures that the children who need it most have access to the same variety of options and high quality care.

Medicare

A New Medicare Program. As the long-term fiscal burden of Medicare becomes more unsustainable, it is clear that – to fulfill the mission of Medicare – small and gradual changes to the program will not suffice. The entire methodology of the program must be converted away from a program that shelters beneficiaries from prices – and is therefore inefficient in restraining rising costs and proficient at sheltering prices from beneficiaries – into one in which Medicare beneficiaries choose the most affordable coverage that best suits their needs.

Just as the Medicare Program requires a new methodology, so too does its structure of financing. The Part A and Part B trust funds are combined to create one unified trust fund. The new Medicare Program and the existing program continue to be financed by trust fund revenues, Medicare payroll taxes, and general revenue contributions. The measure of solvency is converted away from one based on the unfunded liability of the Part A trust fund and into one in which the program’s solvency is measured as a percentage of GDP.

Medicare Payment. For future Medicare beneficiaries who are now 55 or younger (those who first become eligible on or after 1 January 2019), the proposal creates a standard Medicare payment to be used for the purchase of private health coverage. For current beneficiaries, and those older than 55, the plan preserves the existing Medicare Program, as further described below. The payment will be made directly to the health plan designated by the beneficiary (similar to the administration of the refundable health care tax credit), with the beneficiary receiving any leftover amount as a payment from the health plan, or assuming financial responsibility for any difference in the payment and the total cost of the premium. Additionally, this allows the Medicare beneficiary to invest the leftover amount in a Medical Savings Account [MSA] to pay for other medical expenses, or to purchase long-term care insurance.

Each Medicare beneficiary becomes eligible for the payment by enrolling in a health insurance plan. Medicare will publish an annual list of plans that are “Medicare certified.” Medicare enrollees are able to use their payment to pay for one of the Medicare certified plans, or any other plan, such as those offered by former employers or available from the private market.

The standard payment is \$9,500 (the average amount Medicare currently spends per

beneficiary), and is indexed for inflation by a blended rate of the CPI and the medical care component of the CPI. For affected beneficiaries, the payment replaces all components of the current Medicare program (Medicare fee-for-service, Medicare Part B, Medicare Advantage, and Medicare Part D). Payment amounts are risk-adjusted. They also are partially geographically adjusted, with the geographic adjustment phasing out over time.

Risk Adjustment. Medicare beneficiaries receive the standard amount – \$9,500 – once they enroll for the benefit, with the flexibility to receive a positive adjustment of that amount based on a risk-assessment from their chosen health plan. Once enrolled in a plan, Medicare beneficiaries may complete initial health exams through their health insurance plan to determine whether they are eligible to receive a higher risk-adjusted payment. The health plan must submit to the Medicare program any necessary results of the exam in order for Medicare to determine an adjusted risk-assessment.

Under the current system, Medicare frequently overpays for some services and beneficiaries and underpays for others. This reform targets support to those who truly need additional help by risk-adjusting their payments based on their health condition.

Income-Relating. The payment amount is modified based on income, in a manner similar to that for current Medicare Part B premiums subsidies. Specifically: beneficiaries with incomes below \$80,000 (\$160,000 for couples) receive the full standard payment amount; beneficiaries with annual incomes between \$80,000 and \$200,000 (\$160,000 to \$400,000 for couples) receive 50 percent of the standard amount; beneficiaries with incomes above \$200,000 (\$400,000 for couples) receive 30 percent.

Enhanced Support for Low-Income Beneficiaries. While any Medicare beneficiary, regardless of income level, is able to set up a tax-free MSA if he or she desires, the new Medicare Program establishes and funds an MSA for low-income beneficiaries. Specifically, for those who are fully “dual eligible” (eligible under current policies for both Medicare and Medicaid), and beneficiaries with incomes below 100 percent of the poverty level, the plan provides an MSA payment. Those with incomes between 100 percent and 150 percent of poverty receive 75 percent of the full deposit.

Retention of Medicare for Those Over 55. Clearly, the transition to this restructured Medicare Program must protect those at or near retirement – people who have long planned on the existing Medicare Program for their retired years. That is why the transition to the individual purchase of private health insurance applies to those eligible starting on 1 January 2019. For those eligible prior to that date (those over 55), the existing Medicare Program remains, and is strengthened with changes, such as income-relating of drug benefit premiums, to ensure its long-term sustainability.

Premiums continue to be based on an all-beneficiary average, so the phasing of the younger population into the new program will not increase premiums for the population continuing in the existing program.

The proposal also retains the Medicare payroll tax of 2.9 percent of the Federal Insurance Contributions Act [FICA] and Self-Employed Contributions Act [SECA] payroll tax, as is the case now. According to the Office of the Chief Actuary of the Centers for Medicaid

and Medicare Services, this reform plan will assure the solvency of the overall Medicare Program for the long term.