

**EXECUTIVE SUMMARY**  
**Energy and Commerce, Ways and Means, and Education and Labor Committees’**  
**Health Reform Discussion Draft**

The Health Reform Discussion Draft (“Draft”) is proposed legislation which was released by Chairman Waxman of the Energy and Commerce Committee, Chairman Rangel of the Ways and Means Committee and Chairman Miller of the Education and Labor Committee.

Enacting the Draft would break several of President Obama’s major promises to the American people. President Obama promised the American people that, if they liked their health insurance, they could keep it and that nothing would come between patients and their doctors. The Draft would break these promises through the creation of a government health plan and the imposition of new mandates on Americans’ current health insurance. These broken promises will have devastating consequences. According to the Lewin Group, private coverage will decrease by 113.5 million people (approximately 66% of all people currently covered under private health insurance) three years after enactment of the Draft, meaning that over 113 million Americans will not be able to keep their current health insurance and will have to find new doctors. The Draft also breaks President Obama’s promise that health reform will not increase the federal deficit. According to the consulting group HSI Network, the Draft would add \$3.5 trillion to the deficit over ten years.

The Draft will dramatically alter health care as the American people know it through 852 pages of legislative text, which is divided into three major divisions.

**Division A – Affordable Health Care Choices**

**Creates Government Plan**

The Draft requires the establishment of a government health plan that would be available through the new Health Insurance Exchange (which is described below). This plan will be administered by government bureaucrats who will determine benefits, premiums and payments to health care providers. Estimates suggest that private coverage will decrease by 113.5 million people due to the government plan. This decrease will occur because, despite claims to the contrary, the government plan cannot compete fairly with private plans. History shows us that when Washington decides to compete with the private sector, the biggest Treasury always wins.

**Authorizes the Establishment of Health Insurance Exchange and “Health Choices” Commissioner**

The Draft creates a new government agency called the Health Choices Administration, which will be tasked to run the new Exchange that will provide for the sale and regulation of health insurance policies. The Health Choices Administration will be headed by a government bureaucrat called the Health Choices Commissioner. This Commissioner will have the power to do the following: govern the Exchange; transfer

money from a government trust fund to finance the Exchange; prevent citizens from participating in the Exchange; permit (or not permit) employers to join the Exchange; terminate state exchanges; establish benefits standards for Exchange plans (i.e. standards governing amount of cost-sharing); set standards governing provider networks (i.e. allows the Commissioner to regulate access to doctors); set enrollment periods; reduce co-payments for out-of-network providers; develop an auto-enrollment process for those who do not choose a plan (nothing prevents the Commissioner from auto-enrolling those individuals into the government plan); establish a mechanism for pooling risk; prohibit plans from enrolling new individuals; impose civil monetary penalties; and suspend payments to health plans. As this lengthy but not exhaustive list shows, the Draft gives tremendous power to the Commissioner. This power will allow the Commissioner to significantly restrict the health choices of Americans.

### **Establishes New Federal Mandates for Health Insurance**

The Draft requires that all health insurance policies contain “essential benefits”, defined as services related to hospitalization, outpatient hospitals and clinics, doctors, prescription drugs, rehabilitation, mental health/substance abuse and preventative services. This new essential benefits package will serve as the basic benefits package for coverage in the Exchange and over time will become the standard for employer plans. Additional benefits and cost-sharing requirements could be added to these “essential benefits” based on the recommendations of a new entity called the Health Benefits Advisory Council, which would be chaired by the Surgeon General.

Under these new mandates, existing individual health policies could remain in effect but only so long as the carrier “does not change any of its terms and conditions, including benefits and cost-sharing” once the Draft take effect. This provision would prohibit these plans from offering new treatments (i.e. new generic drugs) as covered benefits. As a result, this provision effectively will prohibit individuals from keeping their current health coverage.

Employer coverage will be exempt from these mandates, but only for a five-year period, after which the Draft’s mandates would apply. By applying the new federal mandates and regulations to employer-sponsored coverage, employers will be forced to drop existing coverage.

### **Creates New Employer and Individual Taxes**

The Draft mandates that employers provide adequate health insurance coverage or pay a tax of 8 percent of wages paid. Beginning in the Health Insurance Exchange’s fifth year, employers whose workers choose to purchase coverage through the Exchange will be forced to pay the 8 percent tax to finance their workers’ Exchange policy, even if they otherwise provide coverage to their employees. The Draft also mandates that all Americans purchase health insurance by placing a tax on individuals who do not purchase “acceptable health care coverage.”

## **Division B – Medicare and Medicaid Provisions**

### **Contains Physician Payment Provisions**

The Draft provides for an increase in Medicare physician reimbursements for 2010 equal to the increase in medical inflation. The Draft also exempts physician-administered drugs from the SGR formula.

### **Endangers Specialty Hospitals**

The Draft imposes significant restrictions on physician-owned hospitals. These restrictions would, in effect, prevent specialty hospitals currently under development from opening and existing specialty hospitals from expanding.

### **Cuts Medicare Advantage**

The Draft cuts Medicare Advantage to traditional Medicare fee-for-service levels over a three-year period. CBO estimates that 2 million seniors will lose their current health coverage if these cuts are enacted.

### **Alters Medicare Part D**

The Draft extends the Medicaid drug rebate program to all Medicare beneficiaries receiving a full low-income subsidy, which will harm innovation and unfairly shift costs to the private sector.

### **Places No Limitations on Comparative Effectiveness Research**

The Draft establishes another center for comparative effectiveness research to judge the effectiveness of medical treatments. The Draft does not prohibit agencies, like the Centers for Medicare and Medicaid Services, from using comparative effectiveness research, including cost-effectiveness research, in making coverage and/or reimbursement decisions, which could lead to government rationing of life-saving drugs, therapies, and treatments.

### **Expands Medicaid Eligibility**

The Draft mandates that all States expand their Medicaid eligibility criteria to include every person under the age of 65 whose family income does not exceed 133.33% of the federal poverty level (FPL) (\$14,440 for an individual or \$29,400 for a family of four). For all of the existing Medicaid eligibility categories, the mandated minimum income eligibility level would be increased to 133.33% FPL. Since there is no existing categorical pathway into Medicaid for non-disabled, childless adults between the ages of 19 and 64 in current law, the Draft creates a new Medicaid eligibility category and coverage mandate for these individuals. Until 2018, States will receive full reimbursement for new populations made eligible by this section. This means that the

States will be reimbursed fully for any Medicaid-covered service provided to these individuals, which will eliminate any incentive for States to be fiscally responsible in their spending for these populations.

### **Gives Additional Authority to Family Planning Clinics**

The Draft gives family planning clinics, such as those operated by Planned Parenthood, the authority to designate anyone as eligible for Medicaid coverage for up to two months. The Act contains no limitation on the number of times such individuals can be made presumptively eligible for Medicaid, allowing these individuals to continue to receive taxpayer-funded Medicaid services without ever having to document that they are truly eligible to receive them.

### **Division C – Public Health**

#### **Authorizes Billions of New Spending for Prevention and Wellness**

The Draft authorizes \$33.7 billion in new spending for a “Public Health Investment Fund,” of which \$15.2 billion is dedicated to a “Prevention and Wellness Trust.”

#### **Increases Funds for Community Health Centers**

The Draft authorizes an additional \$12 billion from the Public Health Investment Fund for grants to community health centers.

#### **Authorizes Additional Funds for Workforce Programs**

The Draft increases maximum loan repayment levels for participants in the National Health Service Corps. The Draft also creates a new program for primary care scholarships and loan forgiveness. Finally, the Draft authorizes grants to hospitals and other entities to operate training programs and also provides financial assistance to students in certain medical specialties.