



**A Review and Comments On HR 3200
America's Affordable Health Choices Act of 2009
A Cheat-Sheet To The Bill**

One of the privileges of being an American is our ability to participate in its governance. We elect our officials to represent our views as our country continues to evolve with the changing dynamics internally and with the rest of the world.

Along with our beliefs in individual freedoms, our country also stands for compassion and looking out for the broader good of our society. Sometimes it's difficult to strike the right balance between the individual rights we cherish and the broader needs of our country. The health care debate strikes at the heart of this reality.

We encourage debate and discussion on the issues regarding our current health care system. Accounting for 18% of our economy (and growing), it is too important to leave alone. And as we participate in the discussions over the next weeks and months each individual has a responsibility to be informed about the issues we face, and the solutions we consider (including our elected officials).

The following is a brief summary of the contents of HR 3200 (America's Affordable Health Choices Act of 2009). This Act has provided the "first look" at one approach our country may consider to make the changes in our health care system. The Senate will be producing its own bill and there will be changes along the way, but as the debate begins let's make sure we're debating the real issues and not responding only to the "spin" that will be presented from both sides.

We are biased as we enter this discussion. Our country does provide the best health care in the world. But, we do not have the best health care system in the world. The system that has evolved is fragmented and inefficient, costs too much, and is creating increased financial hardship for many citizens. And, the system we have today will simply be economically unsustainable. Whether we like it or not, we need to make changes to get the costs of our system under control.

As you review our Cheat-Sheet of HR 3200 keep in mind we've attempted to be unbiased in our review. These documents are complex no matter who is responsible for writing them. Others may "interpret" the intent of some of the language differently, but that is the purpose of debate and discussion (we don't have all the answers either).

Our intent is to provide a general summary, in layman's terms, of the contents of the proposed legislation in a manner we can all comprehend. We did not delve into all of the specific details but provided the highlights and some comment where appropriate. We've included the page numbers of the primary Divisions/Topics of the Bill and the list of items included. The items are listed sequentially as outlined in the proposed legislation. This should provide you with an easy reference point if you want to look at the specific language. If you want the details, we've posted all 1018 pages of the Act on our site at www.collaborationhealthcare.com. Our intent is to provide the average citizen with an overall picture of the main contents and a way to find information to address specific concerns. You can decide if this is the approach you would like to use, can build on, need to research further, or take in another direction all-together.

Health care reform is an emotional topic. It always has been, and always will be. But, let's make sure we're debating the facts and not just the emotions when we're making the decisions today that will likely impact not only ourselves, but our children, and our grandchildren in the years ahead.

America's Health Choices Act of 2009 A Summary Major Divisions; Titles; and Items

America's Health Choices Act of 2009 (HR3200) is divided into three primary Divisions.

Division A: Affordable Health Choices covers pages 1-215 and has been one of the more visible topics of discussion. This Division includes the creation of the Health Care Exchange and the introduction of the Public Option methods to manage costs, create more competition, and improve access to care in the private sector.

Division B: Medicare and Medicaid Improvements include pages 215-856 and is the largest segment. This Division outlines all of the financial and delivery-structure changes that are recommended to improve the efficiency and the delivery of care and to maximize the value received for all Medicare programs (Including Medicare Advantage and Part D- Prescription Drugs), Medicaid, and CHIP.

Division C: Public Health and Workforce Development covers pages 856-1016 and includes the funding and recommendations to support the public health segment of our health system.

Division A: Affordable Health Choices (pp 1-215)

The goals of this Division, as stated in the proposed legislation, are to provide affordable, quality health care for all Americans and reduce the growth in health care spending. This would be accomplished by enacting strong insurance market reforms through the creation of the Health Insurance Exchange with a Public Insurance Option for consumers. The approach includes the use of affordability credits and some targeted funding methods to initiate shared responsibility among workers, employers, and the government.

Title 1- Protections and Standards for Qualified Health Benefits Plans (pp 14-72)

1. Protects an individual's ability to "keep what you've got" and provides employers 5 years to meet minimum benefit standards
2. Prohibits Qualified Health Benefit Plans from using pre-existing condition exclusions and rescissions of coverage
3. Limits "profit margins" by establishing a target medical loss ratio that must be maintained by Qualified Health Plans (85%)
4. Prohibits any restrictions (other than cost-sharing) unrelated to clinical appropriateness on the coverage of health care items and services
5. The actual benefit levels included are very general in the document; physician, hospital, etc. As we all know, health care requires specifics. The details of the benefit structure requirements will be interesting as they will substantially impact the costs
6. Establishes a private/public advisory committee- Health Benefits Advisory Committee- to develop and monitor the benefit structure requirements

7. Creates an Independent Agency of the Executive Branch- Health Choices Administration
8. Does not alter or supersede any statutory or other obligation to engage in collective bargaining over the terms and conditions of employment related to health care
9. Establishes standards for financial and administrative transactions to assist the consumer in health care delivery including determination of real-time financial responsibility, real-time adjudication of claims, timely acknowledgements, unambiguous reason and remark codes, and harmonizing common data elements across administrative and clinical transaction standards.
10. Establishes a reinsurance funding method for retirees and surviving dependents (The Retiree Reserve Trust Fund)

Title II- Health Insurance Exchange and Related Provisions (pp 72-143)

1. Creates the Health Insurance Exchange under the Health Choices Administration and under the direction of the Commissioner
2. Uses three segments for determining eligibility requirements for employers; Smallest Group, Small Group, Larger Group
3. Establishes permissible ranges of cost-sharing with consumers (essentially establishes maximum out-of-pocket limits)
4. Utilizes an automatic enrollment process for individuals in the Exchange with an opt-out option to encourage enrollment
5. Discusses premium methods allowed to minimize the impact of adverse selection on Qualified Health Plans
6. Creates the Special Inspector General for the Health Insurance Exchange;- Terminated after 5 years
7. Establishes the Health Insurance Exchange Trust Fund from taxes on individuals not obtaining acceptable coverage; employment taxes on employers not providing acceptable coverage, excise taxes, or taxes levied for failure to meet certain health coverage requirements
8. Provides for the optional operation of State-Based Health Insurance Exchanges through matching grants; States share in the expenditures
9. Creates the Public Health Insurance Option to operate along-side other Qualified Health Plan with a specific goal of providing a low-cost plan without compromising quality or access to care
10. Establishes contract rates for providers for the Public Option that are Medicare-based with a 5% “incentive” as long as providers participate in both Medicare and the Public Plan. Providers are automatically included in the Public Option unless they opt-out (and as long as they are participating in Medicare)
11. Creates Individual Affordability Credits to purchase coverage through the exchange for individuals with income up to 400% of the Federal Poverty Level (FPL)



12. No payment or participation for undocumented aliens

Title III- Shared Responsibility (pp 143-167)

1. All individuals are required to have coverage either through an employer or on their own through the Exchange
2. Minimum contribution levels are established for employers for single and dependent coverage (72.5% Single and 60% Family)
3. Establishes employer contribution requirements for employees declining employer coverage but obtaining it independently on the Health Insurance Exchange.
4. Establishes an employer baseline contribution of 8% of average wages paid by the employer and paid to the Health Choices Commissioner for deposit in the Health Insurance Exchange Trust Fund if an employer does not provide health benefits to employees
5. There are exceptions for small employers (<\$400k payroll)- but still some requirements

Title IV- Amendments to Internal Revenue Code of 1986 (pp 167-215)

1. There is a 2.5% tax (of modified gross income) if an individual does not acquire health care coverage
2. Establishes the employer excise tax for not offering benefits (discussed above)
3. Provides credits for small business employee health coverage expenses
4. There are many reporting requirements and significant disclosure (financial) required on behalf of the individual to determine eligibility for credits
5. Yes, there is a surcharge on high income individuals- From 1% to 5.4% of Modified Adjusted Gross Income (MAGI) (Starting at \$350k)

Division B- Medicare and Medicaid Improvements (215- 856)

Title I- Improving Health Care Value (pp 223-386)

Provisions Related to Medicare Part A (Hospital)

1. Incorporates market basket payment revisions to reflect productivity adjustments for Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Inpatient Acute hospitals
2. Includes prospective payment for Psychiatric Hospitals and Hospice Care
3. Increases payment for nontherapy ancillary service in a nursing facility and establishes a separate rating method for non-therapy ancillary services (but must be budget neutral)



4. Establishes a payment adjustment methodology for providers in response to coverage expansion and a decline in the “uninsured” rate in the country (This one is important for providers as it will be another opportunity to evaluate fees and costs)

Provisions Related to Part B (Physician Services)

5. Implements a Sustainable Growth Strategy for establishing physician fees for Part B and transitioning methodologies for future pricing (Providers should take a look at this as it impacts current and future fees that will be established with Medicare)
6. Establishes Accountable Care Organization Pilot Program in 2012
7. Rectifies potentially misvalued codes and validates existing Relative Value Units
8. Establishes a 5% incentive payments for efficient care delivery within an area
9. Modifies the Physician Quality Reporting Initiative (PQRI) to integrate clinical reporting on quality with reporting requirements related to the meaningful use of electronic health records
10. Specific References to California Fee Schedule Areas
11. Incorporates productivity payment adjustments into payment schedules that don't already have them including: Outpatient Hospitals, Ambulance Services, Ambulatory Surgical Center Services, Laboratory Services, Certain Durable Medical Equipment
12. Redefines the payment for rental and purchase of power-driven wheelchairs
13. Extends the payment rule for brachytherapy
14. Requires a Home Infusion Therapy Report to present to Congress
15. Requires ambulatory surgical centers to submit cost data and other data
16. Reduces payment to certain cancer hospitals if the costs are too high
17. Establishes a Medicare Improvement Fund of \$8 billion from 2011-2019
18. Defines payment for imaging services and for multiple imaging
19. Requires continuity of supplies mainly related to pharmacy providers for oxygen
20. Introduces a MEDPAC study and report on bone mass measurement and the adequacy of payment rates and access

Provisions Related to Medicare A and B (Both Hospital and Physician)

21. Reduces payments to hospitals for readmissions for certain conditions; will be adding additional conditions as identified by MEDPAC (Readmission costs are a major concern today)
22. Funding is made available for use by targeted hospitals for transitional care activities for patient noncompliance, providing care coordination services to assist in transitions from the targeted



- hospital to other settings, for discharge planning, and for providing consumer information (To help hospitals with transitional support required to avoid readmission)
23. Establishes a Post Acute Care Services Payment Reform Plan and Bundling Pilot Program
 24. Converts the Acute Care Episode Demonstration to a Pilot Program with expansion to include post acute services (by January 1, 2011)
 25. Establishes a home health payment update for 2010 with the ability to reallocate pricing based on data
 26. Incorporates productivity improvements into market basket updates for home health services
 27. Limits Medicare exceptions to the prohibition on certain physician referrals made to Hospitals- (Basically ownership-driven)
 28. Requires completion of an Institute of Medicine study of geographic adjustment factors under Medicare- Not later than one year after enactment combined with the revision of Medicare payment systems to address geographic inequities (This will be another important “follow-through” item)

Medicare Advantage (MA) Reforms (Changes for the Health Plans)

29. Phases-in a payment structure based on Fee-For-Service Costs; (This is a major change from the payment methods health plans are receiving today)
30. Establishes bonus payments for high quality Medicare Advantage plans based on a number of measurements: rates of admission and readmission; prevention quality; patient mortality; health functioning; patient safety
31. Simplifies annual beneficiary election periods
32. Improves Risk Adjustment for Payments- Authorizes a study for predicting costs of beneficiaries with chronic or co-morbid conditions and dual-eligibles to introduce required risk adjustments to payments by 2012
33. Eliminates the MA Regional Plan Stabilization Fund
34. Places limits on cost-sharing to individual for receiving health services- Basically establishes the limit at the level of cost-sharing that would be available if an individual wasn't under a Medicare Advantage Plan
35. Allows for continuous open enrollment for enrollees in plans with enrollment suspensions- (Protects a beneficiary from being dropped)
36. Requires MA Plan's to disclose to beneficiaries their medical cost ratios (how much is spent for health care- how much is spent on administration)
37. Modifies the ability to enroll into chronic care specialized MA Plan outside of Open Enrollment periods

Medicare D- (Prescription Drugs)

38. Eliminates the Coverage Gap (or doughnut-hole) with a phased-in approach starting in 2011; by increasing coverage limit and decreasing the out-of-pocket threshold
39. Drug manufacturers are required to provide drug rebates for full-benefit dual eligibles; these funds will be used to eliminate the Coverage Gap discussed above. (Some intense reporting requirements are included here)
40. Requires discounts (50%) from drug manufacturers for certain Part D Drugs included in the original Coverage Gap
41. Repeals provisions relating to the submission of claims by pharmacies located in or contracting with long-term care facilities
42. Includes the costs incurred by AIDS Drug Assistance Programs and Indian Health Service in providing prescription drugs toward the benefit limits Under Part D
43. Prohibits mid-year changes in to a drug formulary that adversely impact an enrollee

Medicare Rural Access Protections

44. Expands the focus on TeleHealth by establishing an Advisory Committee to study and explore remote care delivery opportunities

Title II- Medicare Beneficiary Improvements (p 386-443)

1. Increases asset test levels for Medicare Savings Program and Low-Income Subsidy Program
2. Eliminates Part D (prescription drug) cost-sharing for certain non-institutionalized full-benefit dual-eligible individuals
3. Minimizes barriers to enrollment by allowing self-reporting of assets and income
4. Increases the oversight relating to reimbursement for retroactive low-income subsidy enrollment-45 day payment requirement; (There is a lot of reporting requirements tied to this for the plans)
5. Utilizes “Intelligent Assignment” for enrollment for Part D if you don’t make a choice yourself
6. Includes a special enrollment period and automatic enrollment Process for certain subsidy-eligible individuals (Part D)

Reducing Health Disparities

1. Recommends a “Language Study” to determine the feasibility of payment methodology for on-site interpreters and contracting with agencies to provide language for those with Limited English Proficiency (LEP)



2. Establishes a Demonstration Project to promote access for Medicare beneficiaries with Limited English Proficiency by Providing Reimbursement for Culturally and Linguistically Appropriate Services
3. Authorizes an IOM Report on the impact of Language Access Services with LEP beneficiaries

Other Items

1. Extends the therapy caps exceptions process
2. Extends the months of coverage of immuno-suppressive drugs for kidney transplant patients and other renal dialysis provisions
3. Provides payment for Advance Care Planning Consultation-(THIS IS THE HOT ONE; In speaking with some knowledgeable attorneys, the items listed here are things all of us should have in place anyway; in our view- this is **not** describing support for euthanasia)
4. Special Enrollment Period and Waiver of Limited Enrollment Penalty created for TriCare Beneficiaries which includes rebates of premium increases
5. Exception allowed for the use of more recent tax year to account for gains from sale of primary residence in computing Part B Income-related premium
6. Creates a Demonstration Program on the use of Patient Decisions Aids to encourage shared decision-making. Shared decision-making is defined as *“a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about trade-offs among treatment options and facilitates the incorporation of patient preferences and values into the medical plan.”*

Title III- Promoting Primary Care, Mental Health Services, and Coordinated Care (pp 443-401)

1. Establishes a Accountable Care Organization Pilot Program to test different payment incentive models to improve value, care coordination, and outcomes; These models may include Performance Target funding or Partial Capitation pricing as financial structures to change from the “fee-based” system we have today
2. Establishes a Medical Home Pilot Program emphasizing the use of nurse practitioners to coordinate care delivery (Take a look at the details of this section if you’re interested in another definition of a “medical home”.)
3. Authorizes funding transfers from the Federal Supplementary Medical Insurance Trust Fund for Medical Home-related costs
4. Authorizes a payment incentive for selected primary care services (5% or 10%) if the provider is located in a primary care health professional shortage area
5. Authorizes increased reimbursement rate for certified nurse mid-wives
6. Requires coverage and waiver of cost-sharing for preventive care services



7. Authorizes waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal
8. Excludes Clinical Social Worker Services from coverage under the Medicare Skilled- Nursing Facility Prospective Payment System and Consolidated Payment
9. Expands coverage of Marriage and Family Therapist Services and Mental Health Counselor Services
10. Extends physician fee-schedule Mental Health add-on
11. Expands access to vaccines

Title IV- Quality (pp 501-660)

1. Creates The Center for Comparative Effectiveness Research including all of the details concerning its structure, funding, and operation

Nursing Homes

2. Improves transparency of information available to consumers regarding Skilled Nursing Facilities and Nursing Facilities; including required disclosure of ownership and additional disc losable parties information
3. Requires the establishment of compliance and ethics programs in addition to any Quality Assurance or Performance Improvement Programs that may be in place
4. Includes the use of Nursing Home Compare Medicare Website for nursing home comparisons, establishes additional reporting requirements and includes whistleblower protections for employees
5. Defines civil penalties for non-compliance
6. Establishes a National Independent Monitor Pilot Program Nursing Home Study
7. Defines notification requirements of facility closure
8. Authorizes a study and report on the recommended training required for certified nurse aides and supervisory staff in nursing homes

Quality Measurements

9. Establishes the national priorities for quality improvement initiatives
10. Initiates the process for the development of new quality measurement indicators, the evaluation of the data collection process that will be required, and for the implementation and use of the quality indicators that are established
11. Requires reports on the financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, Chip and physicians and other health care entities



12. Establishes the public reporting requirements for health care-associated infections through Hospitals and Ambulatory Surgical Centers

Title V- Medicare Graduate Medical Education (pp 660-686)

1. Increases the residency limits for applicable institutions particularly for primary care
2. Increases training of practitioners in NonProvider Settings
3. Enhances the accountability for approved medical residency training and recommended GAO Study to evaluate medical residency training programs

Title VI- Program Integrity (pp 686-740)

1. Provides increased funding to fight waste, fraud, and abuse
2. Increases penalties for false statements on provider or supplier enrollment applications
3. Increases penalties for submission of false statements material to a false claim
4. Increases penalties for delayed inspections
5. Establishes context for assuring quality of care delivery for Hospice Care
6. Increases penalties for excluding individuals from program participation
7. Increased penalties for provision of false information by Medicare Advantage and Part D Plans; and with Marketing Violations

Enhanced Program and Provider Protections

8. Increases CMS program protection authority
9. Increases Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations
10. Requires inclusion of a Payment Modifier for certain E&M (Evaluation and Management) Services
11. Requires providers and suppliers to adopt programs to reduce waste, fraud, and abuse
12. Reduces the maximum period for submission of Medicare claims to no more than 12 months (from 36 months today)
13. Physicians who order Durable Medical Equipment (DME) or home health are required to be Medicare enrolled physicians or eligible professionals
14. Requires physicians to provide documentation on referrals to programs at high risk of waste and abuse
15. Requires face-to-face encounter with a patient before physicians may certify eligibility for home health or DME equipment under Medicare

16. Requires repayments of Medicare and Medicaid overpayments
17. Requires billing agents, clearinghouses, or other alternate payees required to register under Medicare
18. Establishes the process for access to information necessary to identify fraud, waste, and abuse
19. Eliminates the duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank
20. Complies with HIPAA Privacy and Security Standards

Title VII- Medicaid and CHIP (pp 740-856)

1. Expands eligibility for individuals with income below 133 ½ percent of the Federal Poverty Level (FPL)
2. Authorizes a report summarizing the reduction of the rate of the uninsured and the continued need for Medicaid DSH- Federal payments are reduced significantly to all states by \$1.5 trillion in 2017, \$2.5 trillion in 2018, and \$6 trillion in 2019
3. Expands coverage for Preventive Services specifically Tobacco Cessation;
4. Optional coverage available of nurse home visitation services
5. State eligibility option created for family planning services

Access

6. Creates a Medical Home Pilot Program with funding that may not exceed \$1.235 trillion over 5 years
7. Optional coverage established for Freestanding Birth Center Services

Coverage

8. Optional Medicaid coverage established for Low-Income HIV infected individuals
9. Extends transitional Medicaid assistance
13. Requires 12-month continuous coverage under certain CHIP programs

Financing

1. Payments to Pharmacists will reflect discounts and rebates received
2. Increased disclosures required to facilitate identification of individuals likely to be ineligible for low-income assistance under the Medicare Prescription Drug Program (Part D) to assist the Social Security Administration's outreach to eligible individuals.



3. Comparative Effectiveness Research Trust Fund established from fees on health insurance and self-insured plans
4. Establishes a Fair Share Per Capita Amount for participation (not quite sure how this works)

Division C- Public Health and Workforce Development (pp 856-1016)

Creates a Public Health Investment Fund

Title 1- Community Health Centers (pp 864-865)

1. Increases funding for Community Health Centers

Title II- WorkForce (pp 865-931)

1. Establishes Loan Repayment structure for Primary Care providers
2. Establishes Loan Repayment structure for other health providers in health professional needs areas
3. Creates a program to build capacity, especially in underserved areas, focusing on training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics, and Physician Assistantship
4. Establishes training of medical residents in Community-Based Settings (Training for General Practice, Pediatric, and Public Health Dentists and Dental Hygienists)
5. Establishes the development of nurse-managed health centers-for underserved or vulnerable populations

Public Health Workforce

1. Establishes the Public Health Workforce Corp whose purpose is to supply public health professionals throughout the nation
2. Establishes a Public Health Workforce Scholarship Program and loan repayment program
3. Establishes a Preventive Medicine and Public Health Training Grant Program
4. Diversity training programs established for Health Professions
5. Training established to monitor cultural and linguistic competency in a diverse health care population
6. Establishes mechanisms to encourage interdisciplinary care training using team-based models
7. Establishes an Advisory Committee on Health Workforce Evaluation and Assessment to monitor supply and access to providers



Title III- Prevention and Wellness (pp 931-965)

1. Establishes the Prevention and Wellness Trust with funding of \$2.4 billion in 2010 to \$4.6 billion in 2019 for administration, research, and delivery of preventive medicine and wellness services throughout the country
2. Funds \$800 million in 2010 to \$1.9 billion in 2019 for Core Public Health Infrastructure and Activities for State and Local Health Departments
3. Establishes a national strategy that is designed to improve the nation's health through evidence-based clinical and community prevention and wellness activities
4. Establishes the Task Force on Clinical Preventive Services
5. Establishes the Task Force on Community Preventive Services

Title IV- Quality and Surveillance (pp 965-980)

1. Establishes a Center for Quality Improvement which will be designed to prioritize areas for identification, development, evaluation, and implementation of best practices for quality improvement activities in the delivery of health care services throughout the country
2. Creates the Assistant Secretary for Health Information

Title V- Other Provisions (pp 980-1018)

1. Expands the drug discount for rural and other hospitals and establishes the rules to coordinate with state reimbursement
2. Establishes the structure for the creation of School-Based Health Clinics
3. Creates the National Medical Device Registry to facilitate analysis of post market safety and outcomes data on medical devices
4. Establishes grants for comprehensive programs to provide education to nurses and create a pipeline to nursing

What Does All This Cost?



We've also posted the Congressional Budget Office's most recent analysis of HR 3200 on www.collaborationhealthcare.com if you want more of the details. But, in summary the CBO projects a significant reduction of the uninsured in the country as a result of the approach in the proposed language of the bill. But, it also projects an increase in the federal deficit of \$239 billion between 2010 and 2019. Most of the negative deficit impact is due to the costs associated with the creation of the Insurance Exchange and the Public Option (and the other items included in Division A). The projected costs included here do not include most of the infrastructure costs that would be required to set it up. We believe the projected \$1.042 billion cost of Division A projected here could be on the very-low side with a real likelihood of increasing the deficit even more.

Divisions B and C actually show a positive impact on the deficit with most of the savings obtained by reforming payments to providers under existing Medicare, Medicaid, and CHIP arrangements- not in a cut in services as is being communicated by some.

Our View and Only Our View

As we said at the beginning, we are biased because we believe our basic health care system needs to change. It is fragmented, it is inefficient, it communicates poorly, it simply costs too much, and too many people are getting hurt by the way it works today. We understand and respect that 80% are satisfied with their personal health care today. What we are talking about is looking beyond today to avoid the freight-train that is heading our way tomorrow. We've got to get a handle on what it costs.

While we agree with a need to provide broader access to quality health care and broader access to coverage for those who want it, Division A just costs too much, seems complex, produces a burden on small employers, and doesn't really address any of the structural changes to the system that are going to be required to fix what we have today. We need to address the costs of delivery and Division A (as written today) relies too much on setting benefit limits and maximums as its cost-control mechanism and taxes and surcharges as a method to fund it. There are some interesting thoughts and approaches that should be explored and we hope the "pre-existing condition exclusion" and "rescission of coverage" rules will survive these discussions. But, overall the Public Option and the Insurance Exchange don't make sense considering the costs and complexity of what is proposed here.

Divisions B and C address many of the fundamental issues facing our health care system. We need to change the way our care is delivered by creating innovative new systems (Medical Home, Accountable Health Organizations), we need to collect the information we need to help guide decision-making and reimbursement, we need to look for other innovative ways to use the resources we have effectively, we need to communicate better, we need to get the waste out of the process, and we need to be able provide appropriate support and resources when needed. We also need to focus more attention on prevention, wellness, and our lifestyle behaviors as they account for a significant portion of our health care costs today. Many of these items are included in Divisions B and C. We did not see any "death panels" or "enforcing end-of-life care" as has been communicated by others. The reporting requirements are very heavy, and the government infrastructure seems complex. But, as always, we need to balance where the government should get involved, with what could be addressed by the private market. We just believe that the private market is limited by the fragmented structure that exists in our health care system today.



Some will think the approaches discussed primarily in Divisions B and C of HR 3200 will be intrusions into the private rights of the individual. You have to decide that one for yourself. We prefer to look at it as the collective approach that is going to be required to fix a fragmented system of delivery that every citizen accesses that needs to work more effectively together. It just depends on how you view it and you'll have to make up your own mind.

In summary:

Would we vote for HR 3200 as it is written today? No.

Were there some ideas presented in HR 3200 that could and should be pursued and discussed further as part of the broader health care debate? Yes

Our biggest concern with this approach- Cost and complexity; especially of the Insurance Exchange and Public Option and with the bureaucracy that seems to be created in the other Division

Were the most critical health care issues facing the system today addressed? Most

Will our country be able to work together to make the changes we need to make in health care? We'll have to see

Now it's your turn to decide.