Universal Health Care Choice and Access Act (S. 1019)

Section 1. Short Title; Table of Contents.

Section 2. Findings.

Title I. Prevention

Section 101. Strategic Approach to Outcome-Based Federal Prevention.

(a) The Secretary of Health and Human Services shall convene and chair an inter-agency coordinating committee to develop a national strategic and implementing plan for outcome-based disease prevention and health promotion, due to Congress within one year of enactment. The plan shall include non-Federal partners including, but not limited to, non-profit organizations, states, and private industry. Implementation shall include elimination of ineffective and duplicative programs to achieve maximum results from effective programs.

HHS shall conduct periodic reviews and grading of every health prevention and promotion initiative, program, and agency. Such reviews shall be evaluated based on effectiveness in meeting metrics-based goals with analysis posted on the agencies' public websites.

(b) Federal Messaging on Health Promotion and Disease Prevention.

The Secretary of HHS, acting through the Director of CDC, shall implement national science-based media campaigns on health promotion and disease prevention within one year of enactment, to be independently evaluated every 2 years.

With private-sector collaboration, CDC shall maintain a website with science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. CDC shall contract for a Federal web-based personalized prevention plan tool.

In collaboration with private partners, CDC shall continue to provide science-based health promotion and disease prevention information to health care providers. CDC shall implement a plan for information dissemination through health care providers in Federal programs.

Out of CDC's annual appropriations, funding for activities authorized under this section shall take priority over grants to states for the same or similar purposes. No more than $500 million may be spent for such purposes.

Section 102. Discretionary Grants to States for Outcome-Based Prevention Efforts.

If the Secretary deems it essential to meeting the health promotion goals of Healthy People 2010, the Secretary may make grants to states for health promotion and disease prevention. Funding for such grants shall take priority over existing authorizations for grants to states. No more than $300 million may be spent for such purposes.

States making measurable progress at reducing morbidity and mortality shall be eligible for bonus funding.

Section 103. Keeping the Federal Food Stamp Program Focused on Nutrition.

USDA shall distribute a science-based nutrition counseling brochure to each individual and family enrolled in the food stamp program.

USDA shall develop, based upon nutritionally-sound recommendations from a commission including public health and nutrition experts and the CDC, lists of foods that are not nutritionally sound and may not be purchased through the food stamp program.

Section 104. Access to CDC-Recommended Immunizations.

Increase funding, State flexibility, and accountability for Section 317 vaccine funding. If States do not reach a benchmark of 80% coverage of CDC-recommended immunizations, then CDC shall provide technical assistance, and if this fails program funding to such State will decrease by 10%. States achieving a vaccination rate of above 90% will be eligible for a bonus grant from a $100 million pool to be used for the purposes of health promotion and disease prevention.

Title II. Tax Incentive Modernization

Subtitle A—Enhancing Health Savings Accounts (HSAs).

Section 201.

(a) Increase HSA contribution limits to the lower of 1) the annual deductible and other annual out-of-pocket expenses or 2) the statutory maximum out-of-pocket expenditure for a high deductible health plan. In addition, individuals with long-term care insurance policies may contribute to their HSA the lower of the premiums for such policy or $1,000.
(b) Allow payments for individually-owned high-deductible health insurance plans to be made from HSAs.
(c) Allow high-deductible health plans to make payments for capitated primary care services before an individual reaches their plan deductible.
(d) Allow high-deductible health plans to cover the maintenance of chronic diseases (in addition to prevention services).
(e) Allow employers to make greater contributions to the HSAs of chronically ill employees.

(f) Allow veterans receiving benefits from VA facilities to open a health savings account in conjunction with a high-deductible health policy.
(g) Allow Native Americans eligible for care at IHS facilities to open health savings accounts.

Section 202. Allow employers to contribute greater amounts to HSAs owned by acutely or chronically ill employees.

Subtitle B—MediChoice Tax Refunds.

Section 211. Tax Refunds for the Purchase of Health Insurance.

All eligible Americans would get a refundable tax credit that would be available in the amount of $2,000 ($5,000 for families) to purchase qualified health insurance wherever they choose.

Individuals may use a portion (up to $150 for individuals, plus $100 for each child for family credits) of their tax credit for wellness exams, if their qualified health insurance plan does not pay for annual wellness exams.

For individuals/families electing a high-deductible health plan, credit amount not used to pay plan premiums may be deposited into a Health Savings Account.

Such credits are indexed annually to chain-weighted CPI.

Section 212. Appropriate amounts of such credits shall be available on a monthly basis.

Section 213. Elimination of the employer tax exclusion.

Eliminates the employer tax exclusion. Effective date 2 years.

Title III. Health Insurance Market Modernization

Subtitle A—Enable Employer Contributions to Individually-Owned Health Insurance

Section 301.

Allow employers to provide contributions to employees who show evidence of individual market qualified health insurance. Portable insurance can still be considered an individual market plan even when employers indirectly contribute to its premium.

Subtitle B—Access to Health Care for Medically Uninsurable Individuals

Section 311. State Reinsurance Pools.

States receiving Federal Medicaid money must establish health insurance "high risk pools" consistent with model NAIC legislation, standards established for high-risk pool Federal seed money, or a state-designed alternative that provides access to private health insurance for "medically uninsurable" individuals. States that establish high-risk pools shall be eligible for a one-time 1% bonus to their Medicaid allotment.

Section 312. The Secretary shall evaluate the effect of the FQHC on proximate rural hospitals every five years. If the FQHC is causing a detrimental effect on private facilities, the Secretary may revoke the grant or limit the FQHC's scope of services.

Subtitle C. Interstate Market for Health Insurance

Section 321. The insurer or issuer is subject to all of the laws of the primary state. They're exempt from most of the laws of the secondary state. Exceptions include that the secondary (the state in which the health insurance policy holder resides) state may: 1) assess premium taxes and other taxes (including high-risk pool assessments); 2) conduct a financial review of the insurer if the primary state didn't 3) require compliance with a lawful order; 4) seek an injunction alleging the insurer is in hazardous financial condition; 5) require participation in the secondary state's guaranty funds; 6) require compliance with the secondary state's fraud and abuse laws; and 7) require compliance with the secondary state's unfair claims settlement practice laws.

All insurance companies selling under this bill be evaluated using a risk-based capital formula, which is the National Association of Insurance Commissioners' gold standard for solvency.

Each individual covered under the bill has access to independent review of medical decisions.

Title IV—Securing Medicare's Future

Subtitle A—Enhancing Medicare Advantage

Section 401. Medicare Advantage benchmark for AB benefits is set to the national average bid for such services, adjusted for geographic price input and to maximize participation of regional and local plans.

Section 402. Enhancement of beneficiary rebates. If a plan bids below the benchmark, 100% of the difference may be used for benefit rebates.

Section 403. If a plan submits a bid for AB benefits, such plan may also offer a plan under Medicare Advantage whose benefit design has been licensed in any state or met ERISA criteria. Seniors may designate a carrier of their individually-owned policy to receive the benchmark payments under Medicare Advantage.

Section 404. Establishment of HSA-qualified plans in the Medicare Advantage program.

Section 405. Expert review of the risk-adjustment mechanism used under the Medicare Advantage program.

Subtitle B—Updating the Medicare Fee-for-Service Program

Section 411. Eliminate the annual indexing of income thresholds for reduced part B premium subsidies.

Section 412. Authority to adjust amount of Medicare Part B premiums to reward positive health behaviors in a budget neutral manner.

Section 413. Recapture of Medicare DSH funds, beginning 2 years after enactment of the Federal tax credit for transition.

Section 414. Hospitals and providers receiving reimbursements from Medicare shall publish their estimated and then actual charges for all services and patients.

Subtitle C—Regulatory Relief

Section 421. Promotion of Value-Based Service Delivery by repealing specific Stark provisions and requiring the disclosure of financial interests in services to which health care providers refer.

Subtitle D—Securing Medicare's Future for Tomorrow's Seniors

Section 431. Medical Retirement Accounts.

New workers may choose to have their 2.9 % FICA taxes diverted into a personal MRA, or may stay in traditional Medicare by paying into the Medicare Trust fund.

For higher income workers, their employee share of 1.45% will go to their MRA while a portion of their employer share would go to a pool to be redistributed to lower-income workers to bring their MRA up to a standard amount. This will be done annually based on tax returns among the age cohort born in the same year.

MRAs would be completely voluntary for existing workers (with option for risk-adjusted cash payouts upon retirement for their average age cohort's contributions to the Medicare Trust Fund). No return to the enhanced Medicare Advantage, if option taken.

Employers may make additional tax-free contributions to workers' MRAs. Additionally, employers may continue to contribute to workers' MRAs during retirement.

Annual contribution limits to MRAs are $10,000; such amount is indexed to chain-weighted CPI.

Individuals may use a one-time rollover of HSA, HRA, MSA, and FSA funds into his/her MRA at retirement.

Continuation of Tax Credit in Retirement

Seniors may continue to get an individual health care tax credit for the purchase of health insurance, if he/she owns an MRA and are not receiving benefits under Medicare.

MRA holder may begin to use funds at retirement age of their choosing, before or after age 65, if the individual has purchased a lifetime catastrophic health care policy.

Medical Retirement Account Uses

MRAs may be used for the same purposes as a Health Savings Account, as amended by this statute. MRA holders must use funds to pay for a minimum catastrophic or high-deductible health plan.

No non-medical withdrawals.

Medical Retirement Account Administration

MRAs shall be administered by the same structure as the Federal Retirement Thrift Savings Board using L funds invested in the private market.

When the holder of the MRA passes, the remaining balance goes to the MRA of the surviving spouse or family members.

Title V—Keeping Medicaid on Mission

Section 501. Creation of Medicaid State Partnership Allotments.

Total Medicaid spending is authorized at $212 billion the year following enactment (including Medicaid DSH money, which shall be available to hospitals for uncompensated care for 2 years after enactment of the Federal tax credit). Authorization level is indexed to chain-weighted CPI annually.

States must match Federal funding at a minimum of 1:3 for maintenance of effort.

No more than 3% of the Federal Medicaid funds may be used for State administrative costs.

States may rollover their unused funding from year to year.

Over a period of 5 years, the Secretary shall gradually change distribution of allotments to each State from the current ratio of each state's Federal share of the total Federal Medicaid spending to a ratio of total Medicaid spending based on each state's relative population, poverty levels, number of dual-eligibles, and disabled population.

> The Secretary is authorized $20 billion over 5 years for the purposes of assistance in the transition for states whose total allotment would otherwise decrease as the allotment ratio changes.

Spending Requirements. States shall use Medicaid allotments to pay only for acute and long-term care for indigent populations. States may use their Medicaid dollars to provide services to individuals who qualify under existing Medicaid eligibility or whose income level is below 133% of FPL. Priority for assistance must go to mandatory populations under existing Medicaid statute.

States shall spend their Medicaid allotments on services that have the same goals as services previously authorized under existing Medicaid statute (mandatory and optional benefits) or by Section 1115 waiver.

States may risk-adjust the amounts based on chronic disease condition.

States may decrease the level of assistance on an income-based sliding scale.

States shall establish initiatives for health promotion and disease prevention to address the state's top 3 disease killers, if receiving Federal Medicaid funding.

States may use their Medicaid allotments to augment the amount of the Federal tax credit (of $2,000), on a risk-adjusted basis, to assist individuals in purchasing private health insurance. States shall establish benefit enrollment counselors to indigent populations eligible for assistance. States shall also ensure accurate and complete plan information is available to beneficiaries.

States may establish mechanisms to facilitate enrollment in default private catastrophic health plans with the Federal tax credit.

Medicaid opt-out. If a state chooses to provide and coordinate benefits for individuals, they must also offer individuals a risk-adjusted amount that is equivalent to the average monetary value of services provided by the state that such individual may use to purchase coverage in the private market.

States must submit reports to the Federal government annually on the use of funds, average per beneficiary spending, and the number of people in their states enrolled in private health coverage.

Section 502. Medicaid Advantage Program.

To provide for a coordinated care model of services for dually-eligible individuals. The federal government shall continue to provide financial support to the states for Medicare benefits, but through a risk-adjusted, capitated system of Medicare payments. States and the Federal government would continue to share the cost of the Medicaid portion of the benefit. States or the plans they select may manage the full spectrum of services for dual-eligible beneficiaries.

Mechanisms. Participating states would contract with competing health plans to provide the full spectrum of care for dually-eligible populations and would enroll individuals into these integrated Medicaid Advantage care management plans.

Dual-eligible patients may choose from among competing Medicaid Advantage plans.

Patients may be automatically enrolled in a competing plan if they do not actively enroll or are not enrolled by a family member or guardian.

All patients may opt-out to traditional Medicare and Medicaid coverage for duals.

Private health plans may participate in a bidding process to participate in Medicaid Advantage, submitting bids representing their cost of providing Medicare and Medicaid-covered services to dual-eligibles as well as other services specified by the states.

States may sign contracts with the plans they select to participate in the program.

Medicaid Advantage plans are required to provide core Medicaid and Medicare services to duals, but states would have more authority and flexibility to tailor benefit packages to the specific needs of patients without having to request waivers.

States shall monitor plans and networks to ensure they meet their contractual obligations, and the federal government shall monitor and audit their reports.

States may provide incentives for plans to compete on the basis of quality and value and could reward health plans that provide higher quality care at a reduced price. States could also share in a portion of these savings.

Plans may partner with recipients with incentives that encourage them to participate in their care management.

States may manage the care and assume full risk.

Financing. The states and the Federal government would each contribute. A new pool of funds would be created that includes federal and state Medicaid contributions plus

federal Medicare and Part D contributions. These would be combined into one funding stream to finance care for duals through the new Medicaid Advantage plans. Existing rate-setting and risk-adjustment systems under Medicare for Medicare Advantage plans and that states use to pay for standard Medicaid managed care programs shall be used for calculating payments.

> Federal Medicare payments, which are generally provided through Medicare's defined benefit structure, would be allocated to the states through a new funding mechanism. The Federal government shall develop a system of capitated, risk-adjusted Medicare payments. Subsidies shall be adjusted to avoid selection bias and to assure access and quality treatment to the sickest beneficiaries. These payments would be sent from the federal government to the states to fund the Medicare portion of services for dual-eligible residents. This is not a block grant because funds would follow each recipient and would be adjusted for that patient's risk profile.
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> State funds from Medicaid Allotments: Those states that decide to contract with private plans to provide coordinated care for their dual populations could calculate an actuarially-sound capitated rate for the state's share of Medicaid services. The plans, not the state, would be at risk.
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> Those states that decide to operate the program themselves and assume the risk shall make contributions based upon their own Medicaid payment experience for services for duals.
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> Drug coverage: shall be integrated into the Medicaid Advantage plans. Medicare shall calculate a Part D allocation that would be returned to each state in the form of a capitated, risk-adjusted payments.

Section 503. Bonus Funding to States that Achieve Universal Private Health Coverage.

States that achieve above a 95% population enrollment in private coverage shall be eligible for bonus funding, to be used for the purposes facilitating enrollment in private health coverage, from a specified Federal pool of funding ($5 billion over 5 years).

Section VI—Administrative Health Care Tribunals

Section 601. States that establish administrative health care tribunals that meet certain broad criteria will be eligible for a one-time bonus to their Medicaid allotment from a specified pool.

Each case must first be reviewed by a panel of experts (half physicians; half attorneys), selected by a state agency (probably the state's department of health) with clearly defined expertise. That panel will make a recommendation about liability and compensation. The parties may then choose to settle, or may proceed to the tribunal. The parties may be represented by counsel at this stage, and each subsequent stage in the process.

Each tribunal must be presided over by special judges with health care expertise, selected by the State. The opinion of the expert panel will be admitted before the tribunal. This judge will have the authority, granted by the state, to make binding rulings on standards of care, causation, compensation, and related issues.

The legal standard for the tribunal will be negligence.

If either party is unhappy with the tribunal's decision, that party may appeal the decision to a state court, to preserve a trial by jury. Any determinations made by the panel and the tribunal will be admissible in court.

Once one-party appeals to a state court, any previous determinations are void. In other words, if the party that appeals to state court is unhappy with the court's decision, the party may not receive the compensation that the tribunal determined to be appropriate.

Section VII—Charter for Independent Health Record Banks

Section 701.

Provides for the establishment of a nationwide health information technology network to improve health quality, reduce medical errors, ensure that appropriate information necessary to make medical decisions is available, produce greater value for health care expenditures by reducing health care costs and ensure that the confidentiality of individual identifiable health information of a patient is secure and protected. The Secretary of HHS shall promulgate regulations that ensure such health record banks are fully HIPAA compliant.

Section VIII. Miscellaneous

Section 801. Dedication of Medicaid and revenue savings to the Medicare Trust Fund.

Section 802. Veterans Choice.
Not later than two years after the enactment of this Act, the VA shall establish procedures for those receiving health benefits coverage of health services furnished by providers and facilities outside of the VA network.

Section 803. Indian Health Care Choice.

Not later than two years after the enactment of this Act, the INS shall establish procedures for those receiving health benefits coverage of health services furnished by providers and facilities outside of the IHS network.