AMERICA'S AFFORDABLE HEALTH CHOICES ACT

QUALITY AFFORDABLE HEALTH CARE

OFFICES OF HOUSE
DEMOCRATIC LEADERSHIP
WAYS AND MEANS COMMITTEE
ENERGY AND COMMERCE COMMITTEE
EDUCATION AND LABOR COMMITTEE

AUGUST 10, 2009

QUALITY AFFORDABLE HEALTH CARE

AMERICA'S AFFORDABLE HEALTH CHOICES ACT

PREPARED BY HOUSE DEMOCRATIC LEADERSHIP AND COMMITTEE STAFF

AUGUST 10, 2009

OVERVIEW

WHAT'S IN THE HEALTH INSURANCE REFORM BILL FOR YOU?

Without reform, the cost of health care for the average family of four is projected to rise $1,800 every year for years to come—and insurance companies will make more health care decisions.

America's middle class deserves better. Here's what America's Affordable Health Choices Act means for you:

LOWER COSTS

- No more co-pays or deductibles for preventive care
- No more rate increases for pre-existing conditions, gender, or occupation
- An annual cap on your out-of-pocket expenses
- Group rates of a national pool if you buy your own plan
- Guaranteed, affordable oral, hearing, and vision care for your kids

GREATER CHOICE

- Keep your doctor, and your current plan, if you like them
- More choice, with a high quality public health insurance option competing with private insurers

HIGHER QUALITY

- You and your doctors make health care decisions — not insurance companies
- More family doctors and nurses will enter the workforce, helping guarantee access
- Mental health care must be covered

STABILITY & PEACE OF MIND

- No more coverage denials for pre-existing conditions
- No more lifetime limits on how much insurance companies will pay
- No reason to ever make a job or life decision again based on health care coverage

HEALTH INSURANCE REFORM TALKING POINTS

WE URGENTLY NEED TO FIX HEALTH CARE

FOR AMERICAN FAMILIES:

- Every day, Americans worry not simply about getting well, but whether they can afford to get well. Millions more wonder if they can afford routine care to stay well.
- Premiums have doubled over the last 9 years, 3x faster than wages.
- The average American family already pays an extra $1,100 in premiums every year for a broken system that supports 46 million uninsured Americans.

FOR AMERICAN BUSINESSES:

- Soaring health care costs put American companies at a competitive disadvantage in a global economy.
- Small businesses are forced to choose between coverage and layoffs.

FOR OUR FISCAL FUTURE:

- We have the most expensive health care system in the world. We spend almost 50% more per person on health care than the next most costly nation. But we're no healthier for it.
- If we do nothing, in a decade, we'll be spending $1 of every $5 on health care. In 30 years, it will be $1 of every $3.
- Health insurance reform is curbing health care costs, the single best tool for deficit reduction.

COST, CHOICE, SECURITY, QUALITY

President Obama and this Congress want to reduce your costs, offer you the choice of doctors and plans, and guarantee affordable, quality health care for all.

- **COST LESS AND COVER MORE**: Through competition and choice, we will make coverage more affordable for everyone—guaranteeing fairness and competition in the marketplace, simplifying paperwork for patients and doctors, saving lives and money with electronic medical records, and cracking down on waste, fraud and abuse. Focusing on primary care, prevention and wellness is the first step.
- **YOUR CHOICE: YOU HAVE IT, YOU LIKE IT, YOU KEEP IT**: The freedom to choose what works best for you and your family—if you like your doctor, keep your doctor. If you like your current plan, keep your current plan. Or get a new one.
- **STABILITY AND PEACE OF MIND**: Your health needs will be covered by insurance and your coverage can never be taken away. You won't be denied insurance based on a pre-existing condition, or go without coverage if your employer drops your insurance, you change jobs, or are out of work.
- **QUALITY PATIENT-CENTERED CARE**: We must have a system driven by patients' needs, not corporate profits, empowering you and your doctor to make informed health care decisions that meet your specific needs.

AMERICAN SOLUTION

We need a uniquely American solution that builds on the best of what works … to foster competition among insurance plans, and provide patients with quality choices.

- **ENSURE EVERY CHILD IN AMERICA IS COVERED** with the health care they need to grow up strong and healthy.
- **INVEST IN PREVENTION AND WELLNESS** to help Americans live longer and healthier lives.
- **ENSURE DOCTORS AND NURSES GET THE INFORMATION THEY NEED** to provide you with the best individualized care.
- **NEVER AGAIN WILL YOUR COVERAGE BE DENIED** because of pre-existing conditions, age, or gender, ending a system where profits come before people, and millions go without vital health care.
- **NEVER AGAIN HAVE TO MAKE A LIFE OR JOB DECISION TO KEEP COVERAGE.**
- **NEVER LET YOUR FAMILY SUFFER FINANCIAL CATASTROPHE** because of high medical costs.

NO IS NOT THE ANSWER

The 'just say no' crowd working to defeat health insuranc reform is content with the status quo—turning their backs on families and businesses, and jeopardizing our economic recovery and fiscal future.

A DOSE OF REALITY: MYTH VS. FACT ON HEALTH INSURANCE REFORM

GOP MYTH: Health reform means fewer choices for Americans.
FACT: The House proposal will increase choice among an array of high-quality private and public health insurance options. Most importantly, if you like what you have, you can keep it. More Americans will have access to greater choices in doctors and plans by taking away the insurance industry's ability to deny coverage and care.

GOP MYTH: Health reform means bureaucrats will ration health care.
FACT: The House proposal will expand and improve the availability of quality health care for all Americans, not ration it. Under this proposal, doctors, nurses and patients will make medical decisions, not big insurance companies or the government. Republicans content with the status quo want to leave patients at the mercy of big insurance companies that make decisions to protect profits not patients.

GOP MYTH: Health reform means raising taxes, or making coverage more expensive.
FACT: Under the status quo, middle-class families pay an enormous "hidden tax" of nearly $1,100 per year to provide care for the uninsured and underinsured. The House proposal will end this tax by containing overall costs and expanding access to affordable care for all Americans. Additionally, the House proposal invests in reforms to contain the costs of health insurance overburdening businesses, families and the federal deficit. Republicans can either continue to be the "Party of No" and defend the status quo that is costing American families and businesses more every year, or they can be part of the solution.

GOP MYTH: Health reform means Americans will be forced out of their current plans.
FACT: The House proposal builds on what works – the employer-based system – while giving every American the peace of mind of knowing that their health needs will be covered by insurance. No one will have to worry about being denied insurance based on a pre-existing condition, or being without coverage if their employer drops coverage, they lose their job, or change employers. Republicans make this claim based on a study of a proposal that is nothing like the House proposal.

GOP MYTH: Health reform means individuals will be forced to buy insurance they can't afford.
FACT: Millions of Americans cannot afford insurance today or are locked out of the system because of a pre-existing condition. The House proposal emphasizes shared responsibility among individuals, businesses and the government and helps make coverage affordable and available to all. Affordability credits will be available to help low- and moderate- income working families afford coverage, regardless of the plan they choose.

GOP MYTH: Health reform will force businesses to cut jobs and squeeze small businesses.
FACT: All businesses will benefit from insurance market reforms and a high performing health system that will reduce costs of health care. The status quo is unsustainable for businesses. Under the House proposal, employers will continue to offer their employees health care or contribute towards coverage. Certain very small businesses would be exempt from this requirement. With tax credits and a reformed market that ensures access to affordable coverage, small business owners and their employees will have new options to purchase affordable health insurance that are not available to them now.

GOP MYTH: Health reform that builds on Medicare and Medicaid will only hurt the programs' long-term sustainability, and cost state and federal governments more.

FACT: Health reform is a critical first step toward containing health care costs for business, individuals, and the federal government in Medicare and Medicaid. By eliminating wasteful overpayments to private plans under Medicare, reforming how doctors are reimbursed, and creating new incentives for coordinated, high quality care we will extend Trust Fund solvency and improve Medicare for generations to come.

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

FACT: 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.

HEALTH CARE BY THE NUMBERS

HEALTH CARE & FAMILIES

- Since 2000, premiums have more than doubled while wages have virtually stood still.
- In the past year, 53% of Americans say their household cut back on health care due to cost concerns.
- Since 1987, the cost of the average family health insurance policy has risen from 7% of median family income to 17%.
- In 2007, 60% of U.S. bankruptcies were due to medical costs.
- America's small businesses are struggling to pay for health care, with small business premiums rising 129% since 2000.
- With employers unable to afford rising health care costs, our country could see an additional 3.5 million people unemployed and without benefits in the next 4 years. At least 46 million Americans are uninsured - more than 85% of whom are in working families. Without wellness and preventive care, families suffer, and their care drives up costs throughout the system.

HEALTH CARE & BUSINESS

- 52% of employers say that the current economic downturn will have an impact their health care programs in 2010.
- In 2008, 38% of small companies offered health coverage, compared with 41% in 2007 and 61% in 1993.
- Forty percent of small businesses said that health costs have had a negative impact on other parts of their business, for example, contributing to high employee turnover or preventing business growth.
- About 10% of small companies are considering ending their employee health coverage plans over the next year, compared with 3% of small businesses in 2005.
- According to a Hewitt Associates survey, 19% of all U.S. businesses plan to halt providing health care benefits to their employees in the next three to five years.

HEALTH CARE & ECONOMY

- In 2006, our economy lost as much as $200 billion because of the poor health and shorter lifespan of the uninsured.
- Without any change, by 2018, health care spending will rise to $4.4 trillion – more than one-fifth of the economy.
- The United States now spends twice as much per capita on health care than almost any other industrialized nation with poorer health outcomes.
- Since the recession began, an estimated 4 million additional Americans have lost their health insurance – and are currently losing coverage at an average of 10,680 workers each day.
- Absent reform, the number of the uninsured will reach 61 million by 2020.
- Annually, federal and state governments pay 75% of the $56 billion in uncompensated care provided to the uninsured.
- Today, only 4 cents of every health care dollar is spent on prevention.

HEALTH CARE Q&A: WHY AMERICANS NEED HEALTH REFORM

WHY DO WE NEED HEALTH INSURANCE REFORM?

America's health care system is home to the world's best providers, greatest technology, and most advanced research and development. But rising health care costs are squeezing American families, burdening businesses, and making us less competitive in a global economy. We have the most expensive care in the world--but we're not the healthiest as a result. The goal of health insurance reform is to build on what works and fix what is broken so health care is more affordable and put doctors and patients--not insurance companies--in charge.

HOW WILL I BENEFIT?

Every day, millions of Americans worry not simply about getting well, but whether they can *afford* to get well. Millions more wonder if they can afford routine care to stay well. Health insurance reform is about giving you and your family the peace of mind in knowing that you will always have access to affordable quality health care.

Health insurance reform will contain the rising health care costs that are squeezing you and your family more each year. Health reform will preserve what works in our system so you can keep your plan if you like it, and provide greater choices with the option of a high-quality, public health insurance plan that would compete with private companies. Health reform will ensure the stability of coverage for you and your family and end the practice of insurance companies denying coverage or raising rates based on a pre-existing condition. And health reform will mean higher quality care, putting the medical professionals – not the insurance companies – in charge of health care decisions, and allowing doctors to focus on the practice of healing, rather than dealing with administrative red-tape.

WILL MY TAXES GO UP?

We will pay for health insurance reform so that it does not increase the deficit and burden future generations. Fiscally responsible reform means we are considering several ideas, including the considerable savings within the health sector that can be achieved through increasing efficiency, reducing administrative waste, eliminating fraud and abuse, expanding our use of proven cost-saving preventive and wellness measures, and improving the accuracy of payment in current federal health programs. The bottom line is that the growth in health care costs will slow --and the quality of your care will go up.

AMERICA IS IN A SERIOUS ECONOMIC RECESSION; SHOULDN'T CONGRESS FOCUS ON THAT FIRST?

Health insurance reform is a critical part of our economic recovery. If we don't act now, skyrocketing health care costs will only get worse -- threatening the budgets of families, businesses, and the nation. In the last ten years, premiums have risen three times faster than wages. U.S. firms, which pay more than twice as much for health care than their foreign competitors, are being forced to choose between covering their employees at a competitive disadvantage or laying them off. And, as the fastest growing segment of our federal budget, health care costs are hitting taxpayers hard and putting our nation deeper into debt. The cost of inaction is too great. The time to act is now.

WILL I LOSE MY CURRENT HEALTH INSURANCE?

No. The legislation builds on what works – the employer-based system and public programs, while

reforming the private health insurance market - so if you like the insurance that you have, you will be able to keep it. We'll even improve it and guarantee you can't lose it. The goal of health reform is to fix only what is broken in order to provide all Americans with affordable choices for high-quality health care. It's a uniquely American solution.

I CAN'T GET INSURANCE BECAUSE I HAVE A PRE-EXISTING CONDITION. WHAT WILL HEALTH CARE REFORM MEAN FOR ME?

Health insurance reform will make it easier for you to find more affordable insurance and give you a lot more peace of mind. Our reforms would prevent insurance companies from cherry-picking policy-holders, by refusing to insure people who have had cancer, heart disease, diabetes, or any other pre-existing condition--or for using that excuse to deny coverage of services or charge excessively high premiums.

ARE YOU PLANNING ON ELIMINATING MEDICARE AND MEDICAID?

No. In fact, Medicare and Medicaid will be strengthened, with Medicare's solvency ensured for years to come.

DOES HEALTH REFORM MEAN THAT MY MEDICARE BENEFITS WILL BE CUT?

Just the opposite. Medicare benefits will be improved. One of the biggest problems facing seniors is rising drug costs -- especially when they hit the so-called "donut hole" gap in Medicare drug coverage. The proposal shrinks the hole by $500 in 2011 and eliminates it over a number of years.

Reform also involves strengthening and improving Medicare to ensure its long-term solvency so that it will be available for future generations. With the looming retirement of the Baby Boomer generation, Medicare spending is projected to continue rising steadily. Ensuring Medicare's long-term solvency and getting a handle on the nation's federal debt and deficits requires that we strengthen and improve the Medicare program by implementing reforms to reduce costs, and increase efficiencies and quality. Such reforms include ending excessive overpayments to Medicare's private health plans ("Medicare Advantage" plans), and adding consumer protections to ensure that these plans are investing premiums in patient care and limiting their abilities to charge higher cost-sharing than traditional Medicare.

WHAT IS A PUBLIC HEALTH INSURANCE PLAN AND WHY DO WE NEED ONE?

There's no incentive for private plans to offer more affordable rates or better coverage unless they have to compete with a plan that puts people first. A public health insurance plan is important to guarantee that all Americans will have an affordable choice among insurance providers with the freedom to choose which plan works best for you and your family. Through competition and choice, we will make coverage more affordable and accountable for everyone.

UNDER THE NEW SYSTEM YOU PROPOSE, CAN THE GOVERNMENT ARBITRARILY DECIDE THAT A TREATMENT IS TOO EXPENSIVE AND REFUSE TO PROVIDE IT OR PAY FOR IT?

No. The legislation puts doctors, nurses and patients in charge of medical decisions, not private insurance companies or the government. We must have a system driven by patients' needs, not corporate profits, empowering you and your doctor to make informed health care decisions that meet your specific needs.

WILL HEALTH REFORM RESULT IN A CANADIAN-STYLE SYSTEM OF CARE OR WHERE CARE COULD BE DELAYED OR DENIED?

No. The legislation provides a uniquely American solution that builds on the private insurance system--but with patient-centered reforms to that system that remove the insurance industry's ability to deny coverage and care. Under our plan, if you like the health plan and doctors you have you can keep them; but if you don't have insurance or want the option of a different plan, there will be choices available for you and your family.

THE COST OF INACTION

THE BURDEN OF HEALTH CARE IN AMERICA NOW

The rising cost of health care is straining the wallets of American families, the balance sheets of our businesses, and the long term health of our federal budget. Right now, America spends nearly 50% more per person on health care than any other country – and all that spending isn't making us any healthier.

- In the last decade the cost of health care for American families has skyrocketed – premiums have doubled and deductibles and out-of-pocket expenses have gone up and up.
- The broken health care system will cost us as much as $248 billion in lost productivity this year alone.
- Providing health care for the uninsured costs insured American families $100 billion every year.

THE STATUS QUO IS UNSUSTAINABLE - Things will only get worse if we do nothing. Every American risks losing their health insurance and seeing their costs skyrocket unless we reform health care now.

IF WE DO NOTHING, THE FUTURE OF HEALTH CARE LOOKS LIKE THIS:

FAMILY BUDGETS ARE CRIPPLED

- The cost an employer-sponsored family health insurance plan reaches $24,000 by 2016 – an increase of 84%. That means most American households spend 45% of their income on health insurance.
- Families are paying more for less as the average deductible increases 73% to almost $2,700 by 2016 and copayments go up.
- More families face economic ruin because of illness as the number of uninsured Americans grows to 66 million by 2019. Middle class families are most likely to lose their coverage.

AMERICAN BUSINESSES FALL BEHIND

- Employer spending on health care premiums more than doubles to $885 billion in 2019 from $430 billion.
- As premiums increase 20%, expected in the next four years, 3.5 million workers lose their jobs.
- Because of rising costs, one in five employers stop offering health benefits in the next three to five years. 11 million Americans lose their employer-sponsored health insurance by 2019.

THE FEDERAL GOVERNMENT GOES BROKE

- As Americans lose their private insurance, many are added to already-strained government programs. Combined with the rising cost of care, spending on Medicare and Medicaid doubles from $720 billion in 2009 to $1.4 trillion in 2019.
- By 2017 the fund that pays for Medicare and Medicaid is broke and can't pay for benefits at the current level.
- Within a decade we spend one out of every $5 we earn on health care. In 30 years, we spend one out of every $3.

DETAILED SUMMARY

AMERICA'S AFFORDABLE HEALTH CHOICES ACT SUMMARY

America's Affordable Health Choices Act provides quality affordable health care for all Americans and controls health care cost growth. Key provisions of the bill released today include:

- COVERAGE AND CHOICE
- AFFORDABILITY
- SHARED RESPONSIBILITY
- CONTROLLING COSTS
- PREVENTION AND WELLNESS
- WORKFORCE INVESTMENTS

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:

- **A Health Insurance Exchange.** The new Health Insurance Exchange creates a transparent and functional marketplace for individuals and small employers to comparison shop among private and public insurers. 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. Over time, the Exchange will be opened to additional employers as another choice for covering their employees. 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.
- **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 the amount of money a person or family spends on covered services in a year.

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 (and 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 not only make insurance premiums affordable, they will also 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.** All new policies will cap annual out-of-pocket spending to prevent bankruptcies from medical expenses.
- **Increased competition:** The creation of the Health Insurance Exchange and the inclusion of a public health insurance option 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 133 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 be fully federally financed. 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 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, fix physician payments, 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.

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 of 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 eight 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 $250,000) are exempt from the employer responsibility requirement. The payroll penalty would then phase in starting at 2% for firms with annual payrolls over $250,000 rising to the full 8 percent penalty for firms with annual payrolls above $400,000. In addition, a new small business tax credit will be available for those firms who want 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. PREVENTION AND WELLNESS

Prevention and wellness measures of the bill include:

- Expansion of Community Health Centers;
- Prohibition of cost-sharing for preventive services;
- Creation of community-based programs to deliver prevention and wellness services;
- A focus on community-based programs and new data collection efforts to better identify and address racial, ethnic, regional and other health disparities;
- Funds to strengthen state, local, tribal and territorial public health departments and programs.

V. WORKFORCE INVESTMENTS

The bill expands the health care workforce through:

- Increased funding for the National Health Service Corp;
- More training of primary care doctors and an expansion of the pipeline of individuals going into health professions, including primary care, nursing and public health;
- Greater support for workforce diversity;
- Expansion of scholarships and loans for individuals in needed professions and shortage areas;
- Encouragement of training of primary care physicians by taking 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 will reduce the growth in health care spending in a numerous ways. Investing in health care through stronger prevention and wellness measures, increasing access to primary care, health care delivery system reform, the Health Insurance Exchange and the public health insurance option, improvements in payment accuracy and reforms to Medicare and Medicaid will all 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 provision of 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. A centerpiece of the proposal is a complete reform of the flawed physician payment mechanism in Medicare (the so-called sustainable growth rate or “SGR” formula), with an update that wipes away accumulated deficits, provides for a fresh start, and rewards primary care services, care coordination and efficiency.

- **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 and eliminating overpayments.** 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.

KEY AMENDMENTS ADOPTED IN COMMITTEES

ENERGY AND COMMERCE COMMITTEE

AMENDMENT OFFERED BY REP. MIKE ROSS (D-AR)

Blue Dog Amendment – Reflecting Waxman-Blue Dog Agreement
Adopted by a vote of 33-26 (D 33-3; R 0-23)

The Blue Dog omnibus amendment included several provisions, including the following:

- **Public Health Insurance Plan:** Provides that the public health insurance plan will negotiate rates with providers, no higher than the average of private plan rates or lower than Medicare. (Under the original bill, in the first three years, the public health insurance plan would pay rates set at those of Medicare, plus 5 percent – with the HHS Secretary having discretion in later years on how rates would be determined.) The amendment also includes further clarifications that the public health insurance plan will compete on a level playing field in the Health Insurance Exchange with private insurers.
- **Affordability Credits:** Trims the subsidies ("affordability credits") provided to households using the Health Insurance Exchange with incomes above 150% of poverty (under the bill, subsidies are provided to households from 133% of poverty to 400% of poverty). Specifically, the amendment increases from 11% to 12% the maximum portion of income spent on premiums for households at the top end of the subsidy schedule (400% of poverty), and makes sliding-scale increases in the rest of the schedule for households with incomes above 150% of poverty.
- **Small Business Exemption:** [Note: This was a key feature of the Waxman-Blue Dog Agreement, which is why it is included here. However, because it was not in the jurisdiction of the Energy and Commerce Committee, its language was not offered in the amendment offered and adopted in the Energy and Commerce markup.] Increases the small business exemption from the employer responsibility requirement from businesses with $250,000 or under in payroll in the original bill to businesses with $500,000 or under in payroll. Also, under the agreement, small businesses with payrolls between $500,000 and $750,000 pay a graduated rate if they do not provide coverage (rather than the 8 percent payroll fee large businesses pay.) Under the original bill, small businesses with payrolls between $250,000 and $400,000 paid the graduated fee.
- **Medicaid Matching:** Starting in 2015, requires states to provide a 10% match for the individuals newly made eligible for Medicaid under this legislation (which makes all individuals with incomes at or below 133% of poverty eligible for Medicaid). Under the original bill, the costs of the new Medicaid eligibles were fully federally-funded. The amendment also provides for a study and report to Congress on the current federal-state matching formula in the Medicaid program.
- **State Cooperative Health Plans:** Provides that states would be able to set up non-for-profit or cooperative health plans that could, like other insurers and the public option, compete in the Exchange. The cooperative plans would not replace the public health insurance plan.
- **Realigning Incentives:** In addition to the delivery reforms already included in the bill, establishes and funds a Center for Medicare and Medicaid Payment Innovation at the Centers for Medicare and Medicaid Services (CMS) to identify and implement payment systems that can improve quality and reduce costs for Medicare beneficiaries.
- **Insurance Agents and Brokers:** Clarifies that nothing in the legislation has any impact on the role of agents and brokers under state law, including the enrollment of individuals in private plans and the public option.
- **End-of-Life Care:** Includes clarifications regarding end-of-life care, calling for information to be provided to individuals on end-of-life planning by health insurers in the Exchange, but ensuring that

such information "shall not promote suicide, assisted suicide or the active hastening of death;" and ensuring that such information "shall not presume the withdrawal of treatment and shall include end-of-life planning information that includes options to maintain all or most medical interventions."

AMENDMENT OFFERED BY REP. TAMMY BALDWIN (D-WI)

Amendment from Committee's Progressives and others
Adopted by a vote of 32-26 (D 32-3; R 0-23)

The Baldwin amendment includes several provisions that are designed to achieve savings. The amendment stipulates that all savings achieved by these provisions will be used to reduce the financial burden of premiums for households using the Health Insurance Exchange who are eligible for subsidies ("affordability credits") – by increasing the subsidies for these families. The provisions in the amendment that are designed to achieve savings are:

- **Public Plan Formulary:** Clarifies that the HHS Secretary shall establish a drug formulary in the public plan.
- **Pharmacy Benefit Manager (PBM) Transparency:** Requires Pharmacy Benefit Managers (PBMs) to provide basic performance information to the insurance plans that hire them, such as information on generic drug utilization rates and the spreads between PBM drug costs and the prices PBMs charge insurers and insured beneficiaries.
- **Accountable Care Organizations in Medicaid:** Requires the HHS Secretary to establish an accountable care organization pilot program in Medicaid, similar to that established under Medicare in this legislation.
- **Administrative Simplification:** Sets out new administrative simplification standards that all health plans must meet.

AMENDMENT OFFERED BY REP. JAN SCHAKOWSKY (D-IL)

Amendment from Committee's Progressives and others
Adopted by a vote of 32-23 (D 32-2; R 0-21)

The Schakowsky amendment also included provisions that are designed to achieve savings. Like the Baldwin amendment, the amendment stipulates that all savings achieved by these provisions will be used to reduce the financial burden of premiums for households using the Health Insurance Exchange who are eligible for subsidies ("affordability credits") – by increasing the subsidies for these families. The provisions in the amendment that are designed to achieve savings are:

- **Prior Approval of Large Premium Increases:** Provides for prior approval of premium increases in excess of 150% of medical inflation for plans in the Health Insurance Exchange. Under the amendment, approval would be granted by states or, if the state has no such program, by the Commissioner of the Exchange.
- **Allowing Medicare Part D Drug Price Negotiation:** Authorizes the HHS Secretary to negotiate drug prices for Part D drugs in Medicare with the nation's drug companies.

AMENDMENT OFFERED BY REP. ANNA ESHOO (D-CA)

Adopted by vote of 47-11 (D 26-10; R 21-1)

The Eshoo amendment would authorize the Food and Drug Administration to approve generic versions of costly biologic drugs derived from human proteins. (Ordinary chemical pharmaceuticals have faced generic competition for more than two decades.) The amendment grants biologics manufacturers 12 years of exclusive use of their drug before generic manufacturers could begin developing competitors.

AMENDMENT OFFERED BY REP. BOBBY RUSH (D-IL)

Adopted by voice vote

The Rush amendment would prohibit brand-name drug companies from settling patent litigation with generic competitors by paying them to delay marketing their products.

AMENDMENT OFFERED BY REP. STEVE BUYER (R-IN)

Adopted by voice vote

The Buyer amendment clarified that nothing related to Health Insurance Exchange-eligible individuals and employers would be construed as affecting the ability of the Secretary of Defense and the Secretary of Veterans Affairs to continue to have sole authority over their respective health care systems. It also clarifies that veterans, military personnel, and their families retain the choice of keeping their respective TRICARE or VA health coverage and obtaining additional private or public health insurance.

EN BLOC AMENDMENT OFFERED BY REP. FRANK PALLONE (D-NJ)

Adopted by voice vote

The en bloc amendment offered by Rep. Pallone included numerous provisions from both Democrats and Republicans, including provisions to increased federal support for trauma centers, and emergency care, and programs to increase government-sponsored research into pain management and post-partum depression.

AMENDMENT OFFERED BY REP. BETTY SUTTON AND DEL. DONNA CHRISTENSEN

Adopted by a vote of 36-23 (D 36-0; R 0-23)

The Sutton-Christensen amendment authorizes $30 million a year over the next five years in grants to states, local governments, and non-profit organizations to send community health workers into "medically underserved" communities to promote positive health behaviors and provide education and information on such issues as proper nutrition, tobacco and alcohol use, and untreated mental health problems.

AMENDMENT OFFERED BY REP. LOIS CAPPS (D-CA)

Adopted by a vote of 33-23 (D 31-3; R 2-20)

The Capps amendment authorizes $50 million a year over the next five years for "evidence-based" sexual education programs for teenagers.

ADOPTED BY THE WAYS AND MEANS COMMITTEE

The only amendment adopted by the Ways and Means Committee in its mark-up of H.R. 3200 was Chairman Rangel's amendment in the nature of a substitute, which included some changes from the original bill. The changes from the original bill in the Rangel substitute were mostly minor and technical in nature. The Rangel amendment in the nature of a substitute was reported by the committee by a vote of 23-18.

CHANGES TO BILL IN CHAIRMAN RANGEL'S AMENDMENT IN THE NATURE OF A SUBSTITUTE

Reported by a vote of 23-18 (D 23-3; R 0-15)

Following is a brief overview of a few of the changes from the original bill in Chairman Rangel's amendment in the nature of a substitute.

- **Parity in the tax rules for employer provided health coverage:** The tax exclusion for employer provided coverage is extended to non-dependents of an employee, such as domestic partners or adult children. The provision does not require an employer to offer such coverage. If an employer chooses to do so, the employer and employee may exclude the value of such coverage for income and payroll tax purposes.
- **Pilot Program on Bundling:** Clarifies types of bundled payments included; requires evaluation of the pilot; adds a study on and demonstration authority for bundling of payments for outpatient services.
- **Telehealth Expansion and Improvements:** Adds a new subsection that provides additional means for credentialing of telehealth providers.
- **Accountable Care Organization Pilot Program:** Clarifies that physicians from various specialties can be the primary point of care for beneficiaries in accountable care organizations.
- **Medical Home Pilot Program:** Adds physician assistants to the definition of primary care for purposes of the medical home pilot program.
- **Medicare-Covered Preventive Services:** Expands the number of preventive services reimbursed by Medicare when furnished by Federally Qualified Health Centers.
- **Medicare Cost-Intensive Diseases and Conditions:** Directs the Administrator of the Centers for Medicare and Medicaid Services to conduct an assessment of the diseases and conditions that are most cost-intensive for the Medicare program. The substitute also directs the Administrator to review and update that assessment and creates a fund for research into such diseases and conditions.
- **Medicare Payments to Hospice:** Blocks a Medicare payment cut to Hospice providers through FY2010.
- **Distributions of Medicine Qualified Only If for Prescribed Drug or Insulin:** Provides that tax-advantaged flexible spending accounts, health reimbursement accounts and health savings accounts may only be used for prescribed drugs or insulin, and not for over-the-counter medications.

ADOPTED BY THE EDUCATION AND LABOR COMMITTEE

AMENDMENT OFFERED BY REP. DINA TITUS (D-NV)

Adopted by a vote of 28-19 (D 28-0; R 0-19)

The Titus amendment opens the Health Insurance Exchange to more small businesses who wish to participate. Specifically, in year 1, the size of businesses eligible for the Exchange will increase from those with 10 or fewer employees to businesses with 15 or fewer employees. In year 2, the size will increase from businesses with 20 or fewer employees to those with 25 or fewer employees. In Year 3, the Commissioner must allow additional small businesses to enter the Exchange and will set the minimum size for an eligible business to one with 50 employees.

AMENDMENT OFFERED BY REP. PHIL HARE (D-IL)

Adopted by voice vote

The Hare amendment is designed to help facilitate the participation of small businesses and the self-employed in the Health Insurance Exchange. It allows Small Employer Benefit Arrangements to contract with the Exchange to provide operational expertise, consumer information, capacity for benefits integration, ongoing management and enrollment to small employers and their employees.

AMENDMENT OFFERED BY REP. JOE COURTNEY (D-CT)

Adopted by voice vote

The Courtney amendment provides a stopgap measure regarding the handling of pre-existing conditions by health insurance companies before the Health Insurance Exchange is up and running in 2013 and the full protections of the bill are in place, in order to better protect consumers. Specifically, until the Exchange is in place, the amendment would shorten the period someone can be denied coverage for a pre-existing condition from a year to three months and would allow a new insurer to look back only 30 days, instead of six months, to determine if such a condition exists. Then, as under the introduced bill, beginning in 2013, the general rule is that no health insurer may deny coverage based on a pre-existing condition.

AMENDMENT OFFERED BY REP. SUSAN DAVIS (D-CA)

Adopted by voice vote

The Susan Davis amendment also provides a stopgap measure regarding COBRA coverage before the Health Insurance Exchange is up and running in 2013 and the full protections of the bill are in place. The amendment would allow unemployed workers currently on COBRA coverage or those who start COBRA in the future to stay on COBRA until the Exchange is up and running, or until the individual finds a job with health insurance, whichever comes first. People are currently eligible for COBRA for 18 months after losing a job.

MANAGER'S AMENDMENT OFFERED BY CHAIRMAN GEORGE MILLER (D-CA)

Adopted by voice vote

The manager's amendment included several changes from the original bill, including the following:

- **Medical Loss Ratio:** Provides that the medical loss ratio (the ratio of what is paid out in claims to total revenues) by health insurers must be at least 85 percent.
- **Eligibility for Affordability Credits in the Exchange:** Makes eligible for affordability credits in the Health Insurance Exchange, individuals and families whose insurance premiums and out-of-pocket costs are more than 11 percent of their income (i.e., individuals and families who are currently underinsured).

- **Employer Wellness Programs:** To promote preventive health care, creates an employer wellness grant program to reward employers who establish or strengthen a workplace wellness program.
- **Health Insurers Changing Coverage:** Prohibits insurance companies from changing the coverage or costs of a health plan mid-year except if the costs are lowered and/or coverage is increased.
- **School Nurses:** Provides grants to states who hire school nurses.

AMENDMENT OFFERED BY REP. BOBBY SCOTT (D-VA)

Adopted by a vote of 30-17 (D 28-0; R 2-17)

The Bobby Scott amendment would guarantee children access to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services as part of any health plan participating in the Health Insurance Exchange.

AMENDMENT OFFERED BY REP. SUSAN DAVIS (D-CA)

Adopted by voice vote

The Susan Davis amendment would instruct the Health Benefits Advisory Committee to examine the health coverage laws and benefits of each state in developing federal baseline standards, with the intention that the federal standards should not undercut those of the states.

AMENDMENT OFFERED BY REP. DAVID WU (D-OR)

Adopted by voice vote

The Wu amendment would establish a study to determine whether an enhanced reimbursement would increase the adoption and meaningful use of electronic health records.

EN BLOC AMENDMENT OFFERED BY REP. RUSH HOLT (D-NJ)

Adopted by voice vote

The Holt en bloc amendment included several provisions including authorizing HHS grants for workforce development training programs for health care workers and directing HHS to establish a Personal Attendant Workforce Advisory Panel to examine training for long-term care workers.

AMENDMENT OFFERED BY REP. JOE SESTAK (D-PA)

Adopted by voice vote

The Sestak amendment defines the “consumer representative” on the Health Benefits Advisory Committee as a person who is “an educated patient or consumer advocate.”

AMENDMENT OFFERED BY REP. JARED POLIS (D-CO)

Adopted by voice vote

The Polis amendment clarifies the data collection provisions to include sexual orientation, race, disability, gender identity, socioeconomic status, language, and geographic settings to be considered in studies of disparities in health care. Such data collection would be voluntary and incorporate privacy protections.

AMENDMENT OFFERED BY REP. MAZIE HIRONO (D-HI)

Adopted by voice vote

The Hirono amendment provides that the bill maintains Hawaii’s Prepaid Health Care Act exemption provided the state statute ensures that health care benefits are equivalent to or greater than those benefits that would be guaranteed by H.R. 3200.

AMENDMENT OFFERED BY REP. DUNCAN HUNTER (R-MI)

Adopted by voice vote

The Hunter amendment directs HHS to grant a waiver from health coverage participation requirements for a two-year period to employers if the employer demonstrates that meeting the requirements would result in job losses.

AMENDMENT OFFERED BY REP. JOE WILSON (R-SC)

Adopted by voice vote

The Wilson amendment clarifies the bill to explicitly state that TRICARE, the health care program for the military and their families, is exempt from the bill's requirements.

AMENDMENT OFFERED BY REP. FUDGE (D-OH) AND REP. TITUS (D-NV)

Adopted by a vote of 28-18 (D 28-0; R 0-18)

The Fudge/Titus amendment on small business counseling requires the Commissioner, in consultation with the Small Business Administration, to establish and carry out a program to provide health insurance counseling and technical assistance to small employers who provide their employees health care through the Exchange.

FACT SHEETS: HEALTH REFORM AT A GLANCE

THE HEALTH INSURANCE EXCHANGE

America's Affordable Health Choices Act will reform the insurance marketplace to ensure that everyone can purchase quality, affordable health insurance coverage. A critical piece is a new Health Insurance Exchange (Exchange) for individuals and businesses to allow them to comparison shop for coverage. This Exchange will revolutionize health care choices and will help reduce the growth in health care spending by encouraging competition on price and quality, not benefit manipulation or efforts to exclude needy patients. Recognizing that many businesses want to continue providing their own health coverage as they do today, business participation in the Exchange is simply a new option for those that are eligible – no business is required to enter.

HEALTH INSURANCE EXCHANGE:

ABILITY TO COMPARISON SHOP

- Give people the ability to choose from a variety of plans — including a new public health insurance option.
- Provide standardized benefit packages so that people will be able to comparison shop and make informed choices based on cost and quality.
- Plans compete locally—so small plans and national plans have an equal opportunity to offer coverage.

AFFORDABILITY (SEE FACT SHEET "MAKING COVERAGE AFFORDABLE" FOR MORE DETAILS)

- To ensure that health care is affordable to people of all incomes, new affordability credits will be available for people purchasing through the Exchange. They will assist people with incomes up to 400% of the federal poverty level ($43,000 for individuals or $88,000 for families of four) and phase-out on a sliding scale basis.
- Includes a cap on premiums and out-of-pocket spending. Regardless of income, everyone will be protected, so no one will face bankruptcy due to medical expenses.

TRANSPARENCY

- Bring transparency to the health care marketplace, so that families know what benefits their plan covers and what it will cost them.
- Require plans to explain their coverage in plain language, so that consumers can make informed choices about their medical care.

STANDARDIZED BENEFITS (SEE FACT SHEET "BENEFITS" FOR DETAILS)

- Allow consumers to choose coverage among several standard benefit packages.
- Provide comprehensive health care services with different levels of cost sharing.
- Include a Premium Plus plan through which people will have options to purchase coverage for additional health care benefits that are not included in the core benefit standards.

ADVANTAGES FOR SMALL BUSINESSES

- Health Insurance Exchange is opened to small employers first (those with 10 or fewer employees in the first year, and 20 or fewer in the second year) and to larger employers over time.

- Offers opportunity to small employers through the Exchange to provide their employees with broad choices for coverage and to be able to eliminate the administrative costs of maintaining their own health plan contracts.

PUBLIC HEALTH INSURANCE OPTION

The goal of health insurance reform is to provide quality, affordable health care for every American while preserving what works in today's system, expanding choice, and containing costs. America's Affordable Health Choices Act provides a public health insurance option that would compete with private insurers within the Health Insurance Exchange.

PUBLIC HEALTH INSURANCE OPTION:

OVERVIEW
- Available in the new Health Insurance Exchange (Exchange) along with all of the private health insurance plans.

LEVEL PLAYING FIELD
- Require public option to meet the same benefit requirements and comply with the same insurance market reforms as private plans.
- Establish the public option's premiums for the local market areas that are designated by the Exchange, just as other insurers do.
- Individuals with affordability credits can choose among the private carriers and the public option.

SELF-SUFFICIENCY
- Public option must be financially self-sustaining, as private plans are.
- Public option will need to build start-up costs and contingency funds into its rates and adjust premiums annually in order to assure its financial viability, as private plans do.

INNOVATION AND COST CONTAINMENT
- Promote primary care, encourage coordinated care and shared accountability, and improve quality.
- Institute new payment structures and incentives to promote these critical reforms.

PROVIDER PAYMENTS AND PARTICIPATION
- Initially utilizes rates similar to those used in Medicare with greater flexibility to vary payments.
- Allow immediate integration of delivery reforms also contained in the bill.
- Provider participation is voluntary – Medicare providers are presumed to be participating unless they opt out.

CONSUMER PROTECTIONS AND INSURANCE MARKET REFORMS

America's Affordable Health Choices Act includes comprehensive reforms to create a transparent, consumer-friendly insurance marketplace that protects consumers and provides them with choices among quality, affordable health care plans.

PROTECTING CONSUMERS

The bill includes strong reforms to the insurance market so that consumers will be more secure in their health coverage.

- Insurers will be prohibited from excluding coverage based on pre-existing conditions.
- Insurers will be prevented from selectively refusing to renew coverage. They will no longer be able to charge people different premiums based on their gender, health status, or occupation; and the percent difference insurers can charge based on age is limited to a rate band of 2:1.
- Requires a standardized annual out-of-pocket spending limit so that no family faces bankruptcy due to medical expenses.
- Medicare beneficiaries enrolled in private plans will no longer be charged cost sharing above traditional Medicare.
- New requirements on plans will ensure that they keep costs down and pass on savings to consumers.

CREATING A MORE USER-FRIENDLY MARKETPLACE

The bill establishes a transparent, consumer-friendly health care marketplace that focuses on quality, affordable choices for all Americans and keeps insurers honest.

- Creates a new Health Insurance Exchange that provides people with a menu of both public and private quality, affordable health care options so they choose the plan that best meets their needs.
- Consumers and employers will have clear information and transparency on plan costs and benefits in the Exchange so they can comparison shop for the best deals and care.
- Consumer Advocacy offices, a website, 1-800 number and other outreach components will help people understand and select plans, ensure that they receive promised benefits and services, and provide additional help.
- Guarantees benefits so that all consumers have plans with high quality, critical and comprehensive health care benefits.
- Streamlines and simplifies all administrative forms, billing codes and other processes so the system is more efficient and less confusing for all plans, providers and consumers.

GUARANTEED BENEFITS

In order to achieve affordable, quality health care for all, America's Affordable Health Choices Act establishes standards to ensure that all plans in the new Health Insurance Exchange cover a comprehensive set of necessary services and offer cost-sharing protections for consumers.

BENEFITS:

GENERAL

- Establishes a standardized benefit package that covers essential health services.
- Eliminates cost-sharing for preventive care (including well baby and well child care) to underscore the importance of preventive health services in making America healthier and lowering the growth of health care costs over time.
- Caps annual out-of-pocket spending for individuals and families so that no one faces bankruptcy from health costs ever again.

- Creates a new independent Benefits Advisory Committee with physicians, other health care providers, business representatives, consumers and other health care experts, chaired by the Surgeon General, to recommend to the Secretary and update the core package of benefits to address the health care needs of Americans.

BENEFIT PACKAGES

The Exchange makes available four tiers of benefit packages from which consumers can choose to best meet their health care needs. Each plan covers the core benefits.

- *Basic Plan:* Includes the core set of covered benefits and cost sharing protections.
- *Enhanced Plan*: Includes the core set of covered benefits with more generous cost sharing protections than the Basic plan.
- *Premium Plan*: Includes the core set of covered benefits with more generous cost sharing protections than the Enhanced plan.
- *Premium Plus Plan*: Includes the core set of covered benefits, the more generous cost sharing protections of the Premium plan, and additional covered benefits (e.g., oral health coverage for adults, gym membership, etc.) that will vary per plan. In this category, insurers must disclose the separate cost of the additional benefits so consumers know what they're paying for and can choose among plans accordingly.

GUARANTEED SET OF BENEFITS

A required core set of benefits provides coverage for essential health care services and items to ensure that consumers will no longer have to worry about being stuck in an inadequate insurance plan if they get sick. The levels of coverage will be defined by the Secretary of Health and Human Services working with the new Benefits Advisory Commission outlined above. Benefits must include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Equipment and supplies incident to physician services
- Preventive services
- Maternity services
- Prescription drugs
- Rehabilitative and habilitative services
- Well baby and well child visits and oral health, vision, and hearing services for children
- Mental health and substance abuse services

MAKING COVERAGE AFFORDABLE

America's Affordable Health Choices Act makes insurance premiums more affordable and reduces cost sharing for individuals and families otherwise unable to confront the high cost of health care.

It provides sliding-scale affordability credits for individuals and families with incomes above the Medicaid thresholds but below 400% of poverty. It also protects individuals and families from catastrophic costs with a cap on total out-of-pocket spending. In addition, it broadens Medicaid coverage to include individuals and families with incomes below 133% of poverty.

AFFORDABILITY:

AFFORDABILITY CREDITS

- Effective 2013, sliding scale affordability credits are provided to individuals and families between 133% to 400% of poverty. That means the credits phase out completely for an individual with $43,320 in income and a family of four with $88,200 in income (2009).
- Premiums: The sliding scale credits limit individual family spending on premiums for the essential benefit package to no more than 1.5% of income for those with the lowest income and phasing up to no more than 11% of income for those at 400% of poverty.
- Cost sharing: The affordability credits also subsidize cost sharing on a sliding scale basis, phasing out at 400% of poverty, ensuring that covered benefits are accessible.
- The Health Insurance Exchange administers the affordability credits in relationship with other federal and state entities, such as local Social Security offices and Medicaid agencies.

CAP ON TOTAL OUT-OF-POCKET SPENDING

- The essential benefit package, and all other benefit options, limit exposure to catastrophic costs with a cap on total out of pocket spending for covered benefits.

MEDICAID (SEE SEPARATE MEDICAID FACT SHEET FOR DETAILS)

- Effective 2013, individuals with family income at or below 133% of poverty ($14,400 for an individual in 2009) are eligible for Medicaid.
- State Medicaid programs would continue to cover those individuals with incomes above 133% of poverty, using the eligibility rules states now have in place.

STRENGTHENING MEDICARE

For more than 40 years, Medicare has offered critical health and financial stability for senior citizens, people with disabilities and those with end-stage renal disease, providing coverage for over 45 million individuals this year. America's Affordable Health Choices Act contains substantial payment and delivery system reforms that reward efficient delivery of quality care and change the incentives in today's health care system to encourage value instead of simply volume. It makes investments that will enable beneficiaries to continue to access high-quality, affordable care, while encouraging prevention and care coordination for those with chronic conditions. These efforts will help modernize the program and strengthen Medicare's financial health, protecting both beneficiaries and taxpayers.

IN MEDICARE, THE LEGISLATION INCLUDES THE FOLLOWING PROVISIONS:

PRIMARY CARE, COORDINATED CARE, AND MENTAL HEALTH SERVICES

- Reforms the sustainable growth rate system in Medicare's physician fee schedule to:
  - Eliminate the 21% cut in physician fees planned for 2011 and put physician payments on a sustainable path for the future
  - Reward primary care, coordination, and efficiency
- Increases reimbursement for primary care services and encourage training of primary care physicians
- Expands programs that reward physicians for spending time coordinating care for their patients
- Encourages more collaboration and accountability among providers via bundling of payments and advancing of Accountable Care Organizations
- Extends key protections for rural providers to ensure access to care in rural areas

- Improves access to mental health services

AFFORDABILITY AND QUALITY OF CARE

- Fills the "donut hole" in Medicare Part D (prescription drug benefit) by combining PhRMA's proposal to discount brand-name drugs in the donut hole with additional policy that fully eliminates the "donut hole" over time
- Eliminates cost-sharing for preventive services in 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 by:
    - Increasing asset limits for programs that help Medicare beneficiaries pay premiums and cost-sharing
    - Improving the Part D benefit for people dually eligible for Medicare and Medicaid
    - Extending the Qualified Individual program for low-income Medicare enrollees
- Enhances access to care for beneficiaries with limited proficiency in the English language
- Enhances nursing home transparency and accountability requirements related to resident protection and quality of care

EXTEND PROGRAM SOLVENCY BY FIVE YEARS OR MORE

- Improves payment accuracy to ensure that the right amount is paid
- Expands funding and authority to fight waste, fraud and abuse
- Eliminates overpayments to private plans

IMPROVING THE MEDICARE PART D DRUG PROGRAM

The Medicare Part D program (Part D) was passed into law in 2003, and has been offering drug benefits to Medicare enrollees since January 1, 2006. The program has helped provide access to drug coverage for millions of beneficiaries. However, analysts have identified a number of problems with the program, including difficulties posed by the so-called "donut hole", which causes seniors to lose coverage entirely for a portion of the year; administrative burdens that cause many low-income enrollees to miss out on benefits; and high drug prices that result from the inability of Part D plans to effectively negotiate with drug manufacturers. America's Affordable Health Choices Act has a number of provisions designed to mitigate these problems.

MEDICARE PART D PROVISIONS:

ELIMINATE PART D DONUT HOLE

- Reduce size of the donut hole by $500 in 2011.
- Eliminate donut hole completely (on a phased-in basis) within 15 years, using drug manufacturer rebates to cover the cost.
- Drug manufacturers provide 50 percent discounts on brand-name drugs in the donut hole to reduce costs during the phase-out.

ACCESS FOR LOW-INCOME BENEFICIARIES

- Increase allowable assets for those individuals who qualify for Part D low-income subsidies and require that the allowable asset level rise to take inflation into account.
- Reduce administrative barriers related to eligibility.

- Allow CMS to use "intelligent assignment" for low-income beneficiaries, assuring that the plans in which they are enrolled provide the best access to necessary drugs at the lowest cost to the beneficiary and Part D.
- Change calculation of which plans are eligible to enroll low-income beneficiaries at $0 premium to allow more enrollees to keep their plan each year, rather than be reassigned to a new plan.

PRESCRIPTION DRUG COSTS

- Establish a new program under which drug manufacturers must provide rebates for dually eligible beneficiaries, and use these rebates to pay for the donut hole closure.
- The rebates restore drug rebate levels in effect prior to 2006 when dual eligible beneficiaries received their drugs through Medicaid (not Part D), and manufacturers paid the higher Medicaid rebates.

CONSUMER PROTECTIONS

- Permit beneficiaries to change drug plans if the plan in which they are enrolled makes a formulary change during the middle of the year.
- Provide for enhanced oversight of reimbursements for beneficiaries who retroactively qualify as low-income beneficiaries.
- Establish new penalties for false or misleading marketing by Part D plans.

MAINTAINING AND IMPROVING MEDICAID

Medicaid covers health and long-term care services for over 60 million low-income Americans. States have over 40 years of experience operating the program with federal matching funds. America's Affordable Health Choices Act builds upon this existing state-based administrative structure to extend coverage to uninsured Americans who have incomes near or below poverty. It will also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries. These services will include preventive services appropriate to low-income children and adults for which there is evidence of effectiveness.

The Children's Health Insurance Program (CHIP) covers over 6 million low-income children who are not eligible for Medicaid. CHIP expires in 2013, the year that the new Health Insurance Exchange would begin operation. The bill ensures that children covered by CHIP at that time could enroll in a plan of their family's choice in the Exchange with no disruption in coverage and with financial assistance to make their new coverage affordable.

MEDICAID:

COVERING LOW-INCOME UNINSURED AMERICANS

- Effective 2013, individuals under age 65, with family incomes at or below 133% of poverty ($14,400 for an individual in 2009) would be eligible for Medicaid. The cost of care for those newly enrolled in Medicaid as a result of this policy would be paid by the federal government, with no state contribution.
- Those individuals with incomes at or below 133% of poverty who lose health insurance coverage within the previous 6 months (e.g., a young college graduate whose coverage under her parents' policy ends) would have the choice of enrolling in Medicaid or enrolling in the Health Insurance Exchange with assistance for their premiums.

- State Medicaid programs would continue to cover those with incomes above 133% of poverty using the eligibility rules that states now have in place.

IMPROVING ACCESS TO SERVICES

Medicaid payments to primary care physicians and practitioners for primary care services are increased from 80% of Medicare rates in 2010, to 90% in 2011, and 100% in 2012 and thereafter. The costs of raising these rates would be paid by the federal government.

INNOVATIVE DELIVERY SYSTEM REFORM

Reining in rising health costs and improving quality hinges on doctors, hospitals, and other providers working together to ensure they are providing the right care to the right patient at the right time. Rather than rewarding the *quantity* of care, payment systems must be modernized to reward high *quality* care. Realigning payment incentives will reduce overuse, slow the growth of health care costs, and improve Americans' health. America's Affordable Health Choices Act contains multiple provisions to reform the health care delivery system.

PROMOTING ACCOUNTABLE CARE ORGANIZATIONS

An "accountable care organization" is an organized group of physicians who are rewarded for providing high quality care at low cost over a sustained period of time. Section 1301 directs the Secretary to establish a comprehensive ACO pilot program and authorizes the continued expansion of the program where it proves successful in improving quality and keeping costs under control.

PROMOTING PAYMENT BUNDLING

Hospital and physician incentives can be restructured by paying a lump sum for an episode of care ("bundling" payments), rather than paying separately for each service provided. Section 1152 directs the Secretary to establish pilot programs to test the effectiveness of payment bundling across the nation in a wide array of formats so we can learn the best way to bundle payments to encourage efficiency and ensure quality.

REDUCING HOSPITAL READMISSIONS

Section 1151 uses new financial incentives to encourage hospitals and post-acute providers to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

REWARDING HIGH-QUALITY AND EFFICIENT CARE

Section 1162 provides for increased payments to Medicare Advantage plans that demonstrate high quality of care and outcomes and plans that significantly improve quality. Section 1123 increases Medicare rates by 5% in the areas of the country that provide the most efficient care.

PROMOTING THE "MEDICAL HOME" MODEL

Section 1302 directs the Secretary to establish a pilot program to reward physicians and nurse practitioners who make their offices a "medical home" for patients by being fully available to patients and by ensuring that patient care is coordinated and comprehensive. The Secretary is authorized to expand the medical home concept if it proves effective in improving quality of care and holding down costs.

PROMOTING "SHARED DECISIONMAKING"

There is evidence that providing patients with more information about the risk and benefits of treatment options can help keep health care costs down and ensures that patients are fully involved in the care they receive. Section 1235 directs the Secretary to establish a demonstration program to evaluate the benefits of having doctors spend more time consulting with their patients about various treatment options.

PROMOTING PRIMARY CARE

Primary care providers can provide lower cost and higher quality care for many ailments. Section 1303 increases payment rates for primary care physicians by 5% and provides an additional 5% payment increase for primary care physicians in health shortage areas. Section 1121 provides for preferential updates for payment rates for primary care services in Medicare. Section 2212 expands scholarships and section 2211 creates a new loan repayment program to train more primary care physicians. Section 2201 builds on current expansions to the National Health Service Corps to get more physicians to health shortage areas, and this expansion in the Corps could eliminate 40% of the current estimated deficit in primary care providers. Sections 1501 and 1502 encourage more training of primary care medical residents and advance training in the outpatient setting, where most primary care is delivered.

DISCLOSING FINANCIAL RELATIONSHIPS

Section 1451 reflects MedPAC recommendations that all manufacturers of drugs and devices should report their financial relationships with health entities, including physicians, pharmacies, hospitals, and other organizations. MedPAC has concluded that such relationships can create conflicts, which lead to increased spending and suboptimal patient care.

UPDATED PAYMENT RATES

MedPAC has identified areas of overpayment to skilled nursing facilities, inpatient rehabilitation facilities, and home health care providers. Sections 1101, 1102, and 1154 adopt these payment changes to ensure we are spending taxpayer dollars appropriately. Sections 1103, 1131 and 1155 embrace the President's recommendation to adjust payments so that providers are encouraged to increased productivity in how they deliver health care.

HEALTHCARE ASSOCIATED INFECTIONS

Section 1461 requires that hospitals and ambulatory surgical centers report public health information on healthcare associated infections to the Centers for Disease Control and Prevention. Section 1751 expands to Medicaid the current Medicare policy of denying payment for certain healthcare associated infections.

MORE AND BETTER HEALTH CARE DATA

The transition to a more efficient, higher-quality health care system begins with getting more data about the clinical effectiveness of medical procedures. Section 1401 invests $2.9 billion in comparative effectiveness research. Sections 1124, and 1441, 1443, 1444 and 1145 expand physician and hospital reporting of quality measures. Section 2531 creates a registry to track the use of medical devices. Section 1442 directs the Secretary to develop improved measures of health care quality. Section 2402 creates the Assistant Secretary for Health Information to provide for ongoing monitoring and reporting on critical population health data.

DEVELOPING NEW INNOVATIVE PRACTICES TO IMPROVE QUALITY

Measurement of quality is only useful if there are levers for change. Section 2401 creates the Center for Quality Improvement at the Agency for Healthcare Quality and Research in order to identify existing best practices, develop new best practices, and disseminate successful models around the country.

PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD AND ABUSE

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments of individuals, businesses, and government. Under America's Affordable Health Choices Act, existing compliance and enforcement tools are strengthened for Medicare and Medicaid. In addition, the new public health insurance option and Health Insurance Exchange contain protections against waste and abuse that build upon the safeguards and best practices gleaned from experience in other areas.

PROGRAM INTEGRITY: STRENGTHEN MEDICARE AND MEDICAID PROGRAM REQUIREMENTS FOR PROVIDERS, SUPPLIERS, AND CONTRACTORS

- Require providers and suppliers to adopt compliance programs as a condition for participating in Medicare and Medicaid.
- Require Medicare and Medicaid integrity contractors that carry out audits and payment review to provide annual reports and conduct regular evaluations of effectiveness.

ADEQUATELY FUND EFFORTS TO FIGHT FRAUD AND AGGRESSIVELY MONITOR MEDICARE AND MEDICAID FOR EVIDENCE OF FRAUD, WASTE, AND ABUSE

- Increase funding for the Health Care Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud. CBO has estimated that every $1 invested to fight fraud results in approximately $1.75 in savings.
- Create a comprehensive "Medicare and Medicaid Provider/Supplier" Data Bank, to enable oversight of suspect utilization and prescribing patterns and complex business arrangements that may conceal fraudulent activity.
- Narrow the window for submitting Medicare claims for payment in order to decrease the opportunities for "gaming" the system.

IMPROVE SCREENING OF PROVIDERS AND SUPPLIERS

- Create a national pre-enrollment screening program to determine whether potential providers or suppliers have been excluded from other federal or state programs or have a revoked license in any state.
- Allow enhanced oversight periods or enrollment moratoria in program areas determined to pose a significant risk of fraudulent activity.
- Require that only Medicare-enrolled physicians can order durable medical equipment (DME) or home health services paid for by Medicare, and allow the Administrator of the Centers for Medicare and Medicaid Services to adopt similar requirements for other "at-risk" programs.

NEW PENALTIES TO DETER FRAUD AND ABUSE

- Create new penalties for submitting false data on applications, false claims for payment, or for obstructing audits or investigations related to Medicare or Medicaid.
- Establish new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.

SHARED RESPONSIBILITY

America's Affordable Health Choices Act will ensure that all Americans have access to quality, affordable health care coverage through shared responsibility among individuals, businesses and government. Individuals would be responsible for purchasing health insurance coverage and most employers would be responsible for offering coverage. Individuals, employers and the government would be responsible for contributing to the cost of coverage.

SHARED RESPONSIBILITY:

THE GOVERNMENT WOULD ENSURE AFFORDABILITY OF COVERAGE THROUGH AFFORDABILITY CREDITS

True access to quality health care cannot happen if coverage is not affordable. The bill will ensure all Americans can afford health care coverage by providing affordability credits and expanding Medicaid for those below 400 percent of poverty.

- Affordability credits will be available for individuals and families with incomes above Medicaid eligibility ($14,404 for an individual or $29,327 for a family of four) up to 400 percent of poverty level ($43,420 for an individual or $88,200 for a family of four). The amount of credit is reduced as individual and family income increases.
- Only individuals and families who seek health care coverage in the Exchange will receive affordability credits.

ALL AMERICANS WILL BE RESPONSIBLE FOR HAVING HEALTH INSURANCE, EXCEPT IN CASES OF HARDSHIP

The reforms in the bill will make health care coverage more affordable so that all Americans have access to coverage that protects against catastrophic costs.

- Individuals who choose not to obtain basic health coverage will be subject to a modest penalty based on 2.5 percent of income. In no case would the penalty exceed the average cost of a health care policy in the Exchange.
- Hardship waivers will be granted to individuals based on criteria such as affordability or religious objections, among other reasons.

EMPLOYERS MAY CHOOSE BETWEEN PROVIDING COVERAGE FOR THEIR WORKERS OR CONTRIBUTING ON BEHALF OF THEIR WORKERS

Under the bill, employers have a responsibility to help make health insurance available for their employees. Businesses that do not offer health coverage to their workers would pay an 8 percent payroll tax to help subsidize coverage in the Exchange.

- Employers would contribute 72.5 percent of the cost of premiums for all full-time employees' health coverage and 65 percent for a family policy.
- Employers have the option of providing part-time employees with health coverage by contributing a share of the expense, or contributing to the Exchange in order for part-time employees to seek coverage there.
- In the fifth year after the Exchange begins, companies that offer health insurance would have to meet minimum coverage standards like those required of plans in the Exchange.

- If an employer chooses not to offer health coverage to its employees, a penalty will be assessed based on the size of company's payroll. That penalty will help fund the Exchange which is where that company's employees will purchase quality, affordable coverage.

SMALL BUSINESSES WOULD BE PROTECTED THROUGH EXEMPTIONS FOR LOW-WAGE FIRMS AND A NEW SMALL BUSINESS TAX CREDIT WOULD HELP FIRMS PROVIDING HEALTH COVERAGE

- Employers with annual payrolls that do not exceed $250,000 are exempt from the requirement to provide health insurance to their workers. For employers with over $250,000 in annual payroll, the penalty for not offering health insurance is 2 percent, rising up to the full 8 percent penalty for firms with annual payrolls above $400,000.
- Workers in exempt firms would still be eligible to get coverage through the Exchange.
- Many small businesses will also be eligible to receive a tax credit for the health insurance offered to their workers.

EMPLOYERS AND HEALTH REFORM

America's Affordable Health Choices Act will continue the principle of shared responsibility. It will also help employers pay for such plans and give them access to more comprehensive and fairer markets and regulations.

EMPLOYER-RELATED PROVISIONS:

FOR SMALL EMPLOYERS

- Provides access to the new Health Insurance Exchange, giving them the benefits of large-group rates normally enjoyed only by large employers, lower administrative costs, greater transparency, and the ability to offer greater choice of plans to their employees.
- Reforms rating rules so that small employers no longer pay higher premiums if they employ a sicker workforce.
- Assures costs of plans for small businesses will be stabilized.
- Provides a tax credit to assist small employers who want to offer coverage.
- Exempts small businesses from the "Pay-or-Play" requirements (see below) and phases in graduated rates as payroll increases.

FOR LARGER EMPLOYERS

- Leave insurance plans offered by larger employers generally unaffected, particularly for the first five years. After that employers can no longer place annual or lifetime caps on coverage.
- Require that larger employers, however, must comply with the "Pay-or-Play" requirements (that is, they must offer insurance to their employees or pay a payroll tax of 8 percent).
- Over time, businesses of all sizes may participate in the Health Insurance Exchange.

FOR ALL EMPLOYERS

- Will benefit as costs for the uninsured are no longer cost shifted onto employers.
- Provide cost control measures designed to increase employers' competitiveness.
- Reform health care delivery system to improve quality, including in employers' health plans.

PREVENTING DISEASE/ IMPROVING THE PUBLIC'S HEALTH

Increased access to treatment, while vitally necessary for fixing our broken health system, is only part of the answer. True reform requires prevention investments to reduce the strain that disease and poor health exert on our health care system. These investments are extremely cost-effective and beneficial, particularly as compared with treatment.

Preventive services can be divided into two general groups. Clinical preventive services are delivered to one patient at a time by a doctor or other health worker in a standard health setting. Community preventive services are delivered outside of this traditional clinical structure, and are frequently implemented across targeted groups.

Examples of Preventive Services	
Clinical Preventive Services	**Community Preventive Services**
▪ Cancer screenings (breast, cervical, colorectal, etc.) ▪ Daily aspirin use to prevent heart disease ▪ Adult and child immunizations ▪ Adult vision screening ▪ Hypertension treatment	▪ Telephone "quit" lines to help smokers kick the habit ▪ Distribution of child safety seats ▪ Improving healthy food availability at worksites to reduce obesity ▪ Educating diabetics about blood sugar control (at churches, libraries, etc.)

America's Affordable Health Choices Act's Prevention and Wellness provisions present a comprehensive policy designed to ensure that all Americans will receive the state-of-the-art in both clinical and community preventive services, undertaking a coordinated effort to make comprehensive prevention research, evaluation, and delivery a permanent part of the national landscape.

PREVENTION AND WELLNESS:

- Expand the capacity of two independent, advisory task forces — the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community Preventive Services (TFCPS) — to undertake rigorous, systematic reviews of existing science to recommend the adoption of proven and effective services.
- Provide new investments in the science of prevention to further expand the base of information available for evaluation by the task forces.
- Deliver clinical preventive services by including USPSTF-recommended services in Medicaid and insurance available in the Health Insurance Exchange.
- Eliminate cost-sharing on recommended preventive services delivered by Medicare and insurance available in the Health Insurance Exchange.
- Deliver community preventive services by investing in state, territorial, and local public health infrastructure and by providing grants to implement TFCPS-recommended services.

STRENGTHENING THE NATION'S HEALTH WORKFORCE

Expansions in coverage will strain an already stressed health workforce. Under America's Affordable Health Choices Act, existing scholarship, loan repayment, and training grant programs are strengthened to address the need for primary care, nursing, and public health professionals. The primary care workforce is also enhanced by expanding the National Health Service Corps and creating a new primary care loan program. Nursing workforce expansions are focused on advanced practice nurses who can deliver primary care services and train the next generation of nurses. A new generation of public health workers will be trained through a new loan repayment and scholarship program modeled on the National Health Service Corps. Finally, improved data and advisory systems, coupled with improved diversity and interdisciplinary programs, will provide ongoing surveillance and flexibility to ensure that workforce policies address the needs of a modern U.S. health system.

WORKFORCE:

PRIMARY CARE WORKFORCE (INCLUDING PHYSICIAN ASSISTANTS AND DENTAL WORKFORCE)

- Increase funding for National Health Service Corps to address workforce shortages in high need areas. Allow flexibility for part-time service.
- Create a new scholarship and loan repayment program for health care providers in areas of moderate need.
- Enhance student loan and faculty loan repayment programs for primary care providers.
- Strengthen grant programs for primary care training institutions.
- Expand general and pediatric dentistry, dental hygienists, and dental health programs.
- Encourage training for primary care physicians, encourage training outside the hospital where most primary care is practiced, and ensure that physicians are trained with the skills needed to practice health care in the 21st century.

Nursing Workforce (including PRIMARY CARE NURSING)

- Expand education, practice, and retention programs for nurses.
- Enhance existing student loan, scholarship, and loan repayment programs.
- Enhance development of advanced practice nurses, including those who deliver primary care services.
- Expand existing loan repayment programs to increase number of nursing faculty.

PUBLIC HEALTH WORKFORCE

- Create a scholarship and loan repayment program for public health workers, modeled after the National Health Service Corps.
- Strengthen programs for recruitment, training, and retention.
- Strengthen existing preventive medicine programs.

ADAPTING WORKFORCE TO EVOLVING SYSTEM NEEDS

- Strengthen existing programs to promote diversity in the health workforce.
- Authorize grants to promote interdisciplinary and community-based training.
- Establish broad interdisciplinary commission to examine workforce issues.
- Establish study center to gather better data on workforce needs.

SMALL BUSINESSES

Small businesses are among those who benefit most from America's Affordable Health Choices Act.

WHY SMALL BUSINESSES NEED HELP

- LESS THAN HALF INSURE WORKERS: Only 45 percent of America's smallest firms can afford to offer health care benefits. In fact, 60% of America's uninsured – or 28 million—are small business owners, workers, and their families.
- COSTS GOING UP: Insurance costs for small businesses have increased 129 percent since 2000.
- WORKERS PAY MORE: Small business workers pay an average of 18% more in premiums than those in large firms for the same benefits. Their deductibles are more than double.
- HIGHER ADMINISTRATIVE COSTS: Up to 25 percent of the cost of premiums for some small business health plans, compared to 10 percent for large firms.

GIVING SMALL BUSINESSES ACCESS TO AFFORDABLE, RELIABLE COVERAGE

UNDER BILL, SMALL BUSINESSES CAN NOW BUY POLICIES THAT NO LONGER:

- Exclude coverage based on pre-existing conditions
- Selectively refuse to renew coverage
- Charge different premiums based on gender, occupation, or pre-existing conditions
- Set unreasonable out-of-pocket spending limits that drive families deeply into debt

ADVANTAGES OF NEW HEALTH INSURANCE EXCHANGE FOR SMALL BUSINESSES

- Affordable large group rates
- Stable pricing from year to year
- Lower administrative costs
- Choice of plans for employees

ACCESS OF SMALL BUSINESSES TO THE HEALTH INSURANCE EXCHANGE

- In first years, the Health Insurance Exchange is targeted to serve employees of small businesses and the uninsured
- Small businesses will be able to participate in the Exchange as follows (under Rep. Dina Titus's amendment adopted by the Education & Labor Committee):
  - In year 1, firms with up to 15 employees will be eligible to enter the Exchange
  - In year 2, firms with up to 25 employees will be eligible to enter
  - In year 3, firms with 50 employees will be the minimum size eligible to enter
- Small Business Benefit Arrangements are authorized to help small businesses work together to navigate the Exchange (under Rep. Phil Hare's' amendment adopted by the Education and Labor Committee).

TAX CREDITS TO HELP SMALL BUSINESSES PROVIDE COVERAGE

- **A PERMANENT TAX CREDIT FOR SMALL BUSINESSES** to help them offer coverage to their employees – which phases out as employers' size and average wages increase
- **TAX CREDITS OF UP TO 50% OF THE COSTS** of providing health insurance to their employees for small businesses with 25 or fewer employees and average wages of less than $40,000

MOST SMALL BUSINESSES EXEMPT FROM SHARED RESPONSIBILITY REQUIREMENT

Just like auto insurance, everyone must be insured to make the system work. The bill is built on the concept of shared responsibility. Under the bill, individuals who are self-employed or unemployed would be required to purchase a plan if they don't qualify for other insurance. Mid-sized and large

businesses would be required to offer health coverage to their employees or pay an 8 percent payroll fee to help subsidize their coverage in the Exchange.

In recognition that providing health insurance is unaffordable for many small businesses, the bill exempts most small businesses from the shared responsibility requirement and subjects others to a lower rate. The following is a description of the provisions, as modified by the Blue Dog-Waxman agreement announced on July 29.

SMALL BUSINESSES GET EXEMPTIONS

- Payrolls of $500,000 or below are completely exempt
- Payrolls between $500,000 and $750,000 face a graduated fee if no coverage is provided

96% OF SMALL BUSINESS OWNERS NOT SUBJECT TO HEALTH CARE SURCHARGE

Under the bill, the wealthiest 1.2% of Americans would pay a surcharge on income over certain levels to help make health insurance affordable for small businesses and the middle class. For small business owners, the surcharge is only on net profits (or what you take out of the business) —receipts minus expenditures (payroll, capital expenses, etc.)—above $280,000 (for single filers) and $350,000 (for married filers).

96% OF SMALL BUSINESSES PAY NOTHING

- The nonpartisan Joint Committee on Taxation estimates that only 4.1% of small business owners would net that much and therefore 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 REMAINING 4%:

- 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% would pay the top rate —among them, hedge fund managers, private equity fund managers, lawyers, and lobbyists making millions of dollars a year

ADDRESSING HEALTH AND HEALTH CARE DISPARITIES

Within the United States, racial and ethnic minorities and other populations experience a broad range of disparities in disease burden, health outcomes, and access to quality health care. Expanding health insurance coverage will help to alleviate some of these disparities, but they must be accompanied by targeted strategies in both clinical and community-based health.

The bill contains a comprehensive set of provisions designed to ensure that health reform will meaningfully reduce or eliminate health and health care disparities.

HEALTH DISPARITIES PROVISIONS IN THE BILL:

- Strengthens and expands programs that promote diversity in the health workforce.
- Requires HHS Secretary to identify key health and health care disparities as part of a National Prevention and Wellness Strategy initiative.

- Directs the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services to take relevant health and health care disparities into account as they develop and disseminate evidence-based recommendations on the use of preventive services.
- Targets at least half of the funding in a new community-level preventive health grants program to proposals with the primary purpose of addressing health or health care disparities. Eligible grantees include "health empowerment zones," areas in which a community partnership provides multiple preventive health services.
- Establishes a new Assistant Secretary for Health Information who will coordinate and develop standards for the collection of key health information, including information that can be used to measure, study, and reduce health and health care disparities.
- Supports centers of excellence and health career opportunity programs to bring underrepresented minorities through the health workforce pipeline.
- Enhances the scholarship programs for students from disadvantaged backgrounds.
- Improves access to care for limited English proficient beneficiaries by providing enhanced funding through Medicaid and initiating a demonstration program in Medicare to reimburse providers for the provision of language services.

MEETING HEALTH CARE NEEDS OF SENIOR CITIZENS & PEOPLE WITH DISABILITIES

Medicare has been a stable, reliable program for senior citizens, people with disabilities and those with End Stage Renal Disease for over four decades and provides coverage for over 45 million individuals each year. Health reform is needed to rein in rising health costs for private and public programs alike. Improving and strengthening Medicare is a critical component of reform.

The House Democratic bill will improve Medicare beneficiaries' access to quality, affordable health care.

MEDICARE PROVISIONS IN THE BILL:

- **Fills the Part D Drug Program Donut Hole:** Addresses one of seniors' top concerns by filling in the Medicare Part D donut hole which will make prescription drugs more affordable. Seniors will receive 50% discounts on brand-name drugs in the donut hole immediately. The donut hole is reduced by $500 in 2011 and it is completely filled over a number of years.
- **Enhances Preventive Coverage:** Eliminates copayments for preventive services in Medicare.
- **Helps Low-Income Seniors:** Improves low-income subsidy programs to help ensure Medicare is affordable for those with low and modest incomes.
- **Combats Waste, Fraud & Abuse:** Ensures the program operates in the best interests of its beneficiaries – and all taxpayers – by expanding authority to fight waste, fraud and abuse.
- **Ends Medicare Advantage Overpayments:** Ends overpayments to private health plans in Medicare, called Medicare Advantage plans, and adds additional consumer protections to ensure that these plans are investing premiums in patient care and do not charge higher cost-sharing than traditional Medicare.
- **Protecting the Doctor-Patient Relationship and Improving Quality:** Resolves a long-standing problem with the physician payment formula in a way that promotes primary care and advances innovation. Investments in health delivery system reform will improve coordinated care, promote efficiency, and enhance quality.
- **Extends the Medicare Trust Fund:** Following the advice of experts at the Medicare Payment Advisory Commission, the proposal makes numerous changes in provider payments that enhance the solvency of Medicare and put it on stronger financial footing for the future.

MEETING WOMEN'S HEALTH CARE NEEDS

In our current health care system, women often face higher health costs than men and multiple other barriers to health insurance. Fewer women are eligible for employer-based coverage, and comprehensive coverage in the individual health care market is often unavailable or prohibitively expensive. As a result, many women are under- or uninsured, and simply can't afford the services they need. In a recent study, more than half of women — compared with 39% of men — reported delaying needed medical care due to cost.

WOMEN'S HEALTH PROVISIONS IN THE BILL:

- Makes key preventive care more affordable by eliminating cost-sharing on recommended preventive services (e.g., breast cancer screening, well baby, and well child care) delivered by Medicare, Medicaid, the new public health insurance option and private plan options in the Health Insurance Exchange. Over a number of years, all employer sponsored health plans would be required to cover preventive benefits without cost-sharing.
- Prohibits new plans from charging women more than men for health insurance. This protection will extend to health plans offered by employers over time as well.
- Includes coverage of maternity services as a benefit category in the essential benefits package. All plans in the Exchange would be required to cover maternity services and over time, plans outside the Exchange would be required to do so as well.
- Bans the insurance industry practice of rejecting applicants with pre-existing conditions, which has kept women with histories of health problems — even survivors of domestic violence — from accessing individual coverage.
- Requires employers to offer, at a minimum, essential health insurance coverage to their employees or contribute into the system to help their workers afford coverage through the Health Insurance Exchange.
- Offers affordability credits to ensure that insurance available in the Exchange is affordable for women and everyone with an income below 400% of poverty.
- All plans within the Exchange and outside the Exchange over time will be required to contain a standardized annual out-of-pocket spending limit to prevent women and their families from facing bankruptcy due to medical expenses.

RURAL AMERICA

The House health reform bill maintains Congress' commitment to rural America by ensuring that all individuals in rural areas have access to the care they need close to home. The bill:

- **Provides Coverage for Uninsured Rural Individuals:** In rural areas, the uninsured rate reaches 23 percent, almost five percent higher than in urban areas, and the current recession means that more people may lose access to their employer-based health coverage. The bill guarantees that individuals without access to affordable health insurance would have options for obtaining affordable, quality health care coverage.
- **Addresses Rural Payment Disparities:** The bill directs the Institute of Medicine to study geographic inequities in Medicare reimbursement rates and the Secretary to revise payment rates based on the IOM's findings.

- **Protects Rural Consumers from Discriminatory Practices that Make Coverage Unaffordable:** Insurance market reforms that prohibit insurance companies from denying coverage based on pre-existing conditions, protect consumers from high annual out-of-pocket spending, and prohibit charging higher premiums based on gender, will all help make health insurance more accessible and affordable for rural residents.

- **Provides Bonuses to Reward Primary Care Doctors that Practice in Shortage Areas:** Only 9 percent of physicians practice in rural America even though 20 percent of the population lives in these areas. The bill provides a 10 percent incentive payment for primary care doctors practicing in underserved areas, which combined with a current bonus for physicians in shortage areas, will help recruit and retain primary care physicians where they are needed most.
- **Ensures that Rural Doctors Are Paid the Same Rate for Their Work as Urban Doctors: Prior to 2003,** the Medicare reimbursement formula paid doctors practicing in rural areas relatively less for their work, even though they have the same training as their urban counterparts. The bill helps rural physicians by extending an existing provision that addresses this payment inequity.
- **Rewards Rural Physicians for Coordinating Care for Patients. Coordination of care by a health care professional can help ensure that patients get the right care at the right time. The bill creates a pilot program for "medical homes" in order to** reward physicians for spending time coordinating care for their patients and takes steps to ensure that small and community based practices, such as those predominately in rural America, can successfully participate.
- **Supports Community Health Centers in Rural Areas:** Community health centers are an important source of care in rural areas. The bill provides billions in new funds to support community health centers, and maintains the current requirement that these rural areas receive special consideration for distribution of funds.
- **Trains Primary Care Providers for Rural Areas:** There is a shortage of health providers in rural America, particularly primary care. The bill emphasizes training for primary care physicians by encouraging training outside the hospital where most primary care is practiced, investing in advanced nurse training, and significantly expanding the National Health Service Corps to address work shortages in high-need areas. A new student loan repayment program directs primary care physicians to areas of need, and also supports other specialties and professions to practice in high need areas.
- **Rewards Physicians who Provide Efficient Care.** The bill provides incentive payments to physicians practicing in areas that are identified as being the most cost-efficient areas of the country, many of which are in rural America.
- **Protects Payments for Rural Outpatient Hospitals:** When Medicare moved to a new payment system for outpatient hospitals in 2000, rural hospitals were protected from potential losses. The bill extends this current "hold harmless" policy for rural outpatient hospitals to ensure that rural residents will continue to have access to care.
- **Helps Certain Rural Hospitals Cover Their Lab Costs:** Rural hospitals have lower patient volume than their urban counterparts, making it more difficult to sustain much needed services such as laboratory tests. The bill helps to maintain access to routine lab tests for patients living in rural areas by paying small rural hospitals their reasonable costs for performing clinical laboratory tests.

- **Protects Ambulance Services in Rural America:** The bill protects seniors' access to ambulance services in rural areas by continuing an existing increase to Medicare reimbursement rates for rural ambulance services. These adjustments help compensate for the additional costs incurred for providing these services over great distances.
- **Ensures Access to Preventive Services in Rural Areas:** The bill eliminates cost-sharing for preventive care (including well baby and well child care) to underscore the importance of preventive health services in making America healthier and lowering the growth of health care costs over time. And the legislation caps annual out-of-pocket spending for individuals and families so that no one faces bankruptcy from health costs ever again.
- **Expands Access to Mental Health Services in Rural Areas:** There is a widespread shortage of mental health providers, particularly in rural areas, with nearly 75 percent of American counties lacking a psychiatrist. The bill addresses this disparity for seniors living in rural America by making marriage and family therapists and mental health counselors eligible for payments under Medicare.
- **Provides Certain Hospitals the Resources They Need to Compete in an Increasingly Competitive Labor Market:** The Medicare Modernization Act enabled certain hospitals, commonly referred to as "Section 508 Hospitals," to be more appropriately reimbursed by Medicare for the services they provide to rural communities. The bill continues these critical payment improvements, enhancing the ability of these rural hospitals to recruit and retain essential staff to care for Medicare beneficiaries in their communities.
- **Addresses Rural Health Disparities:** The bill spends $15 billion over five years on grants to deliver community preventive services to fight things like diabetes, obesity, tobacco use, and substance abuse. Half of these dollars must be spent on programs whose primary purpose is to reduce health disparities, including disparities between urban and rural chronic disease outcomes.
- **Expanded access to lower-price drugs for rural hospitals.** Under the HRSA 340b drug program, rural hospitals and clinics have access to outpatient drugs at low prices -- as low as those paid by the Medicaid program. The legislation extends the eligibility of certain rural and other hospitals under the 340b program to inpatient drugs.

FREQUENTLY REQUESTED LINKS

DISTRICT-BY-DISTRICT HEALTH CARE FACT SHEETS

SECTION-BY-SECTION ANALYSIS

LIST OF SUPPORTERS

LETTERS OF SUPPORT

TIMELINE FOR REFORM

HEALTH CARE SURCHARGE AND HOUSEHOLDS

HEALTH CARE SURCHARGE AND SMALL BUSINESSES

HEALTH BILL WOULD RAISE LESS REVENUE THAN REAGAN AND BUSH TAX INCREASES

HOW THE HEALTH CARE SURCHARGE WORKS

SUMMARY OF REVENUE PROVISIONS

PRESS RELEASE ON CBO SCORE

PRESS RELEASE ON CBO ANALYSIS, JULY 26, 2009

BILL TEXT (PDF)

BILL TEXT (HTML)

ENERGY AND COMMERCE COMMITTEE HEALTH CARE WEB PAGE

WAYS AND MEANS COMMITTEE HEALTH CARE WEB PAGE

EDUCATION AND LABOR COMMITTEE HEALTH CARE WEB PAGE

MAJORITY LEADER HOYER'S HEALTH CARE CLEARINGHOUSE

SPEAKER PELOSI'S HEALTH CARE WEB PAGE

SPEAKER'S DAILY MYTHBUSTERS

PRESIDENT OBAMA'S HEALTH CARE REFORM WEB SITE

HEALTH CARE CHECKUP: A LINE-BY-LINE REBUTTAL TO FALSE EMAIL

TWITTER FEED AT TWITTER.COM/HEALTHREFORMNOW

FACEBOOK PAGE AT WWW.FACEBOOK.COM/HEALTHREFORM