



AN AMERICAN SOLUTION
QUALITY AFFORDABLE
HEALTH CARE

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

JUNE 24, 2009

QUALITY AFFORDABLE HEALTH CARE

TRI-COMMITTEE HEALTH REFORM DISCUSSION DRAFT

OVERVIEW3

- WHAT'S IN THE HEALTH CARE REFORM BILL FOR YOU?
- TALKING POINTS
- A DOSE OF REALITY: MYTHS VS. FACTS
- HEALTH CARE BY THE NUMBERS
- HEALTH CARE Q&A
- COST OF INACTION

DETAILED SUMMARY11

- THE HOUSE TRI-COMMITTEE HEALTH REFORM DISCUSSION DRAFT

FACT SHEETS: HEALTH REFORM AT A GLANCE15

- HEALTH INSURANCE EXCHANGE
- PUBLIC HEALTH INSURANCE PLAN
- CONSUMER PROTECTIONS AND INSURANCE MARKET REFORMS
- GUARANTEED BENEFITS
- MAKING COVERAGE AFFORDABLE
- STRENGTHENING MEDICARE
- IMPROVING THE MEDICARE PART D DRUG PROGRAM
- MAINTAINING AND IMPROVING MEDICAID
- DELIVERY SYSTEM REFORMS
- PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD AND ABUSE
- SHARED RESPONSIBILITY
- EMPLOYERS AND HEALTH REFORM
- PREVENTING DISEASE/IMPROVING THE PUBLIC'S HEALTH
- STRENGTHENING THE NATION'S HEALTH WORKFORCE
- ENDING DISPARITIES
- MEETING HEALTH CARE NEEDS OF SENIOR CITIZENS & PEOPLE WITH DISABILITIES
- MEETING WOMEN'S HEALTH CARE NEEDS

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OVERVIEW

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

We know our economy and fiscal future are tied to building on what works in our health care system and fixing what's broken.

Here are 12 ways health care reform will help you and your family.

LOWER COSTS

- No more co-pays or deductibles for preventive care
- An annual cap on your out-of-pocket expenses—no longer driving Americans to financial ruin
- An end to rate increases based on pre-existing conditions, gender, or occupation
- Group purchasing power of a national pool if you have to buy your own plan
- Guaranteed, affordable oral health and vision care for kids

GREATER CHOICE

- Keep your doctor and your plan if you like them
- More plan choices, including a high-quality public health insurance option that would compete with private companies

STABILITY & PEACE OF MIND

- An end to coverage denials for pre-existing conditions such as heart disease, diabetes, or cancer
- Get the care you need with an end to lifetime limits
- Job and life choices will no longer be based on health care coverage

HIGHER QUALITY

- Doctors—not insurance companies—in charge of health care decisions
- More family doctors and nurses entering the workforce, at better payment rates, helping guarantee your access to quality care

HEALTH CARE 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 care 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 care 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 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.

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 CARE 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 care 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 care 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 care 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 care 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 care 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 discussion draft 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 care 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 discussion draft 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 discussion draft 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

THE HOUSE TRI-COMMITTEE HEALTH REFORM DISCUSSION DRAFT SUMMARY

The discussion draft provides quality affordable health care for all Americans and controls health care cost growth. Key provisions of the discussion draft include:

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

I. COVERAGE AND CHOICE

The discussion draft 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 by creating:

- **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 sets and enforces 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 all 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 includes a public health insurance option. It will create 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 discussion draft also protects consumers by prohibiting lifetime and annual limits on benefits. The proposal 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, dental 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 discussion draft:

- **Provides sliding scale affordability credits.** The affordability credits will be available to low- and moderate- income individuals and families. The credits begin and are most generous for those who are just above the proposed new Medicaid eligibility levels; the credits are completely phased out at 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 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 providers 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 proposal 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 discussion draft 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 based on two percent of 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 a fee 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, an exemption from the employer responsibility requirement will be put in place for certain small businesses. In addition, a new small business tax credit will be available for those firms who want to provide health coverage to their workers, but cannot afford it today. 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 discussion draft include:

- Expansion of Community Health Centers;
- Prohibition of cost-sharing for preventive services in benefit packages;
- 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 discussion draft expands the health care workforce through:

- Increases to 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 discussion draft 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 discussion draft implements major delivery system reform in Medicare to reward efficient provision of health care, including testing of innovative concepts such as accountable care organizations and bundling of acute and post-acute provider payments. New payment incentives will encourage a decrease in 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, creates new consumer protections for Medicare Advantage Plans, and improves low-income subsidy programs and coverage of preventive services, 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 be a leader in implementing value-based purchasing, accountable care organizations, medical homes, and bundled payments. These broad authorities will ensure the public option is a leader in efficient provision of quality care, spurring competition with private plans.

- **Improving payment accuracy and eliminating overpayments.** The discussion draft eliminates overpayments to Medicare Advantage plans and improves payment accuracy for numerous other providers, following recommendations by the Medicare Payment Advisory Commission. 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 discussion draft will simplify the paperwork burden that adds tremendous costs and hassles for patients, providers, and businesses today.

FACT SHEETS: HEALTH REFORM AT A GLANCE

THE HEALTH INSURANCE EXCHANGE

This discussion draft 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) that will lay out choices 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 PROVISIONS IN THE DISCUSSION DRAFT:

ABILITY TO COMPARISON SHOP

- Give people the ability to choose from a variety of plans — including a new public health insurance option — in the Exchange.
- Provide standardized benefit packages so that people will be able to comparison shop and make informed choices based on cost and quality.

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 Health Insurance 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, person 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 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 care reform is to provide quality, affordable health care for every American while preserving what works in today's system, expanding choice, and containing costs. The draft proposal provides a public health insurance option that would compete with private insurers within the health insurance exchange.

PUBLIC HEALTH INSURANCE OPTION PROVISIONS IN THE DISCUSSION DRAFT:

OVERVIEW

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

LEVEL PLAYING FIELD

- Require public plan to meet the same benefit requirements, and comply with the same insurance market reforms as private plans.
- Establish the public plan'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 plan must be financially self-sustaining, as private plans are.
- Public plan will need to build 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.
- Institutes new payment structures and incentives to promote these critical reforms.

PROVIDER PAYMENTS AND PARTICIPATION

- Initially utilizes rates similar to those used in Medicare; this tie is severed over time as more flexible payment systems are developed.
- Allow immediate integration into delivery reforms also contained in the discussion draft.
- Provider participation is voluntary

CONSUMER PROTECTIONS AND INSURANCE MARKET REFORMS

We must create a fair health insurance market where consumers can comparison shop to choose the health plan that best meets the needs of themselves and their families. This step is critical to our goal of controlling health care costs and ensuring quality, affordable health care for all Americans.

The discussion draft 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 discussion draft 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 refusing to renew plans. 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.
- 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 discussion draft 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, complete 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, 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, the discussion draft 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 PROVISIONS IN THE DISCUSSION DRAFT:

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 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., dental 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 dental, vision, and hearing services for children
- Mental health and substance abuse services

MAKING COVERAGE AFFORDABLE

The draft proposal 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. The proposal 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 PROVISIONS IN THE DISCUSSION DRAFT:

AFFORDABILITY CREDITS

- Effective 2013, sliding scale affordability credits are provided to individuals and families between 133% and 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% of income for those with the lowest income and phasing up to no more than 10% 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

Medicare has been a stable, reliable program for the elderly, disabled and those with end-stage renal disease for over four decades, providing coverage for over 45 million individuals this year. The House Democratic discussion draft rewards efficient delivery of quality care and makes investments that will enable beneficiaries to continue to access affordable care. These efforts will help modernize the program and strengthen Medicare's financial health while significantly improving benefits in the program.

PROVISIONS TO STRENGTHEN MEDICARE IN THE DISCUSSION DRAFT:

PRIMARY CARE, MENTAL HEALTH SERVICES AND COORDINATED CARE

- Overhaul 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; and,
 - Reward primary care, coordination, and efficiency
- Increase reimbursement for primary care services and encourage training of primary care physicians
- Improve access to mental health services
- Expand programs that reward physicians for spending time coordinating care for their patients
- Extend key protections for rural providers to ensure access to care in rural areas

AFFORDABILITY AND QUALITY OF CARE

- Fill the “donut hole” in Medicare Part D (prescription drug benefit) by providing an additional \$500 in coverage in 2011, and increasing that amount over time.
- Eliminate “donut hole” within 15 years
- Eliminate cost-sharing for preventive services
- Limit cost-sharing requirements in Medicare Advantage plans to the amount charged for the same services in traditional Medicare coverage
- Improve the low-income subsidy programs in Medicare by:
 - Increasing asset limits for programs that help Medicare beneficiaries pay premiums and cost-sharing
 - Facilitating enrollment in subsidy programs
 - Permanently extending the Qualified Individual program for low-income Medicare enrollees
- Enhance access to care for beneficiaries with limited proficiency in the English language
- Enhance nursing home transparency and accountability requirements related to resident protection and quality of care

PROGRAM SOLVENCY

- Improve payment accuracy to ensure that the right amount is paid
- Expand funding and authority to fight waste, fraud and abuse
- Decrease 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. The discussion draft has a number of provisions designed to mitigate these problems.

MEDICARE PART D PROVISIONS IN THE DISCUSSION DRAFT:

DONUT HOLE

- Effective 2011, reduce size of the donut hole by \$500.
- Eliminate donut hole completely (on a phased-in basis) within 15 years.

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.
- Provide for automatic reenrollment.
- 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.

PRESCRIPTION DRUG COSTS

- Establish a new program under which drug manufacturers must provide rebates for certain beneficiaries.
- Require that rebates for drugs used by “dual eligible” beneficiaries (those who qualify for both Medicare and Medicaid benefits) must be at least as large as drug rebates received by the Medicaid program.
- Restore drug rebate levels in effect prior to 2006 when dual eligible beneficiaries received their drugs through Medicaid (not Part D) and higher rebates were available.

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. The discussion draft builds upon this existing state-based administrative structure to extend coverage to uninsured Americans who have incomes near or below poverty. The discussion draft would also improve Medicaid payments to primary care practitioners to address concerns about access to needed services by Medicaid beneficiaries. After the new Health Insurance Exchange has been running for several years and built up enough capacity, low-income individuals and families would have the choice of enrolling in Medicaid or in a health insurance plan offered through the exchange.

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 discussion draft ensures that children covered by CHIP at that time could enroll in a plan of their family’s choice in the Health Insurance Exchange with no disruption in coverage and with financial assistance to make their new coverage affordable.

MEDICAID PROVISIONS IN THE DISCUSSION DRAFT:

COVERING LOW-INCOME UNINSURED AMERICANS

- Effective 2013, individuals 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.
- After the Exchange has been in operation for 4 years, all individuals eligible for Medicaid could choose to enroll in the Health Insurance Exchange rather than stay in Medicaid.

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.

DELIVERY SYSTEM REFORM

Reining in rising health cost and improving quality hinge 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.

DELIVERY REFORM PROVISIONS IN THE DISCUSSION DRAFT:

COORDINATED CARE

- Adopts payment mechanisms to promote better coordinated care by rewarding physicians that provide high quality care at reasonable costs to their patients.
- Creates incentives to reduce preventable hospital readmissions that reward transition planning and coordination for patients who move from a hospital bed back home or to another health facility.
- Promotes medical homes that compensate primary care providers for managing and coordinating their patients' care over time.
- Establishes demonstration projects to test “bundling” payment methodology under which one payment would be made -- rather than separate payments -- to acute and post-acute providers for a post-acute episode.

PRIMARY CARE AND TRAINING THE 21ST CENTURY WORKFORCE (SEE WORKFORCE FACT SHEET FOR DETAILS)

- Improves payment rates for family doctors and other primary care physicians.
- Provides scholarships, loan repayment, and training grant programs for primary care, nursing, and public health professionals.
- Encourages graduate medical education training of more primary care physicians.

PHYSICIAN ACCESS TO RESEARCH AND INFORMATION

- Builds on recent investments in comparative effectiveness research designed to ensure physician and patient access to the latest and most scientifically complete information on available medical treatments.
- Invests in development of robust quality measures on health outcomes.

WASTE, FRAUD AND ABUSE REDUCE

- Extends the solvency of the Medicare Trust Fund by decreasing overpayments to private plans in Medicare and improving payment accuracy in Medicare payment systems, consistent with recommendations from the Medicare Payment Advisory Commission.
- Expands authority and resources to fight waste, fraud and abuse within the Medicare program.

PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD & ABUSE

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments made by individuals, businesses, and government. Under the draft proposal, 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 PROVISIONS IN THE DISCUSSION DRAFT:

IMPROVE 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-participating 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 or for obstructing audits or investigations related to Medicare or Medicaid.
- Establish new penalties for Medicare Advantage and Part D plans that violate marketing requirements or submit false bids, rebate reports, or other submissions to CMS.

SHARED RESPONSIBILITY

The House Democratic health care reform discussion draft will ensure that all Americans have access to quality and affordable health care coverage through shared responsibility among individuals, businesses and government. Under the discussion draft, 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 PROVISIONS IN THE DISCUSSION DRAFT:

THE GOVERNMENT WOULD ENSURE AFFORDABILITY OF COVERAGE THROUGH AFFORDABILITY CREDITS

True access to quality health care cannot happen if coverage is not affordable. The House Democratic discussion draft will ensure all American can afford health care coverage on a sliding scale.

- Affordability credits will be available for individuals and families with incomes between 133 percent of poverty (\$14,404 for an individual or \$29,327 for a family of four) 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.
- In the fifth year after the exchange begins, childless adults who are eligible for Medicaid and had health coverage for the previous six months would have the choice of enrolling in Medicaid or gaining access to health care coverage in the exchange with the assistance of affordability credits.

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

The reforms in the House Democratic discussion draft will make health care coverage more affordable so that all Americans would 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 income. In no case would the penalty exceed the average cost of a health care policy in the exchange.
- Hardship waivers may 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 House discussion draft, employers have a responsibility to help make health insurance

available for their employees. Businesses that do not offer health coverage to their workers have an unfair competitive advantage over businesses that cover their employees.

- 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 would 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 payroll. That penalty will help employees find quality, affordable coverage in the exchange.

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 under a certain limit would be exempt from the requirement to provide health insurance to their workers. However, workers would still be eligible to get coverage through the exchange.
- Other small businesses would be eligible to receive tax credit for the health insurance offered to their workers.

EMPLOYERS AND HEALTH REFORM

Currently, most Americans under 65 who have health insurance have it as a benefit that is part of their job. Employers and employees usually share the responsibility of paying for this coverage.

The discussion draft will continue that 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 IN THE DISCUSSION DRAFT:

FOR SMALL EMPLOYERS

- Provide access to the new Health Insurance Exchange, giving them the benefits of large-group rates heretofore 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.
- Assure costs of plans for small businesses will be stabilized.
- Provide a tax credit to assist employers who want to offer coverage.
- Exempts small businesses from the "Pay-or-Play" requirements (see below).

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%).

- 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 measure designed to increase employers’ competitiveness.
- Reform health care delivery system to improve quality, including employers.

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
<ul style="list-style-type: none"> ▪ Cancer screenings (breast, cervical, colorectal, etc.) ▪ Daily aspirin use to prevent heart disease ▪ Adult and child immunizations ▪ Adult vision screening ▪ Hypertension treatment 	<ul style="list-style-type: none"> ▪ 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.)

The discussion draft 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 PROVISIONS IN THE DISCUSSION DRAFT:

- 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, Medicaid, 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 this draft proposal, 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 PROVISIONS IN THE DISCUSSION DRAFT:

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.

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 discussion draft 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 DISCUSSION DRAFT:

- Strengthen and expand programs that promote diversity in the health workforce.
- Require HHS Secretary to identify key health and health care disparities as part of a National Prevention and Wellness Strategy initiative.
- Direct 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.
- Target at least half of the funding in a new grants program for the delivery of preventive health services at the community level 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.
- Establish 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.
- Support centers of excellence and health career opportunity programs to bring underrepresented minorities through the health workforce pipeline.
- Enhance the scholarship programs for students from disadvantaged backgrounds.

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 discussion draft will improve Medicare beneficiaries’ access to quality, affordable health care.

MEDICARE PROVISIONS IN THE DISCUSSION DRAFT:

- **Fills the Part D Drug Program Donut Hole:** Addresses one of seniors' top concerns by filling in the Medicare Part D doughnut hole which will make prescription drugs more affordable. The initial investment reduces the gap 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 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 limiting their abilities to 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 DISCUSSION DRAFT:

- 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 private health plans would be required to cover preventive benefits without cost-sharing.
- Requires employers to offer adequate insurance coverage to their employees or pay 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.
- Include coverage of maternity services as a benefit category in the new basic benefit 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.
- Prohibit plans in the Exchange from charging women more than men by banning gender rating. This protection will extend to all health plans outside the Exchange over time as well.

- Ban 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.
- 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.