

Health Care Reform: Chapter Two

***The U.S. House of Representatives and
America's Affordable Health Choices Act***

Southern Early Childhood Association



**SECA Policy Brief
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The House Considers a Bill

On July 12, 2009, the U.S. House of Representatives was presented with draft legislation, ***America's Affordable Health Choices Act (HR 3200)***, that outlines a massive overhaul and change to the current health care system. The bill (a total of over 1000 pages) was created to meet the goal of the Obama administration in providing quality affordable health care for all Americans and controlling health care cost growth.

In discussions about health care reform, three major issues are being addressed:

- Quality of services
- Access
- Cost

On July 17, 2009, the House Education and Labor Committee passed the bill out of Committee. The House Ways and Means Committee also passed it on that day. It is currently in the House Energy and Commerce Committee and it has hit resistance there, particularly from members of the Blue Dog Coalition. (A scheduled hearing on Tuesday, July 21, 2009 was postponed.) Southern members of the House Energy and Commerce Committee are Rep. Mike Ross (AR), Rep. John Barrow (GA), Rep. Bart Gordon (TN), Rep. Gene Green (TX), and Rep. Charles Gonzalez (TX).

Although Speaker Pelosi had previously committed to having a bill voted out of the House before the August recess, that timeline appears to be problematic at this point.

What's In the Bill?

Because of the length and complexity of the bill, many policymakers cannot at this point definitively outline the components or potential impact of the bill; however, the House Education and Labor Committee has provided a summary that gives some insight.

Coverage and Choice

- A ***Health Insurance Exchange*** will be created that will serve as a marketplace for individuals and small employers to purchase health insurance. This is a new federal program. States will have the option of operating the exchange in lieu of the federal exchange if they follow the federal rules.

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- A **public health insurance program** will be created that will be in direct competition with existing health care insurance companies. It will be financed only through premiums collected.
- Health insurance companies will not be able to exclude persons from coverage due to **pre-existing conditions**. It will also change the way in which insurance premiums are set by limiting those factors only to age, geography and family size. Currently, insurance companies can charge rates based on health status, gender or other factors.
- A new **Advisory Committee**, chaired by the Surgeon General, will recommend a benefit package based on standards set in law. This new “essential” benefit package will serve as the basic benefit package for coverage in the Exchange. The basic package will include preventive services with mental health services, oral health and vision for children, a cap on the amount of money a person or family spends on covered services in a year, and no cost-sharing.

Affordability

- **“Affordability credits”** will be created that will be used to help make insurance premiums affordable. These credits will be available to families up to 400% of the poverty level or \$88,000 for a family of four. The credits will be administered by the Exchange with other federal and state entities.
- A **cap on annual out of pocket expenses** will be set.
- **Medicaid expansion** for families at or below 133% of the federal poverty level. The expansion will be fully federally financed. Reimbursement rates for primary care services will be increased with the new federal funding in order to incentivize doctors to participate in the Medicaid program.
- **Modifications to Medicare** will be enacted, particularly in the current drug benefit program.

Shared Responsibility

- Individuals will be **required to purchase** health insurance. Those who choose not to do so will be penalized with a penalty of 2.5 % of modified adjusted gross income.
- **Employers will be required** to provide health insurance to employees or contribute up to 8% of their payroll. The **payroll penalty** would begin at 2% for employers with annual payrolls over \$250,000 and increase to 8% for firms with payrolls above \$400,000.
- Businesses with payrolls that do not exceed \$250,000 are exempt from the previous requirement.



Prevention and Wellness

- **Community Health Centers** will be expanded.
- **Cost-sharing** for preventive services will be prohibited.
- **Community-based programs** to deliver prevention and wellness services will be created.
- A new system of **data collection** will be established to better identify and address racial, ethnic, regional and other health disparities.
- Funds will be provided to **strengthen** state, local, tribal and territorial public health departments and programs.

Workforce Investments

- The **National Health Service Corporation** will receive increased funding.
- Efforts to train additional **primary care doctors** and health professionals will be implemented.
- **Scholarships and loans** will be expanded to support individuals who are training for needed professions and shortage areas.

Controlling Costs

- The bill proposes **major delivery system reform in Medicare**, including new payment incentives to decrease preventable hospital readmissions, improving payment accuracy and eliminating overpayments, and preventing waste, fraud and abuse.
- The bill will **simplify the paperwork burden** in the current health care system.

Source: *America's Affordable Health Choices Act Summary*, <http://edlabor.house.gov>

The Implementation Timeline

If the bill is passed as constructed, how long would it take to implement the components of the legislation? According to an article in the *Arkansas Democrat Gazette*, the bill has the following timelines:

2010

- The Health Benefits Advisory Council would be established.
- Community health centers would receive additional funding.

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- Insurance companies would be unable to cancel existing policies, except for non-payment of premium.
- The paperwork reform effort would begin.
- A planned 20% cut in Medicare fees to doctors would be eliminated.

2011

- The Health Benefits Advisory Council would present the proposed “essential” benefits package to the Department of Health and Human Services.
- DHHS would establish a rule requiring insurance companies to spend a percentage of premiums on medical costs.
- The drug benefit in Medicare would be changed to eliminate the current “hole” in benefits.
- Higher income earners would begin paying a tax increase on their income to offset the costs of the reform effort.

2012

- Additional prescription benefits would be offered to low-income Medicare recipients.

2013

- Insurance companies would be barred from denying coverage based on pre-existing conditions.
- The new Health Insurance Exchange would begin operation and offer support for companies with up to 10 employees.
- The new government health insurance plan would be available.
- Individuals would be required to purchase insurance and employers would be required to offer health insurance or face penalties.
- Medicaid eligibility would be expanded.

2014

- The Health Insurance Exchange would be expanded to cover companies with up to 20 employees and people who can’t afford coverage under their employer’s plan.

2015

- A decision would be made whether to open the Exchange to all employers, regardless of size.

Source: Arkansas Democrat Gazette, July 21, 2009

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Some Questions to Ask

1. How does the **Children’s Health Insurance Program (CHIP)** fit into this new health care scenario? Will it be eliminated, enhanced or blended into the new system?
2. How will an **“affordability credit”** be administered? We have had limited success with credits such as the Earned Income Tax Credit over the years. Will this new credit be accessed by the families who need it?
3. If there is a **penalty assessed for uninsured persons**, what will this mean in terms of access to care? Will an uninsured person be denied treatment until they pay the penalty? Who will monitor and enforce this? Will it be a new requirement for health care providers?
4. With the significant amount of rural territory in the South, **access to care** is a major issue. What type of incentives will realistically encourage physicians to locate in rural areas? How will health care providers such as hospitals find a market base in those areas?
5. Insurance companies pay a **premium tax** to states in order to operate in that state. What is that money used for in your state? What would be impacted if that tax is no longer collected?
6. Children’s advocates have spent many hours over the years fighting for and winning access to **“mandated” health insurance benefits for children**. Will the new “essential” benefits package include all these mandates? What might be lost in order to keep costs down?
7. If the maximum eligibility for the **“affordability credit”** is set at \$88,000 for a family of four, who would be eligible in your state? With the South’s lower socio-economic levels and median incomes in the \$40,000-\$50,000 range, the Southern states would have a significant portion of their population who would be eligible for these credits.
8. What **capacity** currently exists at the state and federal level to implement these enhanced and expanded programs? The **enhanced use of technology** is being proposed; however, in the South, many families who need these services and supports do not have access to technology. How will that be addressed?

