

House Health Care Bill Summary and Discussion

The Health Care Law Creates Jobs

- The health care law makes key investments in health care jobs. The health care law makes critical investments to alleviate the shortage of primary health care providers, including physicians, physician assistants, and nurses. As a first step, in June 2010, funding was released by HHS to support the training of more than 16,000 new primary care providers, including doctors and nurses, over the next five years.

- By lowering costs, especially for small businesses, the law can help create jobs. A study by Harvard Economics Professor David Cutler and USC Health Policy Professor Neeraj Sood found that, because of numerous cost-containment measures that slow the growth of health care spending, the law could create between 250,000 and 400,000 jobs a year over the next 10 years. The cost-reduction provisions in the law, particularly for small businesses, free up money that otherwise would be spent on health care and allow companies to spend it hiring more workers.

- Despite Republican claims that health reform would destroy jobs, 1.4 million private sector jobs have been created since the health care law was enacted in March 2010. In sharp contrast, under the eight years of President Bush, we lost private sector jobs - losing a total of 673,000 private sector jobs.

- Despite Republican claims that health reform would hurt the health care industry, of the 1.4 million private sector jobs created since the health care law was enacted, 243,000 of them have been in the health care industry.

[Link to H.R. 3962 - Affordable Health Care for America Act as Introduced](#)

http://docs.house.gov/rules/health/111_ahcaa.pdf

SHORT SUMMARY

The Affordable Health Care for America Act provides quality affordable health care for all Americans and controls health care cost growth. CBO estimates that it will provide coverage to 96% of Americans, that it does so under the \$900 billion threshold outlined by President Obama, and that it reduces the deficit within the budget window and beyond. Key provisions of the legislation include:

- * COVERAGE AND CHOICE
- * AFFORDABILITY
- * SHARED RESPONSIBILITY
- * PREVENTION, WELLNESS AND PUBLIC HEALTH
- * WORKFORCE INVESTMENTS
- * CONTROLLING COSTS

I. COVERAGE AND CHOICE:: The bill builds on what works in today's health care system and fixes the parts that are broken. It protects current coverage allowing individuals to keep the insurance they have if they like it and preserves choice of doctors, hospitals, and health plans. It achieves these reforms through:

* Immediate reforms. Includes immediate reforms to improve today's health care system as we implement full-scale health reform. These improvements include the creation of a new national program to provide affordable coverage for those who can't get health insurance today because of pre-existing conditions (including the use of domestic violence as a pre-existing condition); implementation of insurance reforms to enforce an 85% medical loss ratio, coverage of young adults on their parents' policies through age 26, limits on pre-existing condition exclusions, protections for treatments for children with deformities; implementation of new programs to protect retiree health benefits; enactment of administrative simplification; and creation of a new federal grant incentives for wellness programs and early advancement of reform by states.

* Health Insurance Exchange. The new Health Insurance Exchange (starting in 2013) creates a transparent and functional marketplace for individuals and small employers to comparison shop among private and public insurers, including new health insurance co-ops. It works with state insurance departments to set and enforce insurance reforms and consumer protections, facilitates enrollment, and administers affordability credits to help low- and middle-income individuals and families purchase insurance. Within three years, the exchange will be open to employers with 100 employees as another choice for covering their employees. Over time, more employers will obtain that option. States may opt to operate the Exchange in lieu of the national Exchange provided they follow the federal rules.

* A Public Health Insurance Option. One of the many choices of health insurance within the Health Insurance exchange

is a public health insurance option. It will be a new choice in many areas of our country dominated by just one or two private insurers today. The public option will operate on a level playing field. It will be subject to the same market reforms and consumer protections as other private plans in the exchange and it will be self-sustaining financed only by its premiums. The Secretary of Health and Human Services will administer the public option and negotiate rates for providers that participate in the public option. The public health insurance option is provided startup administrative funding, but it is required to amortize these costs into future premiums. Providers are presumed to be participants in the public option unless they opt-out of participating.

* Guaranteed coverage and insurance market reforms. Insurance companies will no longer be able to engage in discriminatory practices that enable them to refuse to sell or renew policies today due to an individual's health status. In addition, they can no longer exclude coverage of treatments for pre-existing health conditions. The bill also protects consumers by prohibiting lifetime and annual limits on benefits. It also limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors. Under the proposal, premiums can vary based only on age (no more than 2:1), geography and family size.

* Essential benefits. A new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General, will recommend a benefit package based on standards set in the law. This new essential benefit package will serve as the basic benefit package for coverage in the Exchange and over time will become the minimum quality standard for employer plans. The basic package will include preventive services with no cost-sharing, mental health services, oral health and vision for children, and caps on the amount of money a person or family spends on covered services in a year. Within the Exchange, there will be four plan levels all of which cover the essential benefit package, but have varied levels of cost-sharing. The Premium Plus plans will offer additional benefits such as adult dental or vision and private hospital rooms.

* Ending the Antitrust Exemption for Health Insurers. By eliminating the antitrust exemption for health insurers and medical malpractice insurers, the bill increases competition in the insurance marketplace. It will remove their shield that has allowed them to price fix, divide up territory, and effectively create monopolies in particular markets.

* Helping address long-term health care needs. Creates a new, voluntary, public, long-term care insurance program to help purchase services and supports for people who have functional limitations. Individuals determined to need assistance because of functional limitations would qualify to receive a daily or weekly cash benefit to help purchase the services and supports needed to maintain personal and financial independence. CLASS would supplement, not supplant, traditional payers of long-term care (e.g. Medicaid and/or private long term care insurance).

II. AFFORDABILITY: To ensure that all Americans have affordable health coverage the bill:

* Provides sliding scale affordability credits. The affordability credits will be available to low- and moderate income individuals and families. The credits are most generous for those who are just above the proposed new Medicaid eligibility levels; the credits decline with income (so premium and cost-sharing support is more limited as your income increases) and are completely phased out when income reaches 400 percent of the federal poverty level (\$43,000 for an individual or \$88,000 for a family of four). The affordability credits will make insurance premiums affordable and will reduce cost-sharing to levels that ensure access to care. The Exchange administers the affordability credits with other federal and state entities, such as local Social Security offices and state Medicaid agencies.

* Caps annual out-of-pocket spending. Will cap annual out-of-pocket spending at a maximum of \$5,000 per individual and \$10,000 per family to prevent bankruptcies from medical expenses.

* Increased competition. The creation of the Health Insurance Exchange and the inclusion of a public health insurance option and health insurance co-ops will make health insurance more affordable by opening many market areas in our country to new competition, spurring efficiency and transparency.

* Expands Medicaid. Individuals and families with incomes at or below 150% percent of the federal poverty level will be eligible for an expanded and improved Medicaid program. Recognizing the budget challenges in many states, this expansion will initially be fully federally financed then transition to include a 9% contribution from states starting in 2015. To improve provider participation in this vital safety net particularly for low-income children, individuals with disabilities and people with mental illnesses reimbursement rates for primary care services will be increased to Medicare rates with new federal funding.

* Improves Medicare. Senior citizens and people with disabilities will benefit from provisions that fill the donut hole over time in the Part D drug program, eliminate cost-sharing for preventive services, improve the low-income subsidy programs in Medicare, increase access to primary care providers, and make other program improvements. The bill will also address future fiscal challenges by improving payment accuracy, encouraging delivery system reforms and extending solvency of the Medicare Trust Fund. Companion legislation will permanently reform Medicare's payment formula for physicians.

III. SHARED RESPONSIBILITY: The bill creates shared responsibility among individuals, employers and government to ensure that all Americans have affordable coverage of essential health benefits.

* Individual responsibility. Except in cases of hardship, once market reforms and affordability credits are in effect, individuals will be responsible for obtaining and maintaining health insurance coverage. Those who choose to not obtain coverage will pay a penalty capped at 2.5 percent of modified adjusted gross income above a specified level.

* Employer responsibility. The proposal builds on the employer-sponsored coverage that exists today. Employers will have the option of providing health insurance coverage for their workers or contributing funds on their behalf. Employers that choose to contribute will pay an amount based on a percent of their payroll. Employers that choose to offer coverage must meet minimum benefit and contribution requirements specified in the proposal.

* Assistance for small employers. Recognizing the special needs of small businesses, the smallest businesses (payroll that does not exceed \$500,000) are exempt from the employer responsibility requirement. The payroll penalty would then phase in starting at 2% for firms with annual payrolls over \$500,000 rising to the full 8 percent penalty for firms with annual payrolls above \$750,000. In addition, a new small business tax credit will be available for two years for low-wage, small firms who choose to provide health coverage to their workers. In addition to the targeted assistance, the Exchange and market reforms provide a long sought opportunity for small businesses to benefit from a more organized, efficient marketplace in which to purchase coverage.

* Government responsibility. The government is responsible for ensuring that every American can afford quality health insurance, through the new affordability credits, insurance reforms, consumer protections, and improvements to Medicare and Medicaid.

IV. PREVENTIION, WELLNESS AND PUBLIIC HEALTH: Prevention and wellness measures of the bill

include:

* Community Health Centers. Funding for community health centers is significantly increased, allowing for the creation of new centers and growth in the number of people served.

* Prohibition of cost-sharing for preventive services. Cost sharing requirements in the essential benefits package, Medicare and Medicaid are specifically prohibited.

* Community-based programs. New programs are established to deliver prevention and wellness services at the community level and to support grants to small businesses that promote wellness programs.

* Prevention research. A dedicated funding source is created to support research on clinical and community preventive health services to determine which services are most effective.

* Data Collection. New data collection efforts are required to better identify and address racial, ethnic, regional and other health disparities.

* Public Health Infrastructure. New investments are made to strengthen state, local, tribal and territorial public health departments and programs.

V. WORKFORCE INVESTMENTS: The bill expands the health care workforce through:

* National Health Service Corps (NHSC). Increased funding and greater flexibility in meeting service requirements are provided for the National Health Service Corps.

* Building the nation's health workforce. Increased funding and other improvements are made to programs targeted on training primary care doctors. Similar expansions are made to encourage more health professionals, including nurses, to choose primary care. A new Public Health Service Corps (modeled on the NHSC) is created to ensure an adequate and qualified public health workforce.

* Workforce diversity. Greater support is provided for workforce diversity programs to help ensure that the nation's health workforce reflects the population it serves.

* Scholarship and loan repayment programs. Scholarships and loan repayment programs for individuals in needed health professions and shortage areas are expanded.

* Training for primary care physicians. Puts in place steps to increase physician training outside the hospital, where most primary care is delivered, and redistributes unfilled graduate medical education residency slots for purposes of training more primary care physicians. The proposal also improves accountability for graduate medical education funding to ensure that physicians are trained with the skills needed to practice health care in the 21st century.

VI. CONTROLLING COSTS: The bill reduces the deficit and will reduce the growth in health care spending in a numerous ways. Specifically, it invests in health care through stronger prevention and wellness measures; increases access to primary care; implements health care delivery system reforms; creates a Health Insurance Exchange and a

new Public Health Insurance Option; improves Medicare payment accuracy and makes additional reforms to Medicare and Medicaid -- all of which will help slow the growth of health care costs over time. These savings will accrue to families, employers, and taxpayers.

* Modernization and improvement of Medicare. The bill implements major delivery system reform in Medicare to reward efficient health care, rolling out innovative concepts such as accountable care organizations, medical homes, and bundling of acute and post-acute provider payments. New payment incentives aim to decrease preventable hospital readmissions, expanding this policy over time to recognize that physicians and post-acute providers also play an important role in avoiding readmissions. The bill improves the Medicare Part D program by creating new consumer protections for Medicare Advantage Plans, eliminating the "donut hole" and improving low-income subsidy programs, so that Medicare is affordable for all seniors and other eligible individuals.

* Innovation and delivery reform through the public health insurance option. The public health insurance option will be empowered to implement innovative delivery reform initiatives so that it is a nimble purchaser of health care and gets more value for each health care dollar. It will expand upon the experiments put forth in Medicare and be provided the flexibility to implement value-based purchasing, accountable care organizations, medical homes, and bundled payments. These features will ensure the public option is a leader in efficient delivery of quality care, spurring competition with private plans.

* Improving payment accuracy. The bill eliminates overpayments to Medicare Advantage plans and improves payment accuracy for numerous other providers, following recommendations by the Medicare Payment advisory Commission and the President. These steps will extend Medicare Trust Fund solvency, and put Medicare on stronger financial footing for the future.

* Preventing waste, fraud and abuse. New tools will be provided to combat waste, fraud and abuse within the entire health care system. Within Medicare, new authorities allow for pre-enrollment screening of providers and suppliers, permit designation of certain areas as being at elevated risk of fraud to implement enhanced oversight, and require compliance programs of providers and suppliers. The new public health insurance option and Health Insurance Exchange will build upon the safeguards and best practices gleaned from experience in other areas.

* Administrative simplification. The bill will simplify the paperwork burden that adds tremendous costs and hassles for patients, providers, and businesses today.

[Link to Managers Amendment on HR3962](#)

http://docs.house.gov/rules/health/111_hr3962_dingell.pdf

SUMMARY OF MANAGER'S AMENDMENT

The manager's amendment provides for several changes to the bill, including the following:

- Establishes a process for the review and public disclosure of health insurance premium increases and justifications for those increases by the Secretary of Health and Human Services and states beginning in 2010. Permits the Commissioner of the Health Insurance Exchange, beginning in 2013, to take into consideration excessive and unjustified premium increases in making decisions regarding which insurance companies will be permitted into the exchange and how quickly to open the exchange to employers for the purchase of insurance for their employees. Provides a total of \$1 billion in funding for states for this process over the period 2010 to 2014.

- Repeals the McCarran-Ferguson Act insurance antitrust exemption with respect to health insurance and medical malpractice insurance.

- Authorizes the Federal Trade Commission to investigate insurance companies that are registered as not-for-profit companies.

- Directs the HHS Secretary to work with states that have alternative programs to state high risk pools as a part of the new National High-Risk Pool program for people who can't get health insurance in today's marketplace.

- Amends the National High-Risk Pool to make those early retirees whose premium increases are excessive eligible for the new program.

- Prohibits undocumented individuals from accessing financial assistance from the national high risk pool program with requirements for verification of citizenship or lawful presence.

- Requires that the Medicare fraud and abuse phone number be printed prominently on beneficiaries' Explanation of

Benefits forms.

- Imposes a 90-day waiting period for new durable medical equipment suppliers to be paid if the HHS Secretary believes there is a risk for fraud.
- Establishes a new public health program on mental health and substance abuse screening, intervention, referral, and recovery services.
- Provides for the development of quality indicators for Alzheimer's care.
- Provides for diabetes screening collaboration and outreach through the Department of Health and Human Services in collaboration with the Centers for Disease Control and Prevention.
- Codifies the Office of Minority Health within the Office of the HHS Secretary and establishes satellite minority health offices in various HHS agencies.
- Clarifies that states may reimburse nursing homes for costs incurred in conducting background checks on potential employees.
- Provides a special rule for the expansion of certain physician-owned hospitals that consistently treat the highest percentage of Medicaid patients in their communities.
- Changes the effective date for a payment change for skilled nursing facilities from January 1, 2010 to April 1, 2010.
- Imposes performance assessment and accountability measures on the Health Choices Administration, including requirements for improving customer service and streamlining redundant rules, regulations, and procedures.
- Permits a qualified health benefits plan to provide coverage through a qualified direct primary care medical home plan.
- Repeals the worldwide interest allocation rules.
- Closes down the loophole that allows unprocessed fuels (like black liquor) to claim the \$1.01 producers credit.
- Makes clarifications to the interstate insurance compacts that require the Secretary of Health and Human Services to develop model guidelines for compacting states, ensures that the interstate insurance compacts do not override state laws governing rate review and fraud, and makes clear that the compacting states determine which of the compacting state's laws serve as primary for the insurance company.

-Delays implementation of the provision that would eliminate the ability of employers to deduct Federal subsidies with respect to prescription drug benefits provided to retirees by two years.

-Clarifies that the business/consumer purchasing collaborative provided for in the early access health grants is a non-profit business collaborative.

-Requires HHS Secretary to conduct a study to determine the existence of duplicative HHS programs and establishes a process for the elimination of any such program.

H.R. 3961 - Medicare Physician
Payment Reform Act of 2009

http://docs.house.gov/rules/health/111_sgr1.pdf

COMPANION LEGISLATION TO HEALTH REFORM

As the House considers the Affordable Health Care for America Act, it will also take up legislation to permanently reform the way Medicare pays physicians. The legislation will repeal a 21 percent fee reduction scheduled for January 2010 and replace it with a stable system that ends the cycle of threats of ever-larger fee cuts followed by short-term patches. Permanent reform of physician payments in Medicare will guarantee that Medicare beneficiaries continue to enjoy the excellent

access to care that they do today. It will also follow the President's lead by ending a budget gimmick that artificially reduces the deficit by assuming physician payments will be cut by 40 percent over the next several years even though Congress has consistently intervened to

prevent those cuts from occurring.

PERMANENT PHYSICIAN PAYMENT REFORM

Preserves seniors' access to their doctors with a guaranteed update in 2010. Replaces the pending 21 percent fee cut with an update for 2010 based on the Medicare economic index while a new payment system is being put in place.

Fairer growth targets to keep doctors' pay steady. Wipes away accumulated deficits from current spending targets to provide for a fresh start, but still holds physicians accountable for spending

growth. Excludes items not paid under the Medicare physician fee schedule such as chemotherapy drugs and laboratory services from revised growth targets.

Promotes primary care that can keep you healthier longer. Provides an extra growth allowance for primary care services to promote access to primary care practitioners in Medicare and throughout the health care system.

Encourages integrated care so your doctors communicate on your care. encourages the formation of Accountable Care Organizations which incentivize physicians to take responsibility for improving quality and reducing costs. Accountable Care Organizations may "opt out" of the national spending targets and establish their own organization-specific targets.

FISCAL RESPONSIBILIITY

The Medicare Physician Payment Reform legislation will be considered in the House under a procedure which will add the text of H.R. 2920, the statutory PAYGO Act of 2009, as passed by the House on July 22nd before being sent to the Senate. The "pay as you go" principle of budget

discipline requires Congress to find a way to pay for any new spending, outside of an economic crisis. The Statutory PAYGO Act would make that principle law. A previous Congress established the policy for paying Medicare doctors, so the update for 2010 is not a new policy to be paid for. The Statutory PAYGO Act would apply this principle to all new tax and spending policies, and would allow Congress to exclude the impact of continuing policies currently in place, including Medicare payments to physicians. The Medicare Physician Payment Reform Act would not increase total payments to physicians above what they are today and therefore, would not be subject to the paygo requirement.

House Health Care Bill HR3200 Summary and Discussion

Updated October 8, 2009

The legislation is consistent with President Obama's overall goals of building on what works within the current health care system by strengthening employer-provided care, while fixing what is broken. The bill will ensure that 97 percent of Americans will be covered by a health care plan that is both affordable and offers quality, standard benefits. The House Committees on Education and Labor, Ways and Means, and Energy and Commerce worked together in an unprecedented way as one committee to develop the proposal for health care reform.

The key principles of legislation include, among other things:

Increasing choice and competition. First, the bill will protect and improve consumers's choices.

- If an individual likes their current plan, they will be able to keep it.
- For individuals who either aren't currently covered, or wanted to enroll in a new health care plan, the proposal will establish a health care exchange where consumers can select from a menu of affordable, quality health care options: either a new public health insurance plan or a plan offered by private insurers. People will have similar choices that members of Congress have.
- This new marketplace will reduce costs, create competition that leads to better care for every American, and keep private insurers honest. Patients and doctors will have control over decisions about their health care, instead of insurance companies.

Giving Americans peace of mind. Second, the legislation will ensure that Americans have portable, secure health care plans — so that they won't lose care if their employer drops their plan or they lose their job.

- Every American who receives coverage through the exchange will have a plan that includes standardized, comprehensive and quality health care benefits.
- It will end increases in premiums or denials of care based on pre-existing conditions, age, race, or gender.
- The proposal will also eliminate co-pays for preventative care, cap out-of-pocket expenses, and guarantee catastrophic coverage that protects every American from bankruptcy.

Improving quality of care for every American. Third, the legislation will ensure that Americans of all ages, from young children to retirees have access to greater quality of care by focusing on prevention, wellness, and strengthening programs that work.

- Guarantees that every child in America will have health care coverage that includes dental and vision benefits.
- Provides better preventative and wellness care. Every health care plan offered through the exchange will cover preventative care.
- Grows the health care workforce to ensure that more doctors and nurses are available to provide quality care as more Americans get coverage.
- Strengthens Medicare and Medicaid so that seniors and low-income Americans receive better quality of care and see lower prescription drug costs and out-of-pocket expenses.

Ensuring shared responsibility. Fourth, the bill will ensure that individuals, employers, and the federal government all share responsibility for a quality and affordable health care system.

- Employers who currently offer coverage will be able to continue offering coverage to workers. Employers who don't currently offer coverage could choose to cover their workers or pay a penalty.

- All individuals would be required to get coverage, either through their employer or the exchange, or pay a penalty.

- The federal government will provide affordability credits, available on a sliding scale for low- and middle-income individuals and families to make premiums affordable and reduce cost-sharing.

Protecting consumers and reducing waste, fraud, and abuse. Fifth, the legislation will put the interests of consumers first, protect them from any problems in getting and keeping health care coverage, and reduce waste, fraud, and abuse.

- Provides complete transparency in plans in the health exchange so that consumers have the clear, complete information needed to select the plan that best meets their needs.
 - * Establishes Consumer Advocacy Offices as part of the exchange in order to protect consumers, answer questions, and assist with any problems related to their plans.

- Will identify and eliminate waste, fraud, and abuse by simplifying paperwork and other administrative burdens. Patients, doctors, nurses, insurance companies, providers, and employers will all encounter a streamlined, less confusing, more consumer friendly system.

Some common myths about the Health Care Reform bill and Medicare:

MYTH: Medicare Advantage plans run by private insurance companies have been able to provide better value to U.S. taxpayers than traditional Medicare.

FACT: According to the nonpartisan Medicare Payment Advisory Commission, U.S. taxpayers pay 14 percent more on average to private Medicare Advantage plans to cover Medicare beneficiaries than it would cost traditional Medicare to cover them.

These overpayments to private insurers were created in the Medicare Modernization Act, which the Republican-controlled Congress passed in 2003 and President George W. Bush signed into law.

When the Medicare Advantage program was created, insurance companies said that they would offer coverage for less than it was costing the government under traditional Medicare to provide the same services. Today, this promise has been broken and the taxpayers are paying the price - these Medicare Advantage plans are receiving 14 percent more.

On average, this giveaway to private insurers costs an extra \$1,000 per enrollee. This adds up to an extra \$12 billion a year-and that cost is passed on to all Medicare beneficiaries.

The nonpartisan Medicare Payment Advisory Commission has recommended phasing out these overpayments to Medicare Advantage - which is what the America's Affordable Health Choices Act does.

MYTH: The overpayments to private Medicare Advantage plans mean better coverage for seniors.

FACT: Very little of the extra money going to private plans under Medicare Advantage goes to beneficiaries. Most of these taxpayer funds are used to pad the profit margins of private insurers.

According to a study by the Robert Wood Johnson Foundation, only 14 cents for every extra dollar given to Medicare Advantage (MA) plans end up translating into additional benefits. The other 86 cents goes into the pockets of the insurance companies.

The independent Medicare Payment Advisory Commission notes that the quality of care of traditional Medicare users and MA users are fairly similar -- while MA users actually reported more problems accessing specialists.

MYTH: The current system of Medicare Advantage plans, despite the overpayments, is a good investment for everyone - including America's seniors.

FACT: Everyone pays the price for these overpayments - including the 77 percent of Medicare beneficiaries who are enrolled in traditional Medicare. According to the Chief Actuary for the Medicare program, seniors in traditional Medicare pay higher premiums to subsidize Medicare Advantage plans - a typical couple paying an additional \$90 a year.

The Chief Actuary has also stated that the overpayments to the Medicare Advantage program speeds up the depletion of the Medicare trust fund by 18 months and threatens the long-term solvency of Medicare.

MYTH: Enactment of the House health insurance reform bill will mean the elimination of private Medicare Advantage plans.

FACT: The House health insurance reform bill does not eliminate Medicare Advantage plans - instead, it simply phases out the overpayments going to these plans. Indeed, the Congressional Budget Office projects that most private Medicare Advantage plans would continue to operate, once the current overpayments are phased out.

Under the House bill, Medicare Advantage plans that are able to operate efficiently and provide extra value to their enrollees through care coordination will continue to flourish.

MYTH: Enactment of the House health insurance reform bill will lead to worse health care coverage for Medicare Advantage enrollees.

FACT: As was seen above, most of the extra money going to private plans under Medicare Advantage - which the House bill phases out - does not go to seniors for additional benefits. According to the study by the Robert Wood Johnson Foundation, 86 percent of this extra money simply goes into the pockets of the insurance companies. Hence, the phasing out of these overpayments will mostly impact insurers' extra profits - and not seniors.

Additionally, the House bill makes reforms to Medicare Advantage that will improve the coverage of care for seniors enrolled in those plans. Currently, some Medicare Advantage plans offer lower cost-sharing for drugs and vision care but higher cost-sharing for services such as hospitalizations and home health services. As a result, seniors can end up spending more out-of-pocket under a Medicare Advantage plan, not less.

The House bill contains key provisions that limit cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage - which can end up saving seniors enrolled in certain Medicare Advantage plans thousands of dollars.

How the Health Care Reform bill will impact the 7th Congressional District of Illinois

America's Affordable Health Choices Act would provide significant benefits in the 7th Congressional District of Illinois: up to 13,600 small businesses could receive tax credits to provide coverage to their employees; 5,100 seniors would avoid the donut hole in Medicare Part D; health care providers would receive payment for \$404 million in uncompensated care each year; and 103,000 uninsured individuals would gain access to high-quality, affordable health insurance.

- Help for small businesses. Under the legislation, small businesses with 25 employees or less and average wages of less than \$40,000 qualify for tax credits of up to 50% of the costs of providing health insurance. There are up to 13,600 small businesses in the district that could qualify for these credits.
- Help for seniors with drug costs in the Part D donut hole. Each year, 5,100 seniors in the district hit the donut hole and are forced to pay their full drug costs, despite having Part D drug coverage. The legislation would provide them with immediate relief, cutting brand name drug costs in the donut hole by 50%, and ultimately eliminate the donut hole.
- Relieving the burden of uncompensated care for hospitals and health care providers. In 2008, health care providers in the district provided \$404 million worth of uncompensated care, care that was provided to individuals who lacked insurance coverage and were unable to pay their bills. Under the legislation, these costs of uncompensated care would be virtually eliminated.
- Coverage of the uninsured. There are 123,000 uninsured individuals in the district, 20% of the district. The Congressional Budget Office estimates that nationwide, 97% of all Americans will have insurance coverage when the bill takes effect. If this benchmark is reached in the district, 103,000 people who currently do not have health insurance will receive coverage.
- No deficit spending. The cost of health care reform under the legislation is fully paid for: half through making the Medicare and Medicaid program more efficient and half through a surtax on the income of the wealthiest individuals. This surtax would affect only 7,400 households in the district. The surtax would not affect 97.3% of taxpayers in the district.

This analysis is based upon the following sources: the Gallup-Healthways Survey (data on the uninsured); the U.S. Census (data on small businesses); the Centers for Medicare and Medicaid Services (data on the Part D donut hole, health care-related bankruptcies (based on analysis of PACER court records), and uncompensated care); and the House Committee on Ways and Means (data on the surtax).

COSTS OF INACTION:

Last year, more than half of all Americans postponed medical care or skipped their medication because they couldn't afford it.

- The total cost of health care for the American family is project to INCREASE \$1,800 EVERY YEAR.
- Monthly premiums continue to rise at three times the rate of wages.

- The average American family already pays \$1,100 more a year to cover the cost of 50 million uninsured Americans.
- More and more small businesses are forced to choose between covering their employees and staying afloat.
- State and local governments' skyrocketing health costs are crowding out spending on services like public safety and schools.
- Growth in Medicare and Medicaid continues to be the number one driver of crushing long-term federal budget deficits.

10 Principles Guiding the Merger of the Three House Committee Versions of the HR3200 Base Bill

1. **ENDS INSURANCE COMPANY DISCRIMINATION**-America's Affordable Health Choices Act will stop insurance companies from denying coverage to Americans with pre-existing conditions such as heart disease, cancer or diabetes and from hiking up rates or dropping coverage for those who get sick.

2. **MAKES COVERAGE MORE AFFORDABLE**-The House bill will rein in rising health costs for American families and small businesses-introducing competition that will drive premiums down, capping out-of-pocket spending, ensuring no more copays for preventive care, ensuring no yearly caps on what the insurance company will cover, and providing premium subsidies for those who need them. For small businesses, tax credits will help them cover their workers and eliminating health status rating means they won't pay higher premiums based on their employees' health status.

3. **IMPROVES CHOICE AND COMPETITION**-In most states today, one insurance company controls nearly half the market. To increase competition and keep insurance companies honest, the House bill provides those who must buy their own insurance the choice between private plans and a public health insurance plan. The nonpartisan Congressional Budget Office (CBO) estimates that this public health insurance plan would save taxpayers tens of billions of dollars.

4. **ENSURES QUALITY COVERAGE FOR 97% OF AMERICANS**-The CBO estimates that the House bill will result in health care coverage for 97% of Americans. This will lead to significantly reducing the current cost of providing uncompensated care for 46 million Americans, and result in lower costs for everyone and savings to the economy.

5. **DOES NOT ADD ONE DIME TO THE DEFICIT**-According to CBO, the health insurance reform policies of the House

bill are deficit-neutral, while covering 97% of Americans with quality affordable health care. (Under the budget adopted earlier this year, the bill's provisions extending Medicare physician payment rates are not new policies that must be paid for.)

6. IMPROVES OUR FOCUS ON WELLNESS AND PREVENTION-The House bill will work to change the focus of our health care system from treating sickness to promoting wellness with several provisions such as eliminating out-of-pocket costs for recommended preventive services, strengthening community-based wellness services, and rewarding primary care.

7. IMPROVES QUALITY-The House bill ensures that it is doctors and patients -not insurance companies-making health care decisions. More family doctors and nurses will enter the workforce-helping guarantee access. It moves us toward a system rewarding the quality of care-for instance through accountable care organizations and medical homes.

8. STRENGTHENS MEDICARE-The bill improves Medicare: making sure doctors don't get a 21% pay cut-so they keep seeing Medicare patients; extending Medicare's financial solvency by 5 years; improving coordination of care and reducing errors for seniors with conditions like high blood pressure and diabetes; eliminating the prescription drug "donut hole" coverage gap over a period of years; and providing free preventive care and wellness check-ups.

9. CUTS DOWN ON FRAUD, WASTE AND ABUSE-The House bill will strengthen oversight and enforcement measures to cut down on fraud, waste and abuse in the health care system, which is estimated to cost more than \$60 billion every year.

10. LOWERS COSTS OVER THE LONG TERM-The House bill rewards care that prevents hospital readmissions, promotes doctors working together to coordinate your care better, cuts waste and fraud, invests in prevention and wellness, strengthens primary care, and reforms reimbursement to provide incentives for the quality, not the volume, of services.

Please click on the following links to view text of the legislation as well as background information and summaries of various provisions:

America's
Affordable Health Choices Act: Complete Bill Text (HR 3200)

America's
Affordable Health Choices Act: Summary

Summary and
Description of Revenue Provisions in HR 3200

What's
In the Health Care Reform Bill for You?

Controlling Health Care
Costs

Paying for Health Care
Reform

The Health Insurance
Exchange

Public Health Insurance
Option

Shared Responsibility

Guaranteed Benefits

Making Coverage Affordable

Consumer
Protections and Insurance Market Reforms

Strengthening
the Nation's Health Workforce

Delivery System Reform

Protecting

Program Integrity by Preventing Waste, Fraud and Abuse

Strengthening Medicare

Improving
the Medicare Part D Drug Program

Maintaining and Improving
Medicaid

Preventing
Disease and Improving the Public's Health

ORGANIZATIONS EXPRESSING SUPPORT FOR HR 3200

AMERICA'S AFFORDABLE HEALTH CHOICES ACT OF 2009

[UPDATED 7/17/09]

A letter from 303 Organizations Supporting HR 3200's public health and prevention strategies

AARP

AFL-CIO

AFSCME

AIDS Institute

Alliance for Better Health Care Coalition:

AARP

Academy of Managed Care Pharmacy

Aetna

AFL-CIO

Alliance of Community Health Plans

American society of Health-System Pharmacists

Center for Medical Consumers

Coalition for Health Services Research

Consumers Union

Community Catalyst

CVS Caremark

Express Scripts

Group Health Cooperative

Health Dialog

Kaiser Permanente

Marshfield Clinic

National Partnership for Women & Families

SEIU

American Academy of Family Physicians

American Academy of Nursing

American College of Obstetricians and Gynecologists

American College of Physicians

American College of Surgeons

American Medical Association

American Osteopathic Association

American Psychiatric Association

American Public Health Association

Association of Departments of Family Medicine

Association of Family Medicine Residency Directors

Association for Professionals in Infection Control and Epidemiology

Association of Maternal and Child Health Programs

Association of State and Territorial Health Officials

Breast Cancer Action

Campaign for Tobacco-Free Kids

Cancer Prevention and Treatment Fund

Center for Medical Advocacy

Center for Medical Consumers

Coalition of Full Service Community Hospitals

Communications Workers of America

Consumers Union

Council of State and Territorial Epidemiologists

Doctors for America

Families USA

Government Accountability Project

Healthcare for America Now

Infectious Diseases Society of America

International Association of Firefighters

International Union of Bricklayers and Allied Craftworkers

Main Street Alliance

March of Dimes

National Association of Community Health Centers

National Association of County & City Health Officials

National Breast Cancer Coalition

National Coalition on Health Care

National Consumers League

National Council for Community Behavioral Healthcare

National Education Association

National Medical Association

National Physicians Alliance

National Women's Health Network

National Women's Law Center

North American Primary Care Research Group

Our Bodies Ourselves

Pew Charitable Trusts & Community Catalyst

SEIU

Society of General Internal Medicine

Society of Teachers of Family Medicine

Society for Healthcare Epidemiology of America

TMJ Association

Trust for America's Health

United American Nurses

United Auto Workers

United Steelworkers

US PIRG, Federation of State PIRGs

US Women's Chamber of Commerce

Voices for America's Children

YMCA

Myths and Facts on the Health Care Reform Bill

MYTH: More than 100 million Americans would be forced onto a government-run health plan under the House bill.

First of all, under this bill, no one can ever be "forced onto a government-run health plan." Under this bill, the public health insurance plan is available to all those using the Exchange. All those using the Exchange will have a choice of options various private plans, as well as the public plan. If an employer is providing their employees health insurance through the Exchange, it is the employee, not the employer, choosing the plan. (Under the bill, in the first two years of the Exchange, small employers may participate; in later years, the Administration has the discretion to permit larger employers to participate but there is no timeline for this participation.)

Second, the nonpartisan Congressional Budget Office predicts the number of Americans in private insurance plans will actually increase under the bill (rather than millions being forced out of private plans and into a public plan).

Thirdly, the nonpartisan CBO has estimated that, by 2019, about 9 or 10 million Americans will be enrolled in the public plan. CBO projects that two-thirds using the Exchange will choose a private plan not the public plan. Even if more Americans end up choosing the public plan, it will be their choice, no one can force them into the plan.

MYTH: Millions of Americans would lose the employer-provided health care

they have now, under the House bill.

The nonpartisan CBO has found that, under the bill, not only would millions of Americans not lose their employer-provided coverage, employer-provided coverage would actually increase. Specifically, the CBO projects that under the House bill, by 2019, 164 million people would be covered by employer-provided insurance, compared to 162 million under current law. The House bill builds on the current employer-provided health care system, rather than eroding it.

MYTH: The House bill makes cuts in Medicare that are damaging to seniors and takes away choices for millions of seniors.

The bill requires hospitals, doctors, and pharmaceutical companies to achieve key efficiencies and eliminate waste in Medicare (including eliminating overpayments that are driving up profits for Medicare Advantage plans) and toughens our ability to root out fraud and abuse, but does not make cuts that hurt seniors. It also does nothing to take away choices for seniors.

On the contrary, the bill includes several key provisions that improve Medicare benefits for seniors, including the following:

- Phases in completely filling in the "donut hole" in the Medicare prescription drug benefit (where drug costs are not reimbursed at certain levels), potentially savings seniors thousands of dollars a year.

- Eliminates co-payments and deductibles for preventive services under Medicare.

- Limits cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage.

- Improves the low-income subsidy programs in Medicare, such as by increasing asset limits for programs that help Medicare beneficiaries pay premiums and cost-sharing.

MYTH: The House bill does nothing to control health care costs.

To the contrary, the House bill includes numerous provisions to both achieve cost savings over the next 10 years, as well as to "bend the cost curve" over the long-term. First of all, according to the nonpartisan CBO, this bill achieves net savings in Medicare and Medicaid of \$465 billion over the next 10 years.

For example, these savings include:

- \$156 billion in savings by eliminating overpayments to private Medicare Advantage plans over 10 years;

- \$102 billion in savings by incorporating productivity adjustments into Medicare payment updates to hospitals; and

- About \$110 billion in savings by codifying the White House-PhRMA agreement and also requiring that drug companies provide rebates for individuals enrolled in Medicare and Medicaid that are at least as large as the Medicaid rebates that were provided prior to the enactment of Medicare Part D.

The bill includes numerous provisions to "bend the cost curve" over the

long-term. These provisions are particularly aimed at changing the incentive structure so that instead of rewarding the quantity of care, we are rewarding the quality of care. These reforms which will also improve care -- include:

- Promotes Accountable Care Organizations that provide for hospitals and doctors working together to manage and coordinate care;

- Creates incentives to reduce preventable hospital readmissions that reward transition planning and coordination for patients.

- Establishes pilot projects to test "bundling" payment methodology under which one payment would be made rather than separate payments to any combination of a physician, acute and post-acute providers.

- Promotes "medical homes" where physicians and nurse practitioners focus on ensuring patient care is coordinated and comprehensive.

- Promotes "shared decisionmaking" with physicians and patients, which has been shown to keep health care costs down and patients fully involved in their care.

The bill also includes numerous other provisions to control costs, such as provisions for improving payment accuracy in Medicare and Medicaid; significantly expanding investments in prevention and wellness programs; strengthening primary care; and investing in the health care workforce.

MYTH: The House bill pays for health care reform with a "small business tax" that will kill 1.6 million jobs.

Roughly half of the cost of the bill is paid for by achieving significant efficiencies and savings in Medicare and Medicaid; roughly the other half is paid for through a graduated surcharge on a portion of the income of the top 1%.

This graduated surcharge is not a "small business tax." Only the wealthiest 1.2% of American households will pay the surcharge, on just a portion of their income.

This surcharge will have only a modest impact on America's small business community. According to the nonpartisan Joint Committee on Taxation, only 4.1 percent of all small business owners would pay the surcharge, using the broadest definition of a small business owner (i.e., any individual with as little as \$1 in small business income).

Of the 4.1 percent paying the surcharge, half earn less than one-third of their income from small businesses not what we think of as truly "small business owners."

Only 1.1 percent would pay the top rate among them, hedge fund managers, private equity fund managers, lawyers and lobbyists making millions of dollars a year.

Finally, recent history contradicts the claim that a surtax on the wealthiest Americans kills jobs. Critics of President Clinton's economic plan made this argument in the early 1990s. Subsequent history, however, contradicted this claim: average annual small business job growth was 2.3% in the Clinton years, when taxes on the wealthiest households were increased, and was 1.0% in the Bush years, when they were cut.

MYTH: The health care reforms in the House bill will add to the deficit.

On July 17, the CBO released estimates confirming that the health insurance reform policies in the bill are deficit-neutral over the 10-year budget window -- even producing a \$6 billion surplus. CBO estimated that the cost of the bill's insurance reforms was \$1.042 trillion, while the bill's cost savings and revenues totaled \$1.048 trillion. CBO estimated that these reforms will provide affordable coverage for 97 percent of Americans two years after the program starts.

As was reported in the press, CBO also estimated that the overall bill had a net cost of \$239 billion over 10 years -- but this is entirely due to additional provisions in the bill to maintain current Medicare physician payment rates, costing \$245 billion over 10 years (by preventing scheduled draconian cuts.)

The House agreed earlier this year that this \$245 billion cost should be exempt from PAYGO. Indeed, maintaining current Medicare physician payment rates has bipartisan support. If Congress fails to act, physician payments under Medicare will be slashed by 21 percent on January 1st which would likely result in millions of seniors losing access to their doctor.