

SENATOR MICHAEL B. ENZI
TEN STEPS TO TRANSFORM HEALTH CARE IN AMERICA
*Building on Market-based Solutions and
Strengthening Current Insurance Programs*

TITLE I – AFFORDABLE HEALTH INSURANCE FOR EVERY AMERICAN

SUBTITLE A – Individual Coverage Responsibility

- Ensure every American has access to an affordable health insurance plan (Qualified Core Plan (QCP)).
- All Americans not eligible for the low income subsidy will be eligible for a standard deduction for health insurance (SDHI), making insurance more accessible and affordable and ensuring fairer tax treatment of health care costs for everyone.
- Provide subsidies for low-income individuals purchasing QCP plans.
- The SDHI and subsidy “hybrid” will be provided through the tax system.

Qualified Core Plans (QCP)

A. Qualified Core Plan

1. QCP plans will have a constant annual premium value pegged to one-third of the SDHI value (one-third of SDHI = \$2,500 for an individual and \$5,000 for a family of four).
2. QCP’s will include cost-sharing requirements (e.g., deductibles and co-payments) to ensure a reasonable fiscal benchmark and predictability for consumers.
3. The QCP must include basic preventive services and a medical self-management component for those with chronic illnesses.
4. QCPs are certified by state insurance commissioners and are subject to state oversight, consumer protections, and benefit mandate rules.
5. The full subsidy for eligible individuals will equal the set QCP premium value.
6. All insurance companies must offer at least one QCP plan in any state in which they operate and may not deny anyone enrollment.

B. Qualified Core Compatible Plan

1. A QCCP must be actuarially equivalent to the QCP (and include preventive services and a medical self-management component), but can provide flexibility in plan design, coinsurance, and premium amounts.
2. Those enrolled in QCCP’s are eligible for the subsidy.

Default Enrollment

Individuals who do not purchase health insurance are default enrolled into a QCP plan in that individual’s state or the government program for which he/she is eligible (e.g., Medicaid or SCHIP).

- An individual eligible for Medicaid or SCHIP may choose to opt-out of those programs and monetize part of the cost of that benefit to use to purchase private health insurance.

Uninsured individuals presenting at a health care provider for health services will be referred to that state's insurance commissioner. Each state insurance commissioner will determine how to encourage enrollment of these individuals into a health insurance plan.

Self-Insured Plans

Individuals receiving health insurance through a self-insured plan are eligible to receive the SDHI, but they are not eligible for the subsidy.

SUBTITLE B – Tax Treatment of Health Care

1. The national, above-the-line Standard Deduction for Health Insurance will equal \$15,000 for a family and \$7,500 for an individual. It will replace the employee exclusion and medical itemized deduction to ensure everyone purchasing insurance receives the same treatment under the tax system.
2. Employers will be required to report the portion of health care costs they pay on behalf of employees on the Form W-2 to encourage transparency of health care costs.
3. The Earned Income Tax Credit (EITC) for taxpayers with qualifying children is held harmless so those receiving the EITC now will not be affected by these tax changes.

SUBTITLE C – Government Subsidy

1. The tax subsidy will equal one-third of SDHI which also equals the annual set premium cost of the QCa (\$5,000 for a family, \$2,500 for an individual).
2. The subsidy is available through an advanceable (paid at the beginning of the year before taxes are due), refundable (available to those with no tax liability), and assignable (paid directly from the Internal Revenue Service to the chosen insurance carrier) tax credit.
3. The full subsidy amount is available to individuals at or below 100 percent of the Federal Poverty Level (FPL) (\$20,650 for a family of four). The subsidy is phased out between 101 and 301 percent of FPL, with individuals at 200 percent of FPL receiving half of the subsidy and individuals at 301 percent of FPL not receiving any of the subsidy.
4. Individuals eligible for (or currently enrolled in) Medicare are not eligible for the subsidy. Individuals with non-QCP private health insurance (e.g., employer sponsored plans) are not eligible for the subsidy.
5. Individuals eligible for Medicaid or SCHIP may choose to opt-out of those programs and monetize the cost of that benefit toward purchasing private health insurance; they are also eligible for the subsidy, which they may couple with the monetized amount to pay for private health insurance.
6. Because the number of uninsured individuals presenting at hospitals and receiving "free" care will dramatically decrease, disproportionate Share Hospital payments are reduced by 90 percent.

SUBTITLE D – Education and Outreach

1. Government health programs will simplify their enrollment forms (to a form developed and published by the Secretary of HHS).
2. The IRS will provide information on the SDHI, subsidy, enrollment processes, and default enrollment in tax return instruction booklets one year before the tax subsidies take effect.
3. HHS will develop a website, linked to state insurance commissioner websites, that will include information on available QCP and QCCP plans, the SDHI, the subsidy, and enrollment processes.
4. Health care providers and facilities will provide basic information, provided by to them by HHS, to uninsured individuals presenting for health care services to encourage enrollment.

TITLE II – INCREASING INSURANCE MARKET PORTABILITY AND AFFORDABILITY

SUBTITLE A – Merging of Group and Individual Health Insurance Markets

1. To ensure more stability and affordability in the small group and individual markets, states will merge the group and individual markets; group market rules will apply to individually-purchased and group plans with any size membership.
2. HIPAA group market protections will remain in place and will now apply to individual policies as well.
3. Portability and insurance market protections will be strengthened to include guaranteed issue, guaranteed renewal, and no re-underwriting to provide more security and accessibility to health insurance.

SUBTITLE B – Rating Compression

Currently, individuals with a chronic illness or unforeseen catastrophic health care costs have greater difficulty finding affordable insurance and are subject to re-underwriting and ever-raising premiums. To allow greater access and affordability, each state will reduce variation in premium rates among enrollees to minimum allowable bands, ensuring there is no variation based on health status and limited variation based on age.

SUBTITLE C – Enhanced Market-Based Pooling

1. Cross-state pooling, with state oversight, will be allowed for small business and established groups and associations (not just trade associations) to reduce costs and increase accessibility for small business owners and associations.
2. State benefit mandates in place in a majority of states will apply – uniformly – to these particular plans offered across state lines.

TITLE III – Affordable Access to Health Care for All Americans

SUBTITLE A — Improving the Quality of Health Care by More Effectively Using Health Information Technology

1. Include the “Wired for Health Care Quality Act” to increase the quality and decrease the cost of health care.

2. Clarify that Quality Improvement Organizations may offer quality improvement technical assistance to providers in the Medicare program.
3. It is the Sense of the Senate that modifications to the Medicare physician fee schedule should include incentives to report quality measures using health information technology.

SUBTITLE B – Increasing Access to Physicians and Nurses

There are growing shortages of health care providers nationally, with a shortage of up to 200,000 primary care physicians and one million nurses expected by 2020.

1. The Secretary of HHS will develop metrics to evaluate the Health Professions Education and Nursing Workforce Development programs to determine their efficacy and ways to improve implementation to reduce provider shortages.
2. Competitive matching grants will be available for states to encourage nurses to return to the profession after having left the workforce for three years or more.
3. Programs funding nurse educators and nurse education will be reauthorized.
4. Non-immigrant skilled worker visa slots for nurses serving in medically underserved areas will be slightly expanded.
5. The Medicare Payment Advisory Commission will publish a study on the impact of reimbursement limitations for Graduate Medical Education and residency slots on professions shortages and stagnation of training and teaching facility development.

SUBTITLE C –Increasing Access to Primary Care

1. The Community Health Center (CHC) program will be reauthorized for five years at increased appropriations levels to establish new CHCs in America’s most vulnerable communities.
2. CHCs will be eligible for grants to establish or expand residency slots and capacity to train health professionals in the CHC setting, which improves retention rates in underserved areas.
3. The loan repayment program and grants to states for loan repayment initiatives within the National Health Service Corps program will be reauthorized for five years.
4. To allow for greater access to basic health services, clarification will be made that “Convenient Care Clinics” may accept and receive reimbursement for Medicaid and SCHIP patients.

SUBTITLE D – Improving Access to Care in Rural and Frontier Areas

Programs under Rural Health Care Services in § 330A of the Public Health Service Act will be reauthorized for five years to ensure appropriate development of rural health systems and access to care for rural residents.

SUBTITLE E – Giving Seniors More Options to Receive Care in Their Homes and Community Settings

1. It is the Sense of the Senate that every American should create a living will. The Secretary of HHS will develop a website, livingwill.gov, to help individuals do so.
2. Community- and home-based care is often much preferred, less costly, and proven to increase quality of life. To encourage adoption and evaluation of long-term care in residential settings, HHS will make competitive grants available for demonstration

projects to transition skilled nursing care from institutional settings to community-based or residential settings.

SUBTITLE F – Restoring Reliability in Our Medical Justice System

Include the “Fair and Reliable Medical Justice Act” to restore reliability to our medical justice system, states must encourage early disclosure of preventable health care errors, prompt and fair compensation for injured patients, and careful analysis on patterns of health care errors to prevent future injuries. By funding demonstration projects, states are enabled to experiment with and learn from ideas leading to long-term solutions to the medical litigation crisis that are tailored to the unique needs and circumstances of each state.

1. Authorizes grants for state demonstration programs, under parameters and guidance from the federal government, to test alternatives to current medical tort litigation.
2. Requires participating states to ensure patient-safety organizations capture and analyze data on costs of preventable injuries compensated under their programs.