A summary of HR 3200

America's Affordable Health Choices Act of 2009

Introduction

This is Fifth Freedom's summary of HR 3200, America's Affordable Health Choices Act of 2009. While there are other health care reform bills being discussed, HR 3200 is the one that has been the focus of the majority of the debate, both in Congress and in the media.

Please note that this bill is over 1,000 pages of very complex text. If a section of this summary is of interest to you, you may wish to refer to the original bill to read the complete text. You can read any section of the bill at Thomas.gov: http://u.nu/6t883 . If clicking the link does not work, copy and paste the link into your browser's address bar.

If you are interested in this issue, you may wish to contact your representatives in Congress with your opinion. You can locate your representatives' contact information at Fifth Freedom's Web site: http://fifthfreedom.org/findrep.php .

Also, it should be noted that Fifth Freedom is a not-for-profit organization that strives at all times to be non-partisan. Fifth Freedom takes no official position on health care reform. This document is provided for information purposes only, and does not express or imply support for any particular political party, politician, candidate for office, or piece of legislation.

America's Affordable Health Choices Act of 2009

Sponsor: Representative John Dingell [D-MI]

Co-Sponsors: Representatives Robert Andrews [D-NJ], Dale Kildee [D-MI], Carolyn Maloney [D-NY], George Miller [D-CA], Frank Pallone [D-NJ], Charles Rangel [D-NY], Fortney Stark [D-CA], Henry Waxman [D-CA]

Purposes:

This bill is not designed to create a single-payer health care system. It will not transform American health care into a Canadian or British system. Rather, it would reform the current system by attempting to make health insurance and health care in general more affordable.

This bill…

1. Establishes a mandate (mandatory order or requirement) for most legal United States residents to have heath insurance.

2. Prohibits pre-existing condition exclusions.

3. Prohibits charging different premiums, except for reasons of age, geographic area, or family vs. individual plans.

4. Prohibits cancellation of coverage except for evidence of fraud.

5. Limits annual out-of-pocket expenses to $5,000 per year for an individual and $10,000 per year for a family.

6. Includes a public health insurance option to compete with private insurance.

7. Establishes a Health Insurance Exchange (HIE) within a proposed Health Choices Administration, to provide individuals and employers access to health insurance coverage choices. The HIE would contract with various insurers to offer benefit plans at competitive prices, by establishing a risk-pooling mechanism. This will allow individuals and small companies to band together to bargain for lower rates.

8. Provides a tax credit for low-income individuals and families to help pay insurance premiums.

9. Requires employers with payroll costs over $250,000 that are using the HIE to provide health insurance.

10. Provides for a tax on individuals without health insurance and employers that do not provide the required health insurance.

11. Provides for a tax on individuals with adjusted gross income exceeding $350,000.

12. Reduces Medicare payments to hospitals with excessive re-admissions.

13. Establishes a Center for Comparative Effectiveness Research, which would analyze cost variances for similar treatments across the country.
14. Further expands Medicaid eligibility and scope of covered preventive services, for lower-income individuals and families.

15. Increases Medicaid payments to physicians for primary care.

16. Requires the Secretary of Health and Human Services (HHS) to develop quality measures for the delivery of health care services in the United States.

17. Establishes the Health Benefits Advisory Committee chaired by the Surgeon General.

DIVISION A

Title I

Old individual insurance plans will be "grandfathered" in – If you want to keep your old individual plan and its terms, you can. After five years, all new plans must comply with the terms in this bill, which includes participating in the Health Insurance Exchange in Title II.

These terms include:

PROHIBITING PRE-EXISTING CONDITION EXCLUSIONS.
A qualified health benefits plan may not impose any pre-existing condition or otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent based on any health status-related factors in relation to the individual or dependent.

GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS.
Except for cases of fraud or not paying premiums, insurers may not cancel a plan.

INSURANCE RATING RULES.
Insurers may only charge individuals different rates for premiums due to age and geography. The youngest people covered under the plan may be charged no less than half as much as the oldest people covered under the plan. Insurers may charge more for family plans than for individual plans.

MINIMUM SERVICES TO BE COVERED.

- Hospitalization.
- Outpatient hospital and outpatient clinic services, including emergency department services.

- Professional services of physicians and other health professionals. (Includes fees related to services, supplies, office use, etc.)
- Prescription drugs.
- Rehabilitative and habilitative services.
- Mental health and substance use disorder services.
- Preventive services
- Maternity care.
- Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age.

COPAYMENTS ("COST SHARING")

Cost sharing shall be limited to $5000 a year for individuals and $10,000 a year for families. There shall be no cost sharing for preventative care, "well baby" care, and child care.

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Title II

Establishes the "Health Insurance Exchange" (HIE). The HIE "facilitate[s] access of individuals and employers, through a transparent process, to a variety of choices of affordable, quality health insurance coverage, including a public health insurance option."

Defines "Acceptable Coverage" as one of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE- Coverage under a qualified health benefits plan as defined in Title I.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN- Coverage under a grandfathered health insurance coverage or under a current group health plan.

(C) MEDICARE

(D) MEDICAID

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE

(F) VA- Coverage under the veteran's health care program

(G) OTHER COVERAGE- Such other health benefits coverage, such as a State health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this paragraph.

Individuals who do not obtain or purchase such "acceptable coverage" will pay fines.

The Commissioner of the HIE establishes what benefits are available under all participating health insurance plans.
Individuals making less than 400% of the federal poverty level are eligible for "affordable premium credits," assistance with insurance premium fees. Individuals will have to pay a portion of the premium equal to a percentage of their income, and the credits will pay the balance.

Individuals making 150% or less of the federal poverty level (FPL) will have to pay a portion of the premium equal to 3% of their income. Individuals making 350% to 400% of FPL will have to pay 11% of their income.

For one person, FPL is $10,830. For two, $14,570. For family of four, $22,050.

Eligibility for credits may be determined by state Medicaid offices. Individuals applying for these credits will automatically be checked for Medicaid eligibility. If they are eligible, they will be automatically enrolled instead of being given credits.

Establishes the Public Health Insurance Option. Premiums will vary by the same rules for private insurance – geography, age, and individual vs. family plans. Two billion dollars is set aside for the first year's insurance claims.

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Title IV

More on the taxes to be paid by individuals without "acceptable health care coverage."

Ordained ministers will be exempt from these fines.

In general, employers will pay fines equal to 8 percent of their payroll for not participating in health care coverage.

Surcharge on "high income individuals":
'(1) 1 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $350,000 but does not exceed $500,000
'(2) 1.5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000 but does not exceed $1,000,000, and
'(3) 5.4 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $1,000,000.
After December 31, 2012, this surcharge will double.

Clauses containing exemptions for large corporations and foreign corporations.

DIVISION B – Medicaid and Medicare improvements

Title I

Changes in Medicare Part D coverage limits and out-of-pocket thresholds to eliminate the "coverage gap".

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Title II

A study will be conducted to examine how Medicare service providers use language services, and the best ways to fund these services. **Appears to exclude ASL. "The terms 'interpreting' and 'interpretation' mean the transmission of a spoken message from one language into another".**

Medicare coverage for meeting with your doctor once every 5 years to discuss "advanced care" – i.e., end of life planning. Includes discussing hospice care, living wills, etc. **This appears to be the section that has people scared about euthanasia, but there is no mention of it here or anywhere else in the bill.**

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Title III

Establishment and funding for the "medical home pilot program", patient-centered, community-based medical care. After five years, outcomes will be evaluated, and the program may be re-funded.

Partial coverage for mental health services, including individual therapy, and marriage counseling and family counseling.

Federal government taking over the regulation of hospital construction and expansion.

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Title IV

Establishes the Center for Comparative Effectiveness Research, an organization that will research and compare the outcomes, effectiveness, and appropriateness of health care services and procedures.

The government at large will collect everyone's health care data through this Center. However, dissemination of this research shall "not include any data that the dissemination of which would violate the privacy of research participants".

Importantly, the section notes that "Nothing in this section shall be construed to permit the Commission or the Center to mandate coverage, reimbursement, or other policies for any public or private payer." This appears to mean that the Center has no authority to use its research to dictate what kinds of services or treatments insurance companies must cover.

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Title VI

Adds $100 million in funding to the Social Security Administration for "fighting fraud and abuse".

Creates new and/or increases current penalties for submitting false information in provider applications, private claims, Medicare marketing violations, and other areas.

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Title VII

Increases the number of people eligible for Medicaid.

Big reductions in Medicaid DSH payments - Total Federal payments to all States reduced by $1,500,000,000 in fiscal year 2017, $2,500,000,000 in fiscal year 2018, and $6,000,000,000 in fiscal year 2019.

Reduces payments to hospitals for readmissions.

Elimination of Medicare coverage gap by gradually increasing coverage limit and decreasing out-of-pocket spending.

Drops coverage of stop smoking drugs from outpatient coverage.

Coverage for family planning services, except for individuals who are pregnant. This appears to mean that there will be no federal funding for abortions.

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Title VIII

Sets aside $300 million for 2010-12 for the Health Care Comparative Effectiveness Research Trust Fund, and $375 million for each year thereafter. For 2013 and after, this shall be covered by an additional tax of $2.00 per year per person.

Establishes a tax on “plan sponsors” of self-insured health plans of $2.00 per year per person covered under the plan. “Plan sponsor” refers to employers, employer organizations, etc.

The $2.00 per person is the default amount for the “fair share per capita” of the Health Comparative Effectiveness Research Trust Fund’s expenses. Should these expenses be higher, the Secretary of Health and Human Services is assigned the job of calculating the new fair share per capita. This calculation will be made using the health care figures from the Consumer Price Index.

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Title IX

Removes some provisions from the Social Security Act related to the Trustees' annual report to the President, and presidential oversight of Medicaid. **The Trustees are no longer required to report the financial state of the Medicaid Trust Fund and its projected growth or shortfalls, and the President is no longer required to submit corrective legislation to Congress in the event of a shortfall.**

Establishes a program to administer and funding for "voluntary home visitation for families with young children and families expecting children." The program shall be designed to reduce child abuse and neglect, and to provide parents information about parenting techniques and child development, etc.

DIVISION C – Public Health and Workforce Development

Title II

Establishes the Public Health Investment Fund. This fund will be used to fund community health centers, the National Health Service Corps Program, the National Health Service Corps Scholarship and Loan Repayment Programs, primary care loan funds, primary care education, nursing workforce development, The National Center for Health Statistics, and The Agency for Healthcare Research and Quality.

Individuals with student loan debt to medical school can get up to $50,000 repaid by joining the National Health Service Corps Program and serving 20 hours a week for two years.

Establishes a similar loan repayment program, Frontline Health Providers Loan Repayment Program, for physicians working in underserved areas or fields.

Establishes the Public Health Workforce Scholarship Program. Individuals in med school can sign a contract agreeing to serve full-time as a public health professional in the Corps for 2 years to get a full 4-year scholarship.

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Title XXXI

(The bill skips from Title 2 to Title 31. This must be an error at the Government Printing Office, as all sources are like this.)

Establishes and funds the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services to research, make recommendations regarding, and establish a national strategy regarding preventive medicine.

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Title IV

(It skips again)

Establishes and funds the Center for Quality Improvement to identify, develop, evaluate, and implement best practices in the delivery of health care.

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Title V

Limits hospitals' use of group purchasing organizations to buy medications.

Creates a grant program to establish and fund School-Based Health Clinics (SBHC). Preference will be given to SBHCs that have been shown to serve "a high percentage of medically underserved children and adolescents, communities or populations in which children and adolescents have difficulty accessing health and mental health services, and communities with high percentages of children and adolescents who are **uninsured, underinsured, or eligible for medical assistance under Federal or State health benefits programs.** This appears to mean that Congress is predicting there will still be significant numbers of uninsured people after the bill's reforms become active.

Establishes and funds a national medical device registry to assist in analyzing the safety and effectiveness of Class II medical devices that are "implantable, life-supporting, or life-sustaining," and Class III medical devices.

Device classes are defined in Sec. 513 of the Federal Food, Drug, and Cosmetic Act. Class II devices are essentially medical devices that the FDA has approved for use, but has limited safety data concerning them. Class III devices are in the pre-market approval stage because the FDA has even less safety data concerning them than they do Class II devices.

The Registry will have access to each device's "type, model, and serial number or other unique identifier," and "claims data, patient survey data, standardized analytic files that allow for the pooling and analysis of data from disparate data environments, electronic health records, and any other data deemed appropriate by the Secretary" of Health and Human Services.

For example, a patient gets a new kind of pacemaker implanted. The Registry tracks the patient's medical data to determine how safe and effective the new device is. If it works really well, the device gets moved up to Class I, which is a device that has been proven highly effective and very safe. While the bill does contain numerous other provisions for tracking medical data, this is the only section where that data would have to be linked to individual people.

There is a rumor that this section of the bill mandates that all Americans receive a "tracking chip" or some other device. There is nothing even close to that in this section.

Establishes and funds a grant program to award grants to create nursing education programs and to create "pipeline to nursing" programs to help ancillary health care workers advance their careers by becoming nurses. To be eligible for a grant, the organization must be administered by a health care employer and a labor union representing the health care employees. **Non-union organizations will not be eligible for these grants.**

The funds in the grants are to be used for programs that "provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses" and "assist nurses in obtaining advanced degrees and completing specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis."

Programs may involve **"preparing incumbent workers to return to the classroom through English-as-a-second language education, GED education, pre-college counseling, college preparation classes, and support with entry level college classes that are a prerequisite to nursing."**

Finally, states may have federal health care funding withheld if they do not follow the dictates of this bill and force their counties and cities to do the same.

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