HR 3200, AMERICA'S AFFORDABLE HEALTH CHOICES ACT

MYTHS VS. FACTS

MYTH: HR 3200 will lead to out-of-control deficit spending.

FACT: HR 3200 is 100 percent paid for. It is financed through a combination of payment reforms from within the health care sector and a new surcharge on the richest Americans. This bill meets President Obama's commitment to only sign a health reform bill that is fully paid for. CBO cites an increase in the federal budget deficit of $239 billion over 10 years, however under statutory House pay-go adopted in July, this new spending is already set aside and does not count toward the cost of the bill. This is spending to fix the flawed payment system for physicians in Medicare (the SGR), preventing an automatic 20 percent decrease in reimbursement in 2010 and even greater reductions in subsequent years, and corrects a legacy problem from a Republican policy. There is bipartisan agreement to resolve this longstanding Medicare problem.

MYTH: HR 3200 subsidizes health insurance for illegal aliens.

FACT: HR 3200 explicitly prohibits illegal aliens from receiving any Federal dollars to subsidize health insurance. "Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States", is the direct quote found in Section 246. Section 242 also explicitly limits eligibility for subsidies to individuals who are lawfully present in the US. Some opponents are distorting a provision in this section that ensures that all of the income earned by members of a family is counted for the purpose of determining eligibility for subsidies, to falsely suggest that illegal aliens in a family would be eligible. This is a phony and a blatantly wrong reading of HR 3200.

MYTH: HR 3200 rations care.

FACT: There is absolutely nothing in the bill that would lead to rationing of care. Any opponent of reform should be challenged to point to any section of the bill that requires rationing of care.

HR 3200 provides funding for comparative effectiveness research which helps doctors make decisions about which treatments will be most effective for patients; it does not require doctors to use the findings, nor does it require insurance companies to make coverage decisions based on the findings. Comparative effectiveness research, instead of rationing care, will lead to better care for patients.

The insurance market reforms in HR 3200 will lessen the rationing of care that happens today. Insurance companies will no longer be able to retroactively cancel enrollees' insurance policy when they become sick (unless there is fraud) or refuse to cover important medical services; patients will no longer have to split pills in half because they can't afford their prescriptions; and no one will go bankrupt because of extraordinarily high out-of-pocket costs for health care.

MYTH: HR 3200 requires coverage for abortions and inserts the government into your medicine cabinet.

FACT: Health insurance plans in the Exchange will be required to meet an essential benefits package that is defined only by broad categories of services that anyone would expect an insurance plan to cover, including doctors' visits, hospital visits and prescription drugs. Recommendations around more specific benefits and cost sharing levels are delegated to a Health Benefits Advisory Committee that will be chaired by the Surgeon General and include representatives from all sectors of the health care system – including physicians. In the Exchange there will be four different levels of benefits offered by most plans so individuals will be able to choose which type of insurance plan he or she wants.

MYTH: HR 3200 will lead to single payer as the public option takes over the insurance market.

FACT: No one who has looked at the facts can honestly assert that the public health insurance option is a road to single payer. The public option is only one choice of many in the new Health Insurance Exchange. No one – not the government nor an employer – can force an individual or family to enroll in the public option. If you receive subsidies, you can enroll in the public option or private plans; if your employer offers you coverage through the Exchange, you can enroll in any private plan or the public option; if you choose to purchase coverage on your own in the Exchange, you can enroll in the public option or

private plans. In fact, only a small fraction of the insured population is expected to enroll in the public option. According to CBO analysis of the under-65 population, approximately 9 – 10 million people will choose to enroll in the public option by 2019; this is one-third of the total enrollment in the Exchange, and is less than 4% of all non-elderly individuals with health insurance in America.

MYTH: HR 3200 ends private health insurance and crowds out employer coverage.

FACT: CBO analysis shows that HR 3200 increases the number of people with private health insurance through their employer over the next decade.

If you don't have insurance from your employer and instead purchase health insurance in the individual market, you can also keep it. Once the Exchange is up and running, new individuals purchasing insurance can purchase private plans (or a public option) through the Exchange. Some of the private plans in the Exchange may look very similar to private plans offered outside of the Exchange; however, consumers will have peace of mind knowing that all of the plans in the Exchange have a cap on out-of-pocket spending and cover essential health benefits.

HR 3200 will eventually end sales of some insurance products, such as so-called "mini-med" plans. These are plans that have become notorious through the frequent news articles featuring people who enrolled in the plans, fell sick, and realized that the plan didn't cover basic services like hospital stays. Through a combination of affordability credits, different benefit levels and exemptions, HR 3200 will allow everyone to find a plan that meets their needs, but protects against plans that are falsely labeled as "insurance".

MYTH: HR 3200 leads to job loss by requiring employers to offer health insurance.

FACT: Currently, there is no requirement for employers to offer health insurance to their employees, yet 99 percent of large firms and almost 65 percent of small firms do so anyway. Employers attract high-quality employees by offering a health benefit and offering coverage helps with employee retention. For the firms offering coverage already, health reform will bring much needed competition and affordability to the insurance market. Requiring all employers to share

in the responsibility of providing health coverage creates a level playing field where employers who don't offer coverage can't shift costs onto employers who do. HR 3200 also acknowledges that offering health coverage may be burdensome for some employers and therefore provides assistance:

Exemption from any requirement: HR 3200 includes an exemption for business with up to $250,000 in payroll. Over 75 percent of employers will be exempt from the employer requirement. Above this payroll size, all employers will either have to offer coverage or pay a responsibility rate of 8 percent of payroll; however, employers with payrolls between $250,000 and $400,000 will pay graduated rates of less than 8 percent (section 412 on page 183).

Tax credit for offering coverage: In section 421 on page 188 of HR 3200, a 50 percent credit to help pay for premiums is made available for small businesses with 10 or fewer employees and with average employee wages of $20,000 or less. The credit rate phases out as employee size and average employee wages increase. The credit is fully phased out for firms with 25 employees or average wages of $40,000.

MYTH: Seniors' premiums for Medicare private plans will skyrocket.

FACT: HR 3200 brings equity between payments to Medicare Advantage plans and traditional Medicare. The federal government has been subsidizing private health insurance companies with taxpayer dollars. Private plans that are efficient and offer quality care will still be able to offer seniors affordable care with additional benefits. Plans that are pocketing the overpayments to increase executive pay and Wall Street profits probably won't. HR 3200 also protects seniors who choose a Medicare Advantage plans by prohibiting these plans from charging cost sharing that is any greater than the cost sharing under traditional Medicare.

MYTH: HR 3200 includes damaging cuts to Medicare programs.

FACT: The Medicare changes in HR 3200 work toward making the Medicare program more sustainable for the future and will reduce Part B premium growth in the coming years. All payment reforms in HR 3200 carefully consider seniors' access to and quality of care. HR 3200 restores fiscal responsibility to payments to certain Medicare providers that are currently being overpaid relative to their costs and

have extremely healthy profit margins from Medicare – some as high as 17 percent. The payment reforms are based on recommendations from the President in his 2010 budget or from the Medicare Payment Advisory Commission (MedPAC). Some of the payment cuts to providers are reinvested right back into the Medicare program, for instance to pay for closing the Part D donut hole or assistance for low-income Medicare beneficiaries.

MYTH: HR 3200 promotes euthanasia.

FACT: If a doctor and patient choose to have a conversation about end-of-life care and advance care planning, HR 3200 simply provides Medicare payment for the doctors' time. Doctors and patients can have this conversation as often as they wish, or never; Medicare will reimburse for the doctor's time once every five years, or more often if the patient becomes significantly sicker and wishes to have a conversation. HR 3200 does not require this conversation to ever take place. Section 1233 on page 424 of the bill explains what this conversation might include – such as the doctor educating a patient about an advance directive or living will; sharing what resources are currently available to learn about end-of-life care; and explaining options available for end-of-life care, including hospice. Advance directives are written by patients and help their doctors and family members understand the treatment that they wish to receive.