



League of Women Voters of Nashville—Education Update about Health Reform

MAY 2009

Quick Information about Health Care Reform: Fact Sheets that Condense Proposals for Change

- League of Women Voters of Nashville Program of Service on Health Care
- Obama Administration—Eight Principles to Guide Reform
- Commonwealth Fund PATH to a High Performance U.S. Health System (CWF Report)
- Congressman John Conyers—U.S. National Health Care Act
- Senate Finance Chair Max Baucus—Call to Action: Health Reform 2009 (White Paper)
- Senator Bernie Sanders—Access for All America Act
- Senators Ron Wyden and Bob Bennett—Healthy Americans Act
- Jacob S. Hacker, PhD—Healthy Competition: How to Structure Public Health Insurance Plan Choice (UC Berkeley Law, Brief)

This PDF is available at www.LWVnashville.org. Also check out www.healthreform.gov for information about the Obama Administration's response to the national grass roots movement for health reform and continually updated information on the health care legislative process.

*The information in this publication has been prepared to educate League members and the public about proposals currently being reviewed in Congress that may influence health reform. The LWVN does not endorse any of the reports or legislation presented.

The LWVN 2009 Program of Service on Health Care

Promote a health care financing and delivery system that assures an appropriate level of high-quality health care for all residents of Nashville, including the following services:

- Health and wellness education and promotion
- Primary care: prevention and treatment of illness, reproductive health care, maternal and child health care
- Behavioral health care: mental health care and substance use treatment
- Acute, urgent, and emergency care
- Long-term care: home- and community-based care

Provide information about the impact of TennCare on Metropolitan Government and on access to appropriate health care affecting residents of the county.

Support efforts to contain costs by using evidence-based medicine whenever possible, using best practices in care management, and promoting continuity and coordination of care.

UNDERSTANDING

PRESIDENT OBAMA'S COMPREHENSIVE HEALTH CARE REFORM INITIATIVE

COMMUNITY HEALTH CARE DISCUSSIONS ACROSS AMERICA

In December 2008, the Presidential Transition Team offered the country an opportunity to speak out on health care reform by hosting Community Discussions. During the holiday season over 30,000 Americans from all 50 states and the District of Columbia attended gatherings with family, friends, co-workers, and neighbors and shared their views about the current health care system and their hopes for the future. Ideas generated during those discussions have helped the new administration quickly chart a course of action founded on grassroots support. Participants spoke out for a system that is fair, patient-centered and choice-oriented, simple and efficient, and comprehensive. Their top four issues were: cost, lack of emphasis on prevention, pre-existing conditions limiting insurance access, and concerns about the quality of care. They recommended a White House Summit on Health Reform and continued Community Discussions. In addition, participants recommended positive solutions that clustered around the following themes:

- **Health Insurance Exchange:** Organize health insurance choices for Americans through a purchasing pool or exchange
- **Reducing Prescription Drug Costs:** Take aggressive action to lower the prices of prescription drugs
- **Research, Standards, and Promoting High-Value Health Care:** Improve health care quality and efficiency by using the power of research and standards
- **Simplification and Information Technology:** Harness the 21st century tools of information technology to help the system perform better
- **Education on Health and Wellness:** Educate everyone with the focuses on health and wellness
- **Promoting Healthy Lifestyles:** Combine education on health and wellness with incentives that promote healthy lifestyles
- **Expanding Health System Capacity:** Empower policy makers to invest in an expanded health care workforce and primary care clinics

WHITE HOUSE FORUM ON HEALTH REFORM

Building on this detailed input, President Obama welcomed over 150 guests to a White House Forum on Health Reform on March 5, 2009. Attendees included members of Congress, health care experts and clinicians, business owners, insurers, and everyday Americans. Travis Ulerick, a firefighter and EMT from Indiana who hosted one of the 9,000 community discussions in December reported on his group, thanked the President for challenging him to get involved, and gave his own challenge to the audience, telling them that “the time is now to reform our health system.” Five informative breakout sessions gave participants a chance to hear from other community representatives and to share their concerns with members of the administration and Congress.

Reconvened in the East Room, the President asked all participants to stay involved to ensure that health reform is enacted this year. His 2010 budget, “Jumpstarting the Economy and Investing for the Future,” provides eight principles to guide the reform process:

- ***Protect Families' Financial Health.*** The plan must reduce the growing premiums and other costs American citizens and businesses pay for health care. People must be protected from bankruptcy due to catastrophic illness.
- ***Make Health Coverage Affordable.*** The plan must reduce high administrative costs, unnecessary tests and services, waste, and other inefficiencies that consume money with no added health benefits.
- ***Aim for Universality.*** The plan must put the United States on a clear path to cover all Americans.
- ***Provide Portability of Coverage.*** People should not be locked into their job just to secure health coverage, and no American should be denied coverage because of preexisting conditions.
- ***Guarantee Choice.*** The plan should provide Americans a choice of health plans and physicians. They should have the option of keeping their employer-based health plan.

- ***Invest in Prevention and Wellness.*** The plan must invest in public health measures proven to reduce cost drivers in our system—such as obesity, sedentary lifestyles, and smoking—as well as guarantee access to proven preventive treatments.
- ***Improve Patient Safety and Quality Care.*** The plan must ensure the implementation of proven patient safety measures and provide incentives for changes in the delivery system to reduce unnecessary variability in patient care. It must support the widespread use of health information technology and the development of data on the effectiveness of medical interventions to improve the quality of care delivered.
- ***Maintain Long-Term Fiscal Sustainability.*** The plan must pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.

WHITE HOUSE REGIONAL FORUMS ON HEALTH REFORM

Following the March 5 forum, the administration has worked with Democratic and Republican Governors across the country to put together five regional events to seek additional public input on health care reform. Director of White House Office of Health Reform Nancy-Ann DeParle and White House Director of Domestic Policy Melody Barnes are co-moderating these meetings over the six week period:

- March 12 in Dearborn, Michigan, Michigan Governor Jennifer Granholm and Wisconsin Governor Jim Dole hosted 400 medical professionals, small-business leaders, automotive representatives, and everyday Americans for a town-hall style discussion about the essential role of health reform to economic recovery.
- March 17 in Burlington, Vermont, Vermont Governor Jim Douglas and Massachusetts Governor Deval Patrick hosted the second of five forums designed to include Americans around the country in an open and transparent process of health care reform.
- March 23 in Des Moines, Iowa, Iowa Governor Chet Culver, South Dakota Governor Mike Rounds, and Iowa Senator Tom Harkin hosted 500 people gathered from the two states for a spirited discussion that produced good suggestions and concerns to send back to Washington.
- March 31 in Greensboro, North Carolina, Governor Beverly Perdue hosted the event.
- April 6 in Los Angeles, California, California Governor Arnold Schwarzenegger and Washington Governor Chris Gregoire hosted the event with special guests Marian Wright Edelman, Dr. Dean Ornish, and Dr. Mehmet Oz.
- Those unable to attend one of the regional forums are asked to contribute their ideas and suggestions at www.healthreform.gov

WHAT'S THE BOTTOM LINE FOR US?

For the first time, everyday Americans from across the country are being challenged and accepting the call to design a model for health care reform that can help

- Families struggling with rising costs afford health care and medications
- Individuals who have lost jobs and the health insurance that was tied to employment
- Folks who have experienced catastrophic illness or injury and the economic peril that often accompanies such health care emergencies
- People with pre-existing conditions gain access to affordable health insurance
- Small-businesses and the self-employed find health insurance options
- American businesses retain their ability to compete in the world economy

ADDITIONAL INFORMATION: www.healthreform.gov (see PDF reports: “The White House Forum on Health Reform,” “Health Care Community Discussions,” and the 2010 Budget “Jumpstarting the Economy and Investing for the Future”); Hoffman B. (2003). Health care reform and social movements in the United States. *American Journal of Public Health*, 93(1), 75-85.

UNDERSTANDING

THE PATH TO A HIGH PERFORMANCE U.S. HEALTH SYSTEM (CWF Report)

In February 2009 the Commonwealth Fund Commission on a High Performance Health System published *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*.

The Commission recommends an integrated set of policy actions to:

- Expand health insurance to all
- Change the way we pay, invest in, and organize care to achieve better outcomes
- Substantially slow the growth in projected national health spending

Noting that it is urgent to start now, the Commission acknowledges the importance of leadership and bold steps to moving forward toward a health system that achieves better access, quality, and value in return for investment. While universal coverage is essential, strategic action must change the way health care is paid for and delivered with a new focus on health, disease prevention, prudent use of resources, and innovation.

This approach to health care policy provides a foundation on which to enhance the value of primary care and move from fee-for-service to a bundled methods of payment that encourage coordinated care, in which providers are accountable for improved health care outcomes and prudent use of resources. In addition, investment strategies accelerate the spread and use of health information technology and establish a center for comparative effectiveness to boost knowledge along with the appropriate use of evidence-based care.

WHAT'S IT DO?

Aligns Incentives to Enhance Value

- *Enhances Payment for Primary Care:* Increases Medicare payments for primary care by 5% and applies differential updates for primary care and other care.
- *Encourages Development and Spread of Patient-Centered Medical Homes:* Provides payment per patient in addition to fee-for-service to practices qualified to provide patient-centered care. Reduces premiums and cost-sharing to patients who designate a primary care practice as their medical home. Distributes shared savings based on performance.
- *Bundles Payments for Acute Care Episodes:* Expands and phases-in through 2016 acute care payment to include services during the hospital stay and 30 days post-discharge in a global fee structure.
- *Corrects Price Signals:* Modifies care payments: 1) Slows the rate of Medicare payment updates in geographic areas with high costs; 2) Reduces prescription drug costs by using Medicaid prices for drugs used by dually eligible beneficiaries and determining Medicare payments for unique drugs with effective monopolies based on prices paid in other countries; and 3) Resets benchmarks for Medicare Advantage plans to reflect projected per-capita spending under traditional Medicare.

Invests in Information Infrastructure

- *Accelerates Adoption and Use of Health Information Technology:* Requires all providers to report key health outcomes electronically by 2015 to qualify for payment updates. Provides funding to support health information networks and assistance for safety-net providers and small practices through a 1% assessment on insurance premiums and Medicare outlays.
- *Center for Medical Effectiveness and Health Care Decision-Making:* Creates a mechanism to develop information on the clinical and cost-effectiveness of alternative treatment options. Funds Center with a .05% assessment on insurance premiums and Medicare and Medicaid spending. Uses the information in benefit design with higher out-of-pocket costs or differential pricing depending on comparative effectiveness and includes physician-patient shared decision-making.

Promotes Health and Disease Prevention

- *Reduces Tobacco Use:* Increases federal taxes on tobacco products by \$2 per pack of cigarettes; uses revenues to fund public health programs and insurance expansion.
- *Reduces Obesity and Alcohol Use:* Establishes a new tax on sugar-sweetened soft drinks of 1 cent per 12-ounces to finance state obesity prevention programs, and increases the federal excise tax on alcohol by 5 cents per 12-ounce can of beer, with proportionate increases on other alcohol products; uses funds for prevention and insurance expansion.

HOW'S IT WORK?

- *National Health Insurance Exchange:* Gives businesses and individuals a choice of private plans and a new community rated public plan with phased-in eligibility for all by 2014. Benefits would mirror the Federal Employees Health Benefits Program standard options and use Medicare's claims administrative structure, reformed payment methods, and rates.
- *Individual Mandates:* Requires all individuals to obtain coverage.
- *Affordability:* Caps premiums at 5% of income for low-income individuals and 10% of income for those in higher-income tax brackets.
- *Shared Financial Responsibility:* Requires employers to provide coverage or contribute to a trust fund (modeled at 7% of payroll up to \$1.25 an hour).
- *Medicaid/SCHIP Expansion:* Sets Medicaid acute care benefits eligibility at 150% of the federal poverty income level; raises provider payment rates to Medicare levels with federal matching rates increased to offset state costs.
- *Medicare:* Eliminates the two-year waiting period for coverage of disabled individuals. Offers a supplement with the same acute care benefits as the new public plan with premium affordability provisions.
- *Insurance Market Reforms:* Requires community-rate premiums (age bands permitted) and guaranteed issue and renewal of policies.

WHAT'S THE BOTTOM LINE FOR US?

The Commission's five essential strategies for comprehensive reform provide a framework allowing public policy to move from concept to action by:

- Making coverage affordable for all
- Aligning incentives with value and effective cost control
- Providing accountable, accessible, patient-centered, and coordinated care
- Aiming high to improve quality, health outcomes, and efficiency
- Setting and achieving national goals through accountable leadership and collaboration

The Commonwealth Fund Commission Report embraces approaches to improve population health and provide positive patient experiences. If begun now, specific policies consistent with this vision show reduced projected health spending by a cumulative \$3 trillion by 2020 compared to current projections along with the achievement of universal coverage and improved health care outcomes (estimates by The Lewin Group for The Commonwealth Fund; details of The Lewin Group technical report are available at www.Lewin.com).

ADDITIONAL INFORMATION: www.cmwf.org

UNDERSTANDING

THE UNITED STATES NATIONAL HEALTH CARE ACT or EXPANDED AND IMPROVED MEDICARE FOR ALL ACT (H.R. 676)

Known as the Conyers Bill, H.R. 676 was introduced in 2007 by Congressman John Conyers, Jr. (D-MI) and garnered support from 93 House cosponsors. Congressman Conyers reintroduced the bill in January 2009 (again as H.R. 676) with 64 cosponsors to date. This legislation is presented as a uniquely American universal health insurance program with single payer financing. It would create a publically financed, privately delivered health care system that improves and expands the already existing Medicare program to all U.S. residents as well as all residents living in U.S. territories. Sponsors of this bill view its goal to ensure that all Americans have access, guaranteed by law, to the highest quality and most cost effective health care services regardless of their employment, income, or health care status.

WHAT'S IT DO?

- Provides a United States National Health Insurance Card and ID number to every person living or visiting in the United States and the U.S. Territories
- Covers all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, hearing services, long term care, palliative care, podiatric care, mental health services, dentistry, eye care, chiropractice, and substance abuse treatment
- Ensures patients their choice of physicians, providers, hospitals, clinics, and practices
- Requires no co-payments or deductibles

HOW'S IT WORK?

- Continues the operations of doctors, hospitals, and clinics as private entities
- Prohibits private health insurers from selling coverage that duplicates the benefits of the USNHC program
- Allows private health insurers to sell coverage for cosmetic surgery and other medically unnecessary treatments
- Hires and retrain workers displaced as a result of transition to a nonprofit health care system first and at their same salary for up to two years
- Bases conversion to a not-for-profit health care system on the sale of U.S. treasury bonds (to take place as soon as possible within a 15 year timeframe)
- Negotiates reimbursement rates for physicians annually
- Provides global budgets (monthly lump sums for operating expenses) to hospitals
- Negotiates prices for prescription drugs and medical supplies and equipment
- Establishes a "Medicare For All Trust Fund" to ensure a dedicated stream of funding based on authorized Annual Congressional appropriations for optimal levels of program funding, and to provide the number of physicians and nurses required in the health care delivery system
- Reduces long term health care inflation through savings from lower administrative costs, bulk purchasing, and coordination among providers (*estimated annual savings \$387 billion)
- Maintains current federal and state funding for existing health care programs
- Establishes employer and employee payroll taxes of 4.75%, which include the current 1.45% Medicare tax
- Establishes a 5% health tax on the top 5% of income earners and a 10% tax on the top 1% of wage earners

- Establishes a 0.25% stock transaction tax
- Closes corporate tax loopholes
- Repeals the Bush tax cuts for the highest income earners

WHAT'S THE BOTTOM LINE FOR US?

- H.R. 676 provides guaranteed lifetime comprehensive health care services including medication and durable medical equipment to all Americans
- Patients are ensured their choice of physicians, providers, hospitals, clinics, and practices
- Co-payments or deductibles are not required
- Funding will be shared by individuals, employers, and the government
- Individuals will pay a 4.75% payroll tax, which includes the current 1.45% Medicare tax (*estimated costs for a family of four earning \$56,200 per year is approximately \$2,700; sponsors estimate current total health care costs for a family of four excluding the Medicare tax to be \$4,225)
- Employers will pay a 4.75% payroll tax, which includes the current 1.45% Medicare tax (*estimated costs for an employee earning \$56,200 per year is approximately \$2,700; sponsors estimate the current employer share of annual health insurance premiums (74%) for a family of four excluding the Medicare tax to be \$8,510)
- U.S. Government will pay approximately the same amount as currently expended to cover all Americans

ADDITIONAL INFORMATION: www.conyers.house.gov or Joel Segal (joelsegal@mail.house.gov)

*Dean Baker, Co-Director, Center for Economic and Policy Research (CEPR).

UNDERSTANDING

CALL TO ACTION: HEALTH REFORM 2009 (White Paper)

Senate Finance Chairman Max Baucus (D-MT) released a white paper in November 2008 entitled *Reforming America's Health Care System: A Call to Action*. His report has serious implications for health care legislation during the 2009 session. It begins by understanding the urgent need to develop meaningful health reform that provides coverage for every American while also addressing the underlying problems in our health system.

Baucus' paper asserts that the lack of access to care, cost of care, and need for better quality care must be addressed in concert providing health care reform that is comprehensive in scope. He cites reform as an essential part of restoring America's economy and maintaining our ability to compete internationally. His blueprint for change is structured to create a high-performing health care system.

WHAT'S IT DO?

- Recognizes as intolerable and unsustainable a health care status-quo of high costs, unacceptable numbers of uninsured and underinsured Americans, and far less than optimal quality and value
- Guarantees all Americans affordable, quality coverage no matter their age, health status, or medical history
- Helps end the shifting of costs from the uninsured to the insured by requiring all Americans to have health insurance (obligation could be enforced, possibly through the tax system)
- Develops a coalition of employers, individuals, health providers, insurance plans, and government to bear responsibility and contribute to covering all Americans
- Refocuses our health care system toward prevention and wellness rather than on illness and treatment, strengthening the role of primary care and chronic care management
- Increases quality resulting in lower costs
- Ensures truly portable health care coverage

HOW'S IT WORK?

- Creates a nationwide insurance pool call the Health Insurance Exchange (HIE) for those who need affordable, guaranteed coverage
- Allows individuals who already have health coverage to keep what they have
- Precludes private insurers participating in the HIE from discriminating against clients based on pre-existing conditions (coverage could not be denied to those who had been sick; higher premiums could not be charged because of age or prior illness)
- Mandates individual responsibility to have health coverage
- Provides premium subsidies to qualifying families and small businesses
- Establishes a Medicare by-in to make health care coverage immediately available to Americans aged 55 to 64 while the HIE is being created
- Phases-out the current two-year waiting period for Medicare coverage for individuals with disabilities
- Provides every American living below the poverty level access to Medicaid
- Allows all states to use the Children's Health Insurance Program (CHIP) to cover children at or below 250% of the Federal poverty level (the 2009 reauthorization of CHIPRA provides flexibility to expand CHIP to families with incomes up to 300% of FPL without setting a cap on eligibility)
- Provides additional funding for the Indian Health Service (IHS) to provide care to Native Americans and Alaska Natives

- Covers preventive services under all insurance options offered through the HIE
- Encourages accountability and coordination among providers through integrated, patient-centered care systems (physicians, inpatient hospitals, and post-acute care settings would collaborate to improve quality and save money)
- Invests in comparative effectiveness research and health information technology to improve health care infrastructure
- Curbs excess health care spending by:
 1. Detecting and eliminating fraud, waste, and abuse in public programs
 2. Addressing overpayments to private insurers in the Medicare Advantage program
 3. Increasing transparency of cost and quality information
 4. Requiring disclosure of payments and incentive to providers by drug or device makers
 5. Reform medical malpractice laws for lower administrative costs and health spending while ensuring fair compensation for injured patients
- Shifts focus from institutional care to services provided in the home and community to improve the quality of long-term care and reduce costs
- Explores targeted reforms of the tax code to make incentives more efficient, distribute benefits more fairly, and promote smarter spending of health care dollars by consumers themselves

WHAT'S THE BOTTOM LINE FOR US?

- All Americans will have health insurance and will be responsible to participate in the coalition of coverage
- Affordable, quality coverage will be guaranteed regardless of age, health status, or medical history
- Premium subsidies will be available to those who qualify
- Health insurance will be portable, allowing individuals to keep coverage from job to job
- Prevention and wellness will be emphasized throughout the health care system
- Policies will be enacted to curb excess health care spending

ADDITIONAL INFORMATION: www.finance.senate.gov

UNDERSTANDING **ACCESS FOR ALL AMERICA ACT (S. 486; H.R. 1296)**

Known as the Access for All America Act, this legislation introduced by Senator Bernie Sanders (D-VT) in February 2009 seeks to provide access to comprehensive primary health care services for all Americans and to reform the organization of primary care delivery through an expansion of the Community Health Center and National Health Service Corps programs.

Currently there are 1,100 Federally Qualified Health Centers (FQHCs), which were established over 40 years ago through legislation initiated by Senator Ted Kennedy. Today 18 million Americans are served through these centers, which provide doctors, dentists, mental health counselors, and low-cost prescription drugs in underserved communities. The Access for All America Act will expand the number of centers and includes funds to train additional clinicians for the new centers under the National Health Service Corps. Community health centers have proven themselves to be effective and efficient in helping clients through preventative efforts, providing treatment in clinics rather than emergency rooms, and addressing illness before hospitalization is needed. Many centers have satellite offices or clinics to provide greater access to services.

The Access for All America Act is co-sponsored by 22 other senators (including Edward Kennedy and Ron Wyden). In the House, Representative James Clyburn of South Carolina and 131 House colleagues (including John Conyers) have sponsored the companion bill.

WHAT'S IT DO?

- Completes the circle for universal health care coverage by improving access to medical and other health services through the proven medical home model of Community Health Centers, also known as FQHCs.
- Expands health center programs from 1,100 to 4,800 over five years.
- Ensures access to comprehensive primary medical, dental, and mental health care, and low cost prescription drugs to all 60 million Americans living in medically-underserved areas.
- Increases health service corps-supported primary care clinicians from 4,000 to 28,000.
- Saves between \$45 and \$80 billion by reducing inappropriate emergency room use and unnecessary hospitalizations.
- Saves Medicaid over \$16 billion per year.
- Creates 370,000 new jobs in the most economically-challenged communities (an average center employs 100 clinical, administrative, and support staff).*

HOW'S IT WORK?

- Raises the FQHCs authorization from \$2.065 billion to \$8.333 billion in the fifth year to expand health center programs more than four-fold.
- Increases the National Health Service Corps authorization over the next five years from \$125 million to \$1.155 billion to train an additional 24,000 primary care clinicians (both loan-repayment and scholarship assignees).
- Expands the community health center program and invests in the National Health Service Corps for less than 1% of current health care spending.
- Provides efficient and effective primary and preventative health care using a proven integrated community health center model.

- Reduces costs by 30% for Medicaid patients seen at health centers (about \$1,000 per person; health centers now service 5 million Medicaid patients).

WHAT'S THE BOTTOM LINE FOR US?

- Provides access to primary and preventive health care services for 60 million Americans living in urban and rural medically-underserved areas.
- Offers improved services at lower cost for Medicaid patients through the medical home, integrated care model.
- Eliminates high-cost emergency room and unnecessary hospital care that lead to cost-shift billing practices designed to recoup provider expenses from insured and paying clients.
- Fuels the economy through creation of new jobs.
- Encourages broader adoption of the cost-effective community health center model of care beyond underserved areas and populations (approximately one in eight—80,000 plus patients—now receive care at FQHCs regardless of income or insurance coverage).
- Promotes pursuit and practice of primary care as a career by encouraging willing primary care practitioners to collaborate with community health centers.

ADDITIONAL INFORMATION: www.sanders.senate.gov/news/record.cfm?id=308751

(*Study by George Washington University; cost assessments provided by the American Academy of Family Physicians' Robert Graham Center and The Lewin Group.)

UNDERSTANDING

THE HEALTHY AMERICANS ACT (S. 391; H.R. 1321)

Known as the Wyden-Bennett Bill, this legislation, first introduced in 2007 by Senators Ron Wyden (D-OR) and Bob Bennett (R-UT), was reintroduced in January 2009 because they see an America ready for change marked by the passage of serious health care reform. Wyden and Bennett describe their optimism as rooted in developments that haven't existed before:

- Bipartisanship based on a balanced understanding that universal coverage and market forces important to competition and innovation can function together
- Shared common ground evidenced by multiple alliances for health care reform
- Inability of states to go it alone
- Economic reality that employer-based health benefits must be modernized

To accomplish their goal, they presented a compact Healthy Americans Act (HAA), reaching across the aisle for bipartisan sponsorship by 13 other senators. In the House, seven House colleagues have sponsored the companion bill. The sponsors say that HAA builds on what works and improves what doesn't.

WHAT'S IT DO?

- Guarantees private health care coverage for all Americans and allows them to choose the health insurance that is right for them
- Provides health benefits equal to those that members of Congress now enjoy
- Modernizes the employer-employee relationship regarding health care benefits making health care portable from job to job and, importantly, allowing Americans to keep it between jobs
- Provides incentives for individuals and insurers to focus on prevention, wellness and disease management rewarding Americans for maintaining healthy lifestyles
- Establishes tough cost containment measures to save \$1.48 trillion over 10 years (CBO estimates the plan will pay for itself once the act is up and running by eliminating administrative costs and changing the outdated tax code that gives businesses write-offs for health plans)
- Returns surpluses to the government after the first two years of implementation.

HOW'S IT WORK?

- Individuals and families will continue to have private insurance policies that they can purchase from either their employer or one of their state's approved insurers
- If you currently receive health coverage from your employer, you can keep it, but your employer will no longer be in control of your health care decisions and if you lose your job, you won't lose your health insurance
- Your employer will give you a raise equal to the amount currently paid out for your health care coverage and the federal government will give you the tax deduction that your employer currently gets for providing you coverage
- Individuals who don't get coverage through their employer will also get the tax deduction and subsidies will automatically be applied for those who need them in order to guarantee that everyone can afford insurance
- Every adult and child will be enrolled in a HAA Private Insurance plan, unless coverage is provided through Medicare, Medicaid, a retiree health plan, a collectively bargained plan, a veterans' plan, or a plan of the Indian Health Service
- Employers, individuals, and the government will share responsibility for financing health care

- Employers that provide employee health benefits will have a two-year transition period in which to convert workers' health care premiums into higher wages; employers that do not offer health benefits will have to make phased-in employer shared responsibility payments
- After two years, all employers will make employer shared responsibility payments reflecting the relative ability of small and large employers and low- and high-wage industries to make such payments
- Employees will have the option to stay with current employer-negotiated plans or select a different plan
- Insurance companies will no longer be allowed to deny coverage based on prior illnesses or anything else and will be required to charge subscribers a standard rate (they will not be able to charge people who have pre-existing conditions more for insurance than they can charge healthy individuals)
- HAA also requires that insurance companies compete to keep you healthy and if you aren't satisfied with what your insurance company is providing, you will be able to change companies

WHAT'S THE BOTTOM LINE FOR US?

- HAA (S. 391; H.R. 1321) will require plans to provide benefits for health care items and services that are actuarially equivalent to or greater in value than the benefits offered as of Jan. 1, 2009, under the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefits Program (some plans may offer more alternative medicine coverage, some plans may offer a high-deductible with a health savings account, and others may offer more generous benefits)
- Sign-up will be as easy as checking a box on a tax form and premiums will automatically be withheld through the tax code. You will be responsible for premiums but you are guaranteed affordable coverage because the HAA introduces a generous health care standard tax deduction, which makes most or all of the cost of your coverage tax-deductible
- Health insurance will be portable, allowing you to keep your coverage from job to job
- Self-employed Americans will be able to sign up for a private insurance plan through their state or regional Health Help Agency, which ensures that – unlike under the current system – the self-employed will enjoy the same tax benefits and prices as everyone else
- Young people claimed as dependents will be able to remain on the family policy up to the age of 24 providing medical coverage and protecting against emergencies and serious life-threatening illnesses
- All individuals will be required to participate and those who fail to enroll will be fined an amount equal to the cost of coverage available plus a penalty of 15%
- HAA will provide insurance coverage to all Americans while simultaneously controlling costs by shedding light on how much is actually spent on health insurance and health care; establishing incentives for more economical health coverage purchasing by individuals; creating administrative efficiencies; emphasizing prevention, wellness and disease management; requiring hospital quality improvement; and, requiring all insurers to offer patients an electronic medical record

ADDITIONAL INFORMATION:

www.wyden.senate.gov/Issues/Legislation/Healthy_Americans_Act.cfm

UNDERSTANDING

HEALTHY COMPETITION: HOW TO STRUCTURE PUBLIC HEALTH INSURANCE PLAN CHOICE TO ENSURE RISK-SHARING, COST CONTROL AND QUALITY IMPROVEMENT (Berkeley Center on Health, Economic & Family Security, UC Berkeley School of Law, & Institute for America's Future)

In April 2009, Jacob S. Hacker, PhD, professor of Political Science at UC Berkeley and co-director of the Berkeley Center on Health, Economic & Family Security at the UC Berkeley School of Law, issued the *Healthy Competition* brief. It notes that the health care reform debate is increasingly focused on inclusion of “public plan choice.” Such a new public health insurance would operate within a national insurance Exchange and be modeled after Medicare. It would allow Americans who were under 65 years of age and did not have employer-based health insurance to enroll in a quality, affordable care plan offered through a network of providers across the country.

Properly structured, the new public plan would compete with private insurance on a level playing field, and have authority of bargaining power as one of its tools to achieve greater value in health care delivery. The goal: a health system where private and public plans compete side by side and are rewarded when they deliver better value and health outcomes to their clients. A new public plan offers stability, quality, affordable care, and high standards. Private plans provide pressure for innovation in care management and benefit design as well as an alternative for people who find that the public plan does not serve their needs.

WHAT'S IT DO?

- Promotes healthy competition between public and private health insurance alternatives on a level playing field.
- Places a crucial check on both the public and private plans encouraging them to remedy inherent weaknesses.
- Provides proven cost controls through lower premiums, lower out-of-pocket costs, and a long-term ability to restrain costs.
- Spurs improved quality of care.
- Establishes a hybrid model that builds on the best elements of existing public programs and private benefits while ensuring health security that current health financing plans do not provide.
- Safeguards and improves the Medicare model by upgrading the program.
- Offers a sensible, practical way based on established programs and models for nonelderly Americans without secure workplace insurance to obtain group coverage for quality, affordable care through a broad choice of providers in all parts of the country.

HOW'S IT WORK?

- Initiates a Health Insurance Exchange that interfaces easily with current employee sponsored group coverage and public programs (Medicaid, CHIP) to provide access to Exchange-offered public or private plans.
- Retains employment-based insurance in which employers continue to help pay premiums for privately purchased coverage.
- Requires employer contributions to the exchange for those who do not offer health coverage.
- Continues coverage for people currently covered by existing public programs (Medicaid, CHIP).
- Provides coverage for people younger than 65 without workplace insurance or access under an existing public program through the Exchange, which will be safeguarded by a separate

administrative body for the new public plan, along with rules, risk adjustment, and regional pricing to ensure a level playing field for public and private plans.

- Structures the new public plan to provide *national* terms for patients and providers; *governmental* rather than nonprofit administration under federal charter; *comprehensive* defined benefits on the same administrative platform; *built on Medicare's infrastructure*, using the basic overall structure of Medicare as a foundation for the new plans operations, such as using existing regional and national public administrative bodies and services of insurer who currently act as carriers by processing payments.
- Operates under *rules* that apply to private and public plans: *Community rating*—all plans charge the same rates to all subscribers; *Guaranteed issue*—all plans take everyone who wants to be in them; *Limits on marketing*—choice is based on objective information provided by the Exchange administrator; *Standardized and defined benefits*—at minimum, all plans offer a benefit package that meets a basic actuarial standards, covers the same full range of benefits, and has the same maximum limits on out-of-pocket spending; *Reserve requirements*—private plans must have adequate reserves, the public plan has the full faith and credit of the federal government; *Transparency*—all plans clearly state their terms and open their books for basic review of spending and revenues.
- Recognizes a need for *risk adjustment* that allows plans to be paid different amounts by the exchange based on the expected and realized risk of their enrollees so that neither enrollees nor plans are penalized when a plan attracts less healthy participants.
- Enacts a *regional pricing system* that ensures plans compete fairly with each other within geographic regions and relative disparities in plan costs are reflected in premiums that enrollees pay.
- Uses a *regionally based competitive bidding process* in which plans submit bids to provide standardized benefit packages within the nationally administrated Exchange (benefits provided will vary modestly to encourage plan diversity but within a common baseline for comparing bids).
- Authorizes *countervailing bargaining power* to ensure better rates and controlled costs without evidence of reduced access or impaired health.
- Offers a reasonable number of meaningful choices in which public plans offer stability, wide pooling of risks, affordability of premiums, broad provider access, capacity to collect and use pertinent information on a large scale to improve care.

WHAT'S THE BOTTOM LINE FOR US?

- Ensures quality, affordable coverage for all by providing access for nonelderly Americans without secure workplace insurance to a choice of public or private plans.
- Improves quality, health outcomes, and efficiency.
- Encourages competition that results in both public and private plans maximizing their strengths and, thereby, better serving the public, whether through employer-based or Exchange-based coverage.
- Provides innovative structure, safeguards, and bargaining power that can be adapted for use in Medicare reform.

ADDITIONAL INFORMATION: Hacker JS. 2008. The Case for Public Plan Choice in National Health Reform. www.law.berkeley.edu/files/bclbe/Hacker_final_to_post.pdf; Hacker JS. 2009. Healthy Competition. www.law.berkeley.edu; search for “healthy competition” to find pdf of brief