Congressman Kurt Schrader's Summary of HealthCare Reform
Updated April 12, 2010

Healthcare is getting increasingly expensive for everyone. Even those who are happy with their health coverage are finding it more and more difficult to afford. Individuals and businesses are dropping healthcare coverage because of its cost. Millions of Americans do not have healthcare and many of those that do still worry about losing their coverage or finding their insurance is inadequate.

Meaningful healthcare reform needs to address the concerns of access and affordability for taxpayers, businesses, providers and individuals. Everyone needs to have some shared responsibility for their own healthcare. No one should be denied care based on preexisting conditions or simply because you lost your job. Inefficiencies, waste and abuse in the current system need to be eliminated and competition to drive down cost should be encouraged. More emphasis needs to be put on preventative and primary care. Seniors should feel protected and reform must work to make Medicare more solvent. Reimbursement to providers should be based on getting good health outcomes, not the number of services rendered. Perhaps most importantly, people should have the best information available to make the best decisions regarding their own healthcare.

The Health Care Package finally approved is based more on the Senate amended bill, HR 3590 than the House bill HR 3962 from last year. Although both were similar, there were substantial differences. In an attempt to give you some basic information about what is actually in the final health care package, I have prepared a general summary.

Please feel free to contact my office if you have any additional follow up questions.

A number of individual benefits take effect this year, such as:

- Medicare beneficiaries get a $250 rebate to help start to close the prescription drug donut hole.
- No co-pays or deductibles for preventive care under Medicare or new private plans. (extended to all by 2014)
- Health plans may not drop people from coverage because they are sick, refuse coverage to children with pre-existing conditions, or impose lifetime or annual limits on coverage in new plans. (extended to all by 2014)
- Temporary high risk pool for uninsured that may have pre-existing conditions and temporary reinsurance for 55-64 age retirees until exchanges are available
- Parental coverage extension for children up to 26 years of age.
- New investment in training of primary care doctors, nurses and public health professionals.
- By 2011 seniors get a 50% discount on brand name drugs.

After 2014, all qualified health plans must provide basic services in 10 areas. The services must include: hospitalization, out-patient care, emergency services, prescription drugs, laboratory services, rehab services, mental health services, preventative-wellness-chronic disease management services, maternity and newborn care, and pediatric services (including dental, vision). The Health Secretary is required to be sure that the scope of those benefits be equal to that of a typical employer plan. Notice and public comment by the general public and providers is provided for to establish the details. After 2017, the Secretary may waive the exchange and basic benefit requirement if a state can cover as many at no greater cost.

For non-elderly Americans, private insurance will still be the dominant way Americans obtain access to health care. A new public insurance option (government-run or otherwise) was eliminated from the final proposal. Currently, 56% of Americans get their health care through their employers. The Congressional Budget Office estimates that after 10 years that will still be the case. Non-group and other health plans cover 10% now. With the exchanges (and it's subsidies to help lower income individuals afford private insurance on the open market) individual insurance will grow to 17%. Most of that increase comes from the previously uninsured. The legal uninsured population drops from 17% to 6%. Publicly funded Medicaid (for the poor) and CHIP (for children) rises from 15% to 18% as the eligibility is raised from 100% of federal poverty level to 133% ($16,245 for a single individual).

Individuals and families are required to have health care and pay a part of their premiums and co-pays unless they are very poor and qualify for Medicaid as outlined above. If individuals like their current plan they may keep that plan for as long as they would like under the final proposal. These grandfathered plans will have most of the same consumer protections added as in the newer qualified plans. Most individuals will get insurance through their employer as they currently do now. Individuals may also get private health insurance through the exchange. Under the exchange low and middle income individuals and families between 133% ($16,245 for an individual) and 400% ($67,000 for an individual) of FPL will get federal tax credits on a sliding scale based on income to help them afford health care coverage. However, if your employer offers you affordable health insurance that limits your out-of-pocket expense to no more than 9.5% of your income, you are ineligible for any subsidy tax credits should you decide to get insurance on the exchange. If you do not get insurance you are subject to a penalty on your tax return, but no criminal sanctions. The penalty varies with your level of income up to a maximum of $695 or 2.5% of income whichever is higher.

Employers are not required to provide health care for employees and their families. However, large employers with over 50 employees will have to pay a penalty of $2,000 per employee, excluding the first 30 employees, if they do not offer health care. 96% of small businesses have less than 50 employees and do not have to provide health care at all and are exempt from any penalties. Very small businesses with average payrolls below $25-40,000 will be eligible for a 35-50% tax credit if they chose to provide

insurance for the employee and the family. The employer is free to pick any plan and allocate employer-employee responsibility as he sees fit, regarding premium and co-pay cost sharing, as long as the deductible does not exceed $2,000 per individual or $4,000 per family and the overall cost does not exceed 9.5% of the family's income. For the first time, employers will also be able to deduct the full cost of their own insurance. With the state exchanges, regional collaborations and the SHOP act provisions businesses will be able to join in associations within and across state lines to leverage their collective buying power to drive down insurance rates like the large employers.

The exchange is a state run regulator that meets certain national standards so that it is easier for consumers and insurance companies to access price competitive health insurance. Ideally, private insurance will be more price competitive for individuals and small businesses pooling their collective buying power under the exchanges. If the state is unable to develop an exchange the federal Office of Personal Management that oversees the federal and congressional health care plans will do so. Members of Congress must get their health care through this exchange.

Childless, able bodied, poor adults (under 133% of the poverty level) are added to Medicaid. Historically Oregon's federal match to take care of our Medicaid population runs about 63%. The federal match for this new population will be phased in to 90% over the next 10 years. The States Children Insurance Program will receive a 23% increase in match starting in 2016. Medicaid and Medicare benefits are not reduced. Many efficiencies, productivity improvements and anti-fraud/waste measures are affected in the bill to save billions of dollars and provide better service for the individual, provider and insurer. Because of some profiteering by some companies Medicare Advantage will be changed to a base rate like other Medicare plans but with bonuses available for those plans that provide expanded benefits or access. By 2011, seniors get a 50% discount on brand name drugs. Currently, Medicare's prescription drug program has seniors paying the full cost of their prescriptions after incurring about $2,800 worth of costs up to $5,000 at which point Medicare picks up the bulk of the cost of their prescription needs. This legislation fills in that "donut hole" so there would be no gap in coverage by 2020.

Seniors today often have a difficult time finding a physician to take them on as a Medicare patient due to low rates of reimbursement in the current Medicare system. This legislation increases physician payment for primary care to 100% by 2013-14. This legislation and an executive branch letter signed by the Health and Human Services Secretary also end the Medicare reimbursement discrimination against high quality, low cost states like Oregon over the next two years. These two provisions will increase payment to Oregon's physicians hopefully enabling them to be able to take on new Medicare patients.

Cost containment for health insurance and health care costs is essential for improving our current system. The final legislation lowered subsidies $200 billion from the House

bill to a more sustainable level. Comparative effectiveness research is funded so that doctors and patients have the information they need to make smart healthcare decisions for them. Individuals pursuing healthier lifestyles are able to be rewarded with lower health care premiums. There is considerable investment in rooting out waste, fraud and abuse in our health care system at all levels. Transparency and electronic records will enable consumers to comparison shop prices and clinical results from different hospitals and providers. Oregon will also benefit from the emphasis on medical home delivery systems, accountable care organizations, pay for performance incentives, bundled provider payments, chronic disease management protocols and other coordinated care pilots because we are already pioneering in these areas. The new Center for Medicare and Medicaid Innovation will test innovative payment and service delivery models to further reduce program expenditures. And as referenced earlier, protocols for competition across state lines and a new Medicare reimbursement system based on quality not quantity of care will help control costs through competition. Finally, if cost containment targets are elusive, the Independent Medicare Advisory Board with the Secretary has the authority to make necessary changes to reduce the per capita growth in Medicare spending.

Public health, community based health centers and school based health clinics that provide better coordinated care are expanded. Preventative care and wellness strategies with evidence based results are to be developed. There will be no co-pay for preventative healthcare and primary care providers are reimbursed at 100% of Medicare for providing preventative care, information and primary services. Expanded delivery of public health and preventative care are recognized as ways to curb the long term healthcare cost curve thereby reducing costs to individuals and the system as a whole while providing a healthier life.

The bill recognizes that improving access to health care requires investments in workforce training and paying primary care practitioners better to be willing and able to handle the increased caseload. The legislation encourages graduate medical education, expands loan forgiveness for primary care practitioners, recognizes and incentivizes rural practitioners, promotes training in family, general internal and pediatric medicine, geriatrics, dentists, physician assistants, dental hygienists and nurse practitioners. A national advisory commission is established to review our health care workforce needs.

The final health care package is deficit neutral and fully paid for. Half of the cost of the final health care bill is paid for by savings in our Medicare and Medicaid systems. These efficiencies also extend the solvency of Medicare another 9 years beyond our current situation. The bulk of the other half comes from new fees and revenues from individuals earning more than $200,000 per year, insurers, pharmaceutical companies, and device manufacturers. The earliest begins in 2011, most by 2014. The Congressional Budget Office indicates that the health care legislation will decrease the nation's deficit by $143 billion in the next 10 years and more in the ensuing decades. It will also reduce federal expenditures on health care over time.

While the legislation is comprehensive, much work needs to be done in the coming years to provide the implementing details of the health care reform. Congress and all America will get to participate in making sure we get it right. Patients, providers, advocates, and businesses will all play a central role in making sure the reform works for all of us to reduce health care costs, provide more access, and make our nation healthier.