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

Promoting Healthy Lifestyles and Preventing Disease

As the saying goes, "An ounce of prevention is worth a pound of cure." In practical terms, prevention is worth trillions of dollars saved in medical costs, increased productivity, improved quality of life, and added years of healthy living. Over the last century, for example, the average U.S. lifespan has increased by more than 30 years, with 25 of these added years attributed to prevention.[1]

Yet, five *preventable* chronic diseases (heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes) cause two-thirds of American deaths while 75 percent of total health expenditures are spent to treat chronic diseases that are largely preventable.[2]

Billions of dollars are spent every year on prevention and health promotion by the federal government, but the cost of care for preventable conditions is growing. More adults and children today are developing diabetes and becoming overweight/obese, two conditions that often can be avoided with diet and physical activity.[3] Epidemics like HIV/AIDS have been difficult to contain and emerging threats, such as avian flu and bioterrorism, pose new challenges.

Prevention requires efforts and costs today that are expected to provide long term cost savings and other benefits. These outcomes are often difficult to measure, which hinder efforts to prioritize prevention and also allow ineffective programs to continue.

The Universal Health Care Choice and Access Act seeks to improve and promote prevention initiatives in a cost effective and measurable manner.

It does so specifically by:

<u>Coordinating Federal Prevention Efforts</u>

Numerous federal departments and agencies currently administer duplicative and overlapping prevention efforts. This bill will establish an interagency committee to develop and coordinate a national strategic prevention plan. The committee shall include the secretary of the Department of Health and Human Services (HHS), the gurgeon general and representatives from the National Institutes of Health (NIH), Centers for

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[1] "Guide to Smart Prevention Investments," Partnership for Prevention, Fall 2001. http://prevent.org/images/stories/Files/publications/Invest_Final.pdf

[2] "Chronic Disease Overview," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, November 18, 2005. http://www.cdc.gov/nccdphp/overview.htm#2

[3] "Guide to Smart Prevention Investments," Partnership for Prevention, Fall 2001. http://prevent.org/images/stories/Files/publications/Invest_Final.pdf

Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), U.S. Department of Agriculture (USDA), Centers for Medicare and Medicaid Services (CMS), Environmental Protection Agency (EPA), Indian Health Service (IHS), Administration on Aging (AoA), Department of Veterans Affairs (VA), Department of Education, Department of Labor, and Department of Defense (DoD).

Setting National Priorities with Measurable Goals

More than coordination is needed to ensure that prevention programs are working. The interagency committee will, therefore, develop a specific strategic plan and set national priorities for health promotion and disease prevention focused on science-based initiatives regarding nutrition, exercise, smoking reduction, and the nation's top five disease killers. The committee shall provide annual reports on the progress meeting the specific metrics outlined in the strategic plan.

Empowering Individuals to Make Healthy Decisions

Prevention largely requires individuals to adopt healthy lifestyles and behaviors. This can be accomplished without creating more government agencies and programs by providing science-based recommendations directly to individuals.

Under this act, CDC will establish a web-based prevention tool that would create a personalized prevention plan for individuals based upon personal health and family history, body mass index, and other individualized health factors. The Web site would provide daily healthy living recommendations developed from the latest scientific data.

CDC also will implement national science-based media campaigns on health promotion and disease prevention. These shall address proper nutrition, regular exercise, smoking reduction, obesity, the nation's leading disease killers, and secondary prevention through promotion of disease screening. These efforts will undergo an independent evaluation every two years and be tied to measurable outcomes.

USDA will distribute nutritional information to each individual and family enrolled in the federal Food Stamp Program.

Awarding Prevention Success

Seniors who adopt healthier behaviors would be rewarded with lower Medicare premiums.

States that demonstrate the greatest progress in reducing disease rates and risk factors and also increasing healthy behaviors could be awarded federal "Wellness Bonus Grants." States that receive wellness bonuses must demonstrate the greatest progress meeting specific science-based metrics.

Increasing Vaccine Availability

Vaccines provide cost-effective immunity against many diseases. The influenza vaccine, for example, is estimated to save $30 to $60 in hospitalization costs per $1 spent on vaccination.[4] Yet many Americans have not been vaccinated against many diseases for which vaccines are available. This bill would expand access points for federally funded vaccines and encourage states to achieve higher vaccination rates by awarding bonus grants to states with 90 percent vaccination rates.

Eliminating Ineffective and Counterproductive Government Programs

Government health programs should adhere to the Hippocratic oath to "first, do no harm." This means federal programs should not promote or support unhealthy behaviors and taxpayers should not be expected to support programs that do not show positive results.

This act would require reviews of existing programs and the consolidation of overlapping programs and the elimination of ineffective programs. Additionally, "junk food" that does not meet nutrition standards would be prohibited for purchase under the federal Food Stamp Program.

[4] "An Ounce of Prevention…What Are the Returns?," 2nd edition. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1999.

Providing Patients Tax Rebates to Ensure Everyone Can Afford Health Care Coverage

The existing tax code discriminates against individuals who do not receive health insurance from their employer, which has contributed to the 45 million Americans who are uninsured. Because employers receive tax breaks for purchasing health insurance for workers, the system primarily rewards corporations rather than patients. As a result, employers typically select patients' health care insurance for them. Subsidizing health *insurance* instead of health *care* has resulted in a third-party payer system that has compromised patients control over their own health care decisions. It also has contributed to skyrocketing premiums and lack of choice. The current tax code provides $208.6 billion[5] in tax subsidies through businesses, but only offers $12.4 billion[6] if you buy health insurance on your own. Wealthy Americans receive $2,680 from the government in tax breaks for health care while the poorest Americans get only $102.[7]

Since 2000, premiums for family health coverage have increased by 87 percent, compared with cumulative inflation of 18 percent and cumulative wage growth of 20 percent. During this same period, the percentage of employers offering health benefits has fallen from 69 percent to 61 percent, and the percentage of workers covered by their own employer also has fallen. The current employer-based system offers little choice in health plans to employees: nearly nine out of 10 American firms offer only one health plan type. [8]

Extending Health Care Choice and Tax Breaks to Individuals

Health insurance is unaffordable for many Americans who do not receive health coverage from their employer because the current tax structure gives tax breaks to corporations for health insurance but does not extend these same tax advantages to individuals who might purchase their own health insurance.

Under the act, Americans would be eligible for a tax rebate to purchase health insurance. The "Medi-Choice" rebate would be made directly to a patient's health insurer and would be worth $2,000. Families would receive a $5,000 tax rebate.

In Oklahoma, the average price of an individual health care policy is $1,586. [9] An Oklahoman can purchase a health insurance policy and then keep $414 to save for the next time they need to visit a doctor. The national average health policy costs $2,268 in the individual market.[10]

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[5] Health Affairs: Tax Subsidies for Employment-Related Health Insurance, November/December 2006
[6] Congressional Research Service
[7] John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004"
[8] Kaiser Family Foundation, 2006 Employer Health Benefits Survey
[9] Ehealthinsurance.com
[10] America's Health Insurance Plans, Center for Policy and Research, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," August 2005, p. 1.

The tax rebate may be used for wellness exams or to purchase a coverage plan that pays for annual doctor's office visit.

This targeted approach ensures that lower-income Americans can access the same health care advantages as wealthier Americans do and can choose from some of the same health care plans.

The overall impact would be a shift of health care tax benefits and medical decisions from corporations to patients.

Putting Patients in Control of Their Own Health Care with Health Savings Accounts

Individuals and families could choose a "catastrophic" or high-deductible health plan, which is an inexpensive health insurance plan that generally does not pay for the first couple thousand dollars of health care expenses but will generally cover expenses after a deductible has been reached. In these plans, leftover money not used to pay plan premiums may be deposited into a Health Savings Account (HSA), which is essentially a personal, tax-free savings account that a patient can use to pay for health care costs. You own and you control the money in your HSA. Decisions on how to spend the money are made by you, rather than by your boss or a health insurer. This means a patient can chose their own doctor and make other health care decisions without the prior approval of an insurance company. HSAs also can pay for routine health care costs that are not typically covered by traditional health insurance. For example, most health insurance does not cover the cost of over-the-counter medicines or dental and vision care**,** but HSAs can. The unused balance in a Health Savings Account automatically rolls over year after year.

If an individual selects an insurance plan that is cheaper than the value of the credit, they can keep the difference in their Health Savings Account.

Currently, Americans must pay taxes on the amount they pay to purchase health insurance. This act would allow health insurance premiums to be paid tax-free from an HSA as well as increasing the amount of tax-free dollars an individual can keep for their health care.

The Medi-Choice tax rebate will ensure universal and affordable health care coverage for all Americans with choices that they do not currently enjoy.

Reducing Costs Through Competition

Health insurance premiums have skyrocketed in recent years in large part because health insurance has evolved into "pre-paid" health care. Third parties, such as insurance companies, are paid to cover health care costs that might arise for individuals enrolled in an insurance plan.

HSAs put patients in charge of their own health care decisions and expenditures. When individual consumers own their health care dollars, they can choose their own health care providers and make their own health care decisions. This means health insurance plans and health care providers will be forced to compete for patients. This type of competition, which does not exist in the current health care system, will force health care providers to improve quality and services and ensure affordability in order to attract customers.

Meeting Patients' Specific Health Care Needs

The act would allow high-deductible health plans to cover preventive services, maintenance costs of chronic diseases, and capitated primary care services. Under a capitated plan, a physician gets paid a specified dollar amount, for a given time period, to take care of the medical needs of a specified group of patients. Under this approach, a patient with diabetes with an HSA could purchase a high deductible plan that is specifically designed to cover the needs of diabetics. The act also would allow employers to contribute greater amounts to the HSAs owned by acutely or chronically ill employees.

Creating Choices for Patients that Meet Individual Health Care Needs

The vast majority of the 45 million uninsured Americans cite the high cost of insurance as the primary barrier to accessing health coverage. They also face other significant hurdles, including limited choices of insurers, inflexible benefit options and unfair tax laws.

The high cost of insurance is increased by excessive state regulations. States have passed more than 1,800 benefit mandates, requiring insurance companies to cover services that are not medically necessary, from hair prosthesis (wigs) to acupuncturists and massage therapists. These mandates increase the cost of health insurance and contribute to the number of uninsured. For every 1 percent increase in the cost of health insurance, 300,000 people lose their coverage, according to the Congressional Budget Office (CBO). Our priority should be ensuring everyone has access to health care coverage that is affordable and best meets a patient's individual needs rather than creating a one-size-fits-all, government-run system that increases costs, red tape and the number of uninsured Americans.

Providing Patients a Diverse Selection of Health Care Plans to Meet Individual Needs

The act creates a diverse market for consumers providing patients with the opportunity to shop for insurance products that best meet their individual health needs and to purchase an affordable health insurance policy. This will create incentives for insurance companies to offer innovative and customized insurance products. Patients who have an interest in a particular benefit, such as infertility treatments or management of a chronic disease, will be able to select a policy which includes that benefit.

This act also will enable consumers to shop for health insurance the same way they do for other products and services – online, by mail, over the phone, or in consultation with an insurance agent in their hometown.

Insurance policies in one state may provide coverage for a service that a patient in another state desires but does not currently have as an option. Similar insurance policies may be cheaper in another state. For example, self-only policies range from a low of $54 in Long Beach, California, to $334 in New York City.[11] Under this act, consumers will no longer be limited to insurance plans only available in their states. Instead, patients would be able to select from the wide array of insurance policies qualified in every state. This allows consumers to choose the policy that best suits their needs, and their budget, without being limited by state boundaries.

[11] EHealthInsurance.com, '"The Most Affordable Cities for Individuals to Buy Health Insurance," June 28, 2005.

Allowing Patients to Maintain Insurance Coverage When Changing Jobs

Existing federal laws prevent employers from contributing to premiums of individually purchased insurance. In effect, this prevents patients from selecting a health plan not offered by an employer or from keeping their existing plan if they change jobs.

This act would allow employers to offer workers portable insurance as a group plan or to contribute to an insurance plan which their employee buys. This would make it easier for employees to retain insurance if they change jobs and end the "job lock" some patients with chronic health conditions experience. Job lock refers to the fear of losing an existing plan and provider network by changing jobs.

Employers would have the flexibility of contributing different amounts to different plans. This would allow employers to provide larger amounts for patients with higher premium costs because they may be older or suffer from a chronic condition.

Ensuring Health Coverage for High-Risk Individuals

State-sponsored risk pools are intended to assist those Americans who are denied health insurance coverage by private companies because of a pre-existing medical condition. Private insurers who deny coverage to individuals must pay a penalty. That penalty goes to help subsidize a pool for high risk patients so they can purchase private insurance like everyone else.

State high-risk health insurance pools are designed to serve a small, but very important segment of the individual insurance market – those few individuals who are uninsured and have a high-risk health condition, such as cancer, diabetes, heart disease or other chronic illness which causes them to be denied insurance coverage. Thirty-three states have created state high-risk health insurance programs which serve as a safety net to guarantee access to private health insurance for the otherwise uninsurable population. Enrollees pay a premium for their health insurance, and most states design their pools to make up financial shortfalls by assessing the insurance companies.

This act builds on the experience of the 33 existing state high-risk pools by encouraging all states receiving federal Medicaid dollars to set up a state-designed privately-financed reinsurance pools.

Creating Transparency of Health Care Costs and Services

The current health insurance system largely separates patients from the payment costs of health care services. Patients pay premiums and co-pays, but it is usually an insurance company, the federal or a state government, or an employer who makes the actual payments for check ups, surgery and other services that a patient may receive.

As a result, most patients have no idea what a visit to a doctor truly costs. Yet prices vary widely from physician to physician and from hospital to hospital. For example, an internist in the Cincinnati area charges insurance companies $161.32 to see a new patient with moderate to severe problems, while another physician a few blocks away charges $132.23 for the same office visit. The first doctor also charges $41.89 for a chest X-ray taken from two angles, while the latter doctor's price is $34.34. In the Milwaukee area a hip replacement may range from $20,000 to $41,800, depending on the hospital.[12] Hospitals typically charge uninsured Americans as much as three to five times what they charge those with insurance or enrolled in government programs.

This act requires hospitals and providers receiving reimbursements from Medicare to publish their estimated and actual charges for all patients. This will guarantee consumers have the tools they need to comparison-shop for health care the way that they do for cars, computers, or other products and services.

Additionally, when consumers shop for cars, blenders, or other products they can ensure they are getting the biggest "bang for their buck" by relying on a name brand they trust or by looking up products in *Consumer Reports* for independent evaluations of quality and value. By giving patients the power to choose what doctor or hospital is right for them, you could see something similar to *Consumer Reports* evaluating hospitals and physicians. A few of these patient resources exist today: *Consumers' Guide to Hospitals* or *Consumers' Guide to Top Doctors*. When patients are allowed to make decisions about their health care, more independent evaluations of physicians and hospitals will be available.

Preserving the Availability of Community Hospitals

The act would require a periodic review of Federally Qualified Health Centers located near rural hospitals to ensure that such centers, which provide government subsidized health care, do not compromise the sustainability of community hospitals.

[12] http://www.galen.org/fileuploads/Price_Transparency.pdf

Securing Medicare's Future and Increasing Senior Choice

Seniors rely on Medicare to help cover the costs of their health care needs. All workers pay taxes that partially fund the Medicare Trust Fund with the assumption the program pays for the majority of their health care needs during retirement.

The future of Medicare, however, is gravely endangered.

According to the 2006 Medicare Trustees report, the Medicate Hospital Insurance (HI) Trust Fund that pays hospital benefits exceeded revenues in 2006, and will be bankrupt by 2018. The trustees concluded the trust fund "could be brought into actuarial balance over the next 75 years by an immediate 121 percent increase in program income, or an immediate 51 percent reduction in program outlays (or some combination of the two)."[13]

Seniors will soon lose access to physician services as physician reimbursements will be cut by 10 percent in 2008 and 34 percent by the year 2015.[14] Experts project these cuts will mean 45 percent of physicians will restrict the number of Medicare patients they accept.[15]

None of these options — massive tax hikes, dramatic reductions in health care services or allowing Medicare to go bankrupt — will guarantee seniors get the care they deserve.

As designed, Medicare is susceptible to fraud and abuse and isolated from the free market forces that encourage innovation, competition, ever expanding options and affordability. The program loses $20 billion annually in erroneous and fraudulent payments. No private company could survive such losses, yet Medicare administrators are unwilling or unable to stop it.

Fortunately, there is a solution. Medicare can be modernized to make the program more efficient and less costly while protecting the access to care seniors need. Modernizing Medicare also will expand options for current recipients and future retirees. Only the market forces of personal choice and competition can solve the Medicare fiscal crisis without massive tax hikes or slashing benefits.

Reducing Government Handouts to Wealthier Americans

Wealthy Americans (with an income above $80,000, if single, or $160,000, if married) currently pay higher Medicare premiums. This income level rises annually. This act

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[13] Social Security and Medicare Boards of Trustees. "Status of the Social Security and Medicare Programs, A SUMMARY OF THE 2006 ANNUAL REPORTS,"http://www.ssa.gov/OACT/TRSUM/trsummary.html

[14] American Medical Association, "2006 AMA Member Connect Physician Survey: Physicians' Reactions to the Projected Medicare Payment Cuts," at *www.ama-assn.org/ama1/x-ama/upload/mm/468/medicarepaymentmc.pdf* (November 20, 2006).

[15] American Medical Association

would end the annual adjustment and maintain the current limits for higher premiums. This will save the Medicare program $7.1 billion over five years.[16]

Rewarding Healthy Behaviors

The act would allow premium discounts for seniors who adopt and maintain healthy behaviors. Maintaining good health reduces medical costs and, thereby, saves money for both Medicare and patients.

Promoting Health Care Excellence

The act would allow physicians to purchase certain medical equipment for their offices to deliver more convenient and cost-effective services for their patients.

Preserving Medicare while Enhancing Choices for Seniors

This act leaves traditional Medicare intact, but provides seniors additional health care options. Like younger Americans, seniors would be provided choices of various health care coverage plans under this act. Current workers also would be offered the ability to better plan and begin saving for health care coverage in their retirement years.

Competing Plans Increase Seniors' Choices, Reduce Costs and Strengthen Medicare

This act updates Medicare re-imbursement rates and encourages true competition among private plans to hold down costs. This model already is working in Medicare's prescription drug benefit program, achieving a savings of 26 percent, or $136 billion, below the Congressional Budget Office's original estimate between 2007 and 2013.[17] The result is greater choice and more affordable health care for seniors. Medicare recipients would finally have similar health care options which members of Congress and younger Americans enjoy. Seniors could choose from among the benefit designs offered to employees of Fortune 500 companies, plans that have been licensed by other states, or Health Savings Account plans. The increased flexibility in benefit design will promote innovative new products for seniors and allow Medicare recipients to choose the health care coverage that best meets their individual health care needs while reducing overall Medicare program costs.

[16] President Bush's 2008 Budget: A Brief Overview, Senator Judd Gregg, Ranking Member Senate Budget Committee

[17] Congressional Budget Office, January 24, 2007: *The Budget and Economic Outlook: Fiscal Years 2008 to 2017*

Securing Medicare for Tomorrow's Seniors

The act would allow today's workers to voluntarily invest the Medicare payroll taxes they pay into a tax-free savings account they would own. These medical retirement accounts would be administered in a similar manner as the Federal Thrift Savings Plans, which members of Congress and other federal government employees can contribute to for their retirement.

After a lifetime of saving, seniors could use the money they have accumulated in their medical retirement account to supplement the amount of the Medi-Choice tax rebate they would receive under this act and purchase the health insurance of their choice. This proposal would allow Americans to keep the same health insurance that they had during their working years.

Again, traditional Medicare coverage is preserved for those who prefer the existing plan.

Keeping Medicaid On Mission

In 1965, Medicaid was designed as a critical safety net for the poor and indigent at a cost of $1 billion. Today, Medicaid covers one out of every six Americans with a price tag of $338 billion.[18] Total Medicaid spending has more than doubled since 1995.[19]

In 2003, for the first time ever Medicaid surpassed education in consuming the largest piece of states' budgets.[20] In 2004, 21.9 percent of states' budgets were spent on Medicaid compared to 21.5 percent for education.[21]

Yet, Medicaid beneficiaries lack the same choices most Americans with private insurance enjoy. Approximately 40 percent of physicians limit the number of Medicaid patients they will see.[22] The current eligibility structure also forces individuals to choose between free health care and a better paying job — keeping Medicaid recipients with less than optimal health care.

A Commonwealth survey found that while 65 percent of Americans would prefer private coverage, only 10 percent desired Medicaid or Medicare.[23]

The current Medicaid funding structure does not target resources to the neediest Americans. Nine states receive half of the federal Medicaid money. States with the highest poverty rates, such as Louisiana, Alabama and Mississippi, received lower Medicaid payments per capita than wealthier states like New York and several New England states. Per capita Medicaid payments range from $1,736 in Nevada to $6,780 in Maine. In 2004, Wyoming received $233 *million* from the federal government while New York got $21.4 *billion*.[24] As designed, states with greater available resources can game a greater return from the federal government which means the poor in poorer states receive less federal support. This certainly is not the way a "safety net" should function.

While Medicaid spending continues to increase, waste, fraud and abuse abound in the program. For example, investigators estimate as much as $18 billion worth of abuse occurs every year in New York alone.[25]

Clearly, Medicaid dollars need to be better targeted to ensure that those who are truly needy receive the best possible health care.

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[18] Bureau of Economic Analysis
[19] Congressional Budget Office
[20] National Governor's Association
[21] http://www.boston.com/news/education/higher/articles/2006/01/19/medicaid_spending_overtakes_education/
[22] MedPAC
[23] Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey," The Commonwealth Fund, *Issue Brief*, August 2002, p.7 at http://www.cmwf.org/usr_doc/edwards_erosion.pdf.
[24] *The Medicaid Commission Report: A Dissent* by Robert Helms, January 2007
[25] *New York Times*, July 2005

Freeing States to Innovate

This act encourages states to improve Medicaid through innovations that improve quality and reduce costs.

The bill eliminates the bureaucratic red tape of the current program. Instead of federal micromanagement, states may design more-effective ways to offer the same, or improved, services to Medicaid recipients. The program would set benchmarks for states to achieve, using a similar model that has been so successful with welfare reform. States' success, for example, would be measured by the percentage of their population enrolled in private health insurance.

States could use Medicaid funds to add to a beneficiaries' federal Medi-Choice rebate of $2,000, so long as the credit is used by the individual to purchase private health insurance. Individuals who choose not to be a part of the state-designed Medicaid program could receive the value of the Medicaid services for which they are eligible to purchase health insurance in the private market.

States also could set up ways for individuals to enroll in private default catastrophic health insurance. Massachusetts has experimented with this approach in their universal health care plan.

This patient-driven approach supports the direction some states are already taking with their Medicaid programs.

Oklahoma, South Carolina and Florida are all experimenting with choice and competition to improve their Medicaid programs. Under these plans, the state gives a defined contribution to Medicaid eligible patients and helps them to choose from a menu of state-approved private health care plans.[26]

Arkansas, New Jersey and Florida were the first states to experiment with "Cash and Counseling," a project that provides certain disabled Medicaid beneficiaries a cash allowance with which to purchase needed services. The success story resulted in high levels of beneficiary satisfaction, near elimination of fraud and savings to the Medicaid program.[27]

West Virginia has some of the highest rates of diabetes, heart disease, obesity and high blood pressure in the country. The state's Medicaid program recently designed an innovative approach to change wellness behaviors and attitudes intended to reduce the prevalence and long term costs of these diseases. Beneficiaries must sign a pledge to follow healthy behaviors (such as attending health improvement programs, reading the information their doctors provide, getting regular checkups, or taking medication as directed). Patients who adhere to their pledge will receive additional Medicaid benefits

[26] http://www.heritage.org/Research/HealthCare/wm920.cfm, *They'd Sooner Fix Medicaid* by Tom Coburn and Regina Herzlinger, May 18, 2006, The Wall Street Journal
[27] http://www.heritage.org/Research/HealthCare/BG1618.cfm

such as free prescription medicine, mental health benefits, smoking reduction, and weight loss courses.[28]

Instead of a federal one-size-fits-all approach to universal health care, this act recognizes each state has unique needs and challenges that need to be recognized and addressed in order to achieve health care coverage for every citizen. In fact, some states already are trailblazing solutions.

Massachusetts recently enacted landmark reform for universal health care that included a statewide insurance purchasing exchange, income-based subsidies to buy private coverage, and a personal responsibility mandate.

[28] http://www.heartland.org/Article.cfm?artId=20604

Coordinated Care for Patients Eligible for Both Medicare and Medicaid

Almost 7.5 million Medicaid recipients (14 percent) also are eligible for Medicare. These "dual-eligibles" account for 40 percent of Medicaid spending.[29] On average, total spending for duals, including Medicare and Medicaid contributions, is more than twice as high as that for non-duals – $20,840 compared to $10,050.[30] Most dual-eligibles have very low incomes, substantial health needs, and are more likely to live in nursing homes compared to other Medicare beneficiaries. Long-term care services account for the majority (66 percent) of Medicaid expenditures for dual-eligibles.

Dual-eligibles are Medicaid's most vulnerable recipients, yet they often fall into a fragmented care delivery system that fosters episodic rather than coordinated care. Patients may have difficulty accessing the medical care they need, and information about their care can be scattered among providers and facilities facing two or more different payment systems and sets of program rules.

Because physicians and others treating these patients often do not have the patient's complete medical profile, patients can face gaps as well as duplication in treatments with no one to help coordinate their care. In addition, providers are paid for procedures, regardless of outcomes and without incentives to improve quality.

Coordinating Coverage to Ensure Improved Care

This act promotes better coordination of care, by combining funding sources, that integrates Medicare and Medicaid coverage to allow providers to focus on the best way to design and provide benefits to dual-eligible beneficiaries. This will better ensure that these seniors receive the right care in the right setting.

Providing Assistance to Those Most in Need

This act replaces the current Medicaid funding scheme that rewards the wealthiest states rather than the neediest patients, with a formula that ensures federal dollars are targeted to the states and individuals who need assistance most. Funding would be allocated based on state per capita income, population, number of dual-eligibles, and number of disabled. This would ensure that those most in need receive assistance.

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[29] Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries." Kaiser Commission on Medicaid and the Uninsured. July 2005. http://www.kff.org/medicaid/upload/4091-04%20Final(v2).pdf

[30] Report to the Congress: New Approaches in Medicare." See Chapter 3, "Dual-eligible beneficiaries: An overview." The Medicare Payment Advisory Commission. June 2004. http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf

Increasing the Efficiency and Security of Medical Records

Every doctor's office contains shelves and shelves of color-coded folders containing valuable and private medical information. Every time you visit your doctor, a nurse must record the same health and family history that you shared the last time you visited the same doctor. It can take months for the insurance company to pay your doctor after you have gone for a check up. Instead of money going to pay for treatment, dollars get caught up in the administrative quagmire that exists under our outdated medical information system. It is little wonder that one out of four health care dollars does not help anyone get well. What if all health information was computerized and readily available — just like the rest of the American economy?

This act proposes adopting the same model used by the financial services industry in promoting the use of automated teller machines (ATMs). Every American could get a card – just like their ATM card — that would maintain their insurance and medical history information from an independent health record bank. Every time you visit your doctor, you would swipe the card for instant access to your medical history and insurance payment information. The potential annual savings from use of health information technology is estimated to be $162 billion annually.[31] More importantly, the better information about medical histories can improve medical outcomes and even save lives.

The legislation would provide the charter for creating member-owned Independent Health Record Bank accounts that are operated cooperative institutions (much like member-owned credit unions are in the financial services industry). Medical information would adhere to strict privacy guidelines.

[31] Rand Corporation

Ensuring Compensation for Injured Patients and Quality Care for All

There is a medical liability crisis in our country, and it affects virtually everyone. Frivolous lawsuits and excessive verdicts increase health care costs and result in reduced access to care. The crisis has two components.

The first component is the financial burden on health care providers. Instead of offering you lower prices for their services, American doctors pay as much as $126 billion to protect themselves from lawsuits.

The second component is the negative effect on patients. The costs doctors must pay to purchase medical malpractice insurance drives up the cost of care for patients. Furthermore, doctors perform unnecessary medical tests on patients, not for the patient's benefit, but for the doctors' benefit to protect themselves from potential lawsuits. The high costs of "defensive medicine" and litigation cause patient care to suffer. When the cost of insurance becomes too high, many doctors relocate or retire prematurely, thereby reducing patients' access to care. Additionally, studies suggest that a great majority of injured patients do not seek claims,[32] and when they do, relief is often not available for years.

These two components are intertwined. Because the medical liability system is so threatening, medical professionals spend between $70 billion and $126 billion per year on defensive medicine.[33] In other words, physicians order unnecessary tests because they fear being sued. This money should be spent on better patient care. Additionally, many doctors can no longer afford their malpractice insurance and are leaving the medical field or are avoiding specialized practices.[34] Finally, the litigation system discourages doctors from acknowledging any wrongdoing, and often discourages injured patients from pursuing claims because of the length and difficulty of the process. So, doctors do not learn from their mistakes, and many injured patients suffer without compensation.

The solution traditionally offered to this crisis is some form of tort reform (lawsuit reform) that would allow injured patients to receive damages, but would cap the amount. States have begun to explore other options that are more capable of addressing the second component of this problem – patient care and compensation.

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[32] *See* David M. Studdert et al., "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *The New England Journal of Medicine*, Vol. 350, No. 19 (May 11, 2006) at http://www.hsph.harvard.edu/faculty/articles/litigation.pdf.

[33] Medical Liability Reform-NOW!: A compendium of facts supporting medical liability reform and debunking arguments against reform. *American Medical Association* July 19, 2006, at http://www.ama-assn.org/ama1/pub/upload/mm/-1/mlrnow.pdf.

[34] *See Id*.

Establishing Health Courts to Remedy Patient Injuries

Under this act, the federal government would financially assist states to establish an Administrative Health Care Tribunal, or "health courts." These health courts will offer injured patients the opportunity to receive compensation quickly, without ultimately losing their access to courts. At the same time, this act will help states ensure the accessibility of care for everyone by stopping the rising costs of medical malpractice litigation in this country. The health court is entirely run by the state, not the federal government, enabling each state to tailor its health court system to its own needs.

Establishing Independent Health Courts to Resolve Medical Disputes

Medical malpractice trials often become a "battle of the experts." Each party hires an expert to testify, and the most convincing expert gains the trust of the jury. Under this act, states will ensure experts continue to play a pivotal role in malpractice cases. Instead of the opposing parties picking their own experts, however, the head of the state agency responsible for health will appoint a panel of six independent experts to review each case before it goes to the State Administrative Health Care Tribunal. Three of the experts will be attorneys, who can bring an understanding of the law relating to the injuries alleged in each dispute. The other three experts will be medical professionals who are particularly qualified to evaluate the type of alleged injury.

The expert panel will reach a determination about whether a health care provider is responsible for a patient's injury, and if so, what penalty is appropriate. If both the health care provider and patient are satisfied with the decision, they can accept it and end the dispute. Such a swift resolution stands in stark contrast to the months or even years of hearings, trials, and appeals that are currently necessary for a patient to receive compensation for their injuries.

Involving a Qualified Judge and Preserving Access to State Courts

If either party to a malpractice suit is unhappy with the result, they can request a hearing before a State Administrative Health Care Tribunal. Each health court will be presided over by a judge with health care expertise, who can make the same binding rulings that a state court can make. This health court can commission experts and consider the recommendation made by the expert panel.

The health court makes a final, binding determination as to liability and compensation. Even at this point in the process, the parties will receive a much swifter resolution than if they had pursued their case in state court.

Nonetheless, if either party is not satisfied with the health court's decision, this act explicitly provides that the states receiving federal funds must allow parties to have

access to state court to appeal the decision. Also, states may not preclude any party to a dispute from having legal representation at any point in the proceedings.

Health courts encouraged under this act create a fair and efficient system. To encourage parties to rely on the health courts, parties that appeal to state courts, but are not satisfied with the state court's decision, forfeit the ability to receive compensation previously awarded by the health court.

Ensuring that Veterans Get the Care They Deserve

Veterans, who have made the greatest of sacrifices for all Americans, deserve the best medical care available at the doctor and hospital that is closest to their home and loved ones. This Act directs the Secretary of the Veterans Administration to allow just that right. Competition from private facilities will also ensure that VA facilities provide the best medical care possible for our great American heroes.

Giving Choice to American Indians

The secretary of the Indian Health Service would have the ability to set up a system for eligible American Indians to access medical care outside of the Indian Health Service facilities. Not only will this give American Indians more choice in where they receive medical care, it will challenge Indian Health facilities to provide the best care possible to American Indians.