COMMITTEE ON
WAYS & MEANS REPUBLICANS
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THE COMMON SENSE HEALTHCARE REFORM AND AFFORDABILITY ACT:

Making Health Insurance More Affordable for Families, Affordable for Small Businesses & Affordable for America

Republicans believe your health care is too important and too complex to risk on a 1,990 page piece of legislation that Democrats in Congress negotiated behind closed doors and are now rushing through Congress. That is why Republicans are proposing a commonsense, step-by-step approach to comprehensive health care reform that will lower the cost of health coverage. By focusing on immediate reforms, the Republican plan will lower health coverage costs – the first step to expanding coverage – without raising taxes, without cutting Medicare, without spending over $1 trillion and without expanding welfare programs like Medicaid. The Republicans' reform makes health insurance affordable for families, affordable for small businesses and affordable for America.

DIVISION A—MAKING HEALTH CARE COVERAGE AFFORDABLE FOR EVERY AMERICAN

Helping Those With Pre-Existing Conditions and High Medical Costs

Section 101: Establish universal access programs to improve high risk pools and reinsurance markets.

> The bill requires States establish either a functioning high risk pool or a reinsurance program and provides $25 billion in federal funding for these programs. Insurance offered through these programs will ensure everyone has access to affordable health care, regardless of their health status. States will have to eliminate high risk pool waiting lines and premiums for enrollees in high risk pools would be limited to 150% of the average premium charged in a State (currently capped at 200%). The Democrats' bill explicitly allows for waiting lines.

Section 102: Elimination of certain requirements for guaranteed availability in individual market.

The bill extends existing HIPAA guaranteed availability protections, which will improve insurance portability and protections for Americans with pre-existing conditions. Under current law, individuals purchasing health insurance in the individual market are protected from pre-existing condition exclusions if there is not a substantial break in coverage, their previous coverage was through an employer, and they fully exhaust COBRA coverage. This provision would allow individuals to receive those same protections regardless of the source of their prior coverage and without requiring them to exhaust COBRA coverage, which is often very expensive for both employees and employers.

Section 103: No annual or lifetime spending caps.

The bill prohibits health plans from arbitrary annual or lifetime spending caps, thereby protecting individuals with a catastrophic diagnosis or chronic disease by ensuring health plans meet their obligations to those with the most expensive medical needs.

Section 104: Preventing unjust cancellation of insurance coverage.

The bill prohibits health insurers from unlawfully canceling health insurance ("rescissions"). If an insurance company attempts to cancel health coverage on the basis of fraud the policy holder can appeal that decision with an independent external appeals panel and the coverage would remain in force while that appeal is being considered. This provision insures that no American's access to needed medical care will be harmed by the wrongful cancelation of their health insurance plan.

Section 111: State Innovations Program.

The bill provides $50 billion in incentives to States who adopt reforms that reduce the cost of health insurance and expand coverage. States will have to meet targets for reductions in health plan premiums and the number of uninsured in order to receive federal funds. States could not meet these targets by directly subsidizing health insurance or expand eligibility for government programs, like Medicaid. CBO predicts the State Innovation Program will lower premiums for families, individuals, and small business and reduce the number of uninsured.

Section 112: Health plan finders.

This provision will allow the creation of State health plan finders so consumers can effectively comparison shop for health insurance. By increasing the information available to consumers they will be empowered to make the best decisions for their families when purchasing health insurance.

Section 113: Administrative Simplification.

The provision will create greater standardization in health care forms and transactions thereby improving efficiency in the health care system. CBO believes this provision will lower the cost of health insurance by removing waste and duplicity.

DIVISION B—IMPROVING ACCESS TO HEALTH CARE
Lower the Cost of Health Coverage and Expanding Access

Sections 201-205: Expanding Access and Lowering Costs for Small Businesses.

These provisions will allow small businesses to pool together through Association Health Plans (AHPs) to leverage lower cost health insurance on behalf of their employees. By creating larger insurance pools for small businesses, these provisions will make health insurance more affordable and more accessible. CBO believes this provision will result reduce the number of uninsured by hundreds of thousands.

Section 211: Extending coverage to dependents.

If a health insurance plan offers coverage to dependents, then the plan must cover dependents up through their 25th birthday. The provision provides parents with the ability to keep their children on their health plan through young adulthood, thereby increasing young adults' access to affordable health coverage. Young adults shouldn't lose their coverage simply because they needed 5 years to complete college or were unable to find a job after graduation.

Section 212: Allowing auto-enrollment into employer sponsored coverage.

This provision allows employers to adopt auto-enrollment for health insurance, provided that employees are allowed to decline the coverage, by removing any potential legal barriers. Similar provisions have been adopted for 401(k) plans and have resulted in increased enrollment. Currently, almost 10 million employees have access to employer sponsored insurance and do not enroll.

Section 221: Interstate purchasing of health insurance.

Differences in state regulation of health insurance have resulted in significant variance in health insurance costs from state to state. Americans residing in a state with expensive health insurance plans are locked into those plans and do not currently have an opportunity to choose a lower cost option. This provision will allow Americans to purchase licensed health insurance in any state. Insurance sold in a secondary state will be still be subject to the consumer protections and fraud and abuse laws of the policy holder's state of residence. This provision will provide access to more affordable health insurance options.

Section 231: Saver's credit for contributions to health savings accounts.

Under current law, low and moderate-income individuals are eligible for a limited, nonrefundable tax credit for a portion of their contributions to IRAs and 401(k)s. Section 231 expands this "saver's credit" to cover contributions to Health Savings Accounts (HSAs), making HSAs more attractive to families earning under $50,000 annually.

Section 232: HSA funds for premiums for high deductible health plans.

This provision allows taxpayers to use HSA funds to pay monthly premiums on their high deductible health plans (HDHPs), but only if, after the distribution, taxpayers retain a balance in their HSAs equal to or greater than twice the amount of the minimum annual deductible. (In 2009, the minimum is $1,150 for self-only coverage and $2,300 for family coverage, and these minimums are adjusted annually for inflation.)

Section 233: Requiring greater coordination between HDHP administrators and HSA account administrators so that enrollees can enroll in both at the same time.

This provision provides regulatory authority to the Treasury Secretary to encourage better coordination between insurance companies offering HDHPs and financial institutions offering HSAs to reduce the administrative burden on taxpayers by making it easier for them to simultaneously enroll in their HDHP and their HSA.

Section 234: Special rule for certain medical expenses incurred before establishment of account.

Under current law, taxpayers may use HSA funds only for qualified medical expenses incurred after the establishment of the HSA, which might be some time after the establishment of the HDHP. Section 234 allows taxpayers to use HSA funds for qualified medical expenses incurred after the establishment of the HDHP but before the establishment of the HSA, as long as the expenses are not incurred more than 60 days after the establishment of the HDHP.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

Common Sense Reform that Lowers the Cost of Health Coverage

Sections 301-310: Medical Liability Reform.

It's widely accepted that defensive medicine is driving up health care costs. The Democrats' bill has decided to put trial lawyers before patients. These sections include the same language as the HEALTH Act that passed each year under Republican control of the House. These provisions include: a statute of limitations on bringing a case; cap on noneconomic damages to $250,000 with assignation of proportional responsibility; allows the court to restrict lucrative attorney contingency fees; clarifies and limits punitive damages; and protects states with existing functional medical liability laws.

These provisions set no caps on economic damages, which are often the largest component of liability awards, thus patients will continue to have their rights to economic damages protected. CBO predicts this provision will reduce the deficit by $54 billion.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP
Stopping the Government from Making Decisions About Americans' Health Care

Sections 401-402: Protecting the doctor-patient relationship.

This provision repeals the Federal Coordinating Council on Comparative Effectiveness Research. Patient and physician groups are concerned about the federal government rationing care, as is done in other countries. This removes the potential authority of the federal government to ration care based on cost of treatment.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS
Rewarding and Encouraging Healthy Behaviors

Section 501: Incentives for prevention and wellness programs.

Under current law, employers and insurers are limited in the value of financial rewards, whether it be through reductions in premiums, deductibles, or co-payments, that can be used to incentivize healthy lifestyle changes. This provision will increase the financial rewards that can be offered to plan enrollees from 20% to 50% of value of the plan for successful completion of a standards based wellness program. Under this provision employers, for example, could provide a 50% discount on premiums for an employee who successfully quits smoking.

DIVISION F—PROTECTING TAXPAYERS
Ridding the Health Care System of Waste, Fraud, and Abuse

Section 601: Provide full funding to HHS OIG and HCFAC.

Combats waste, fraud and abuse in the Medicare program by increasing funding for the HHS Office of Inspector General and the Health Care Fraud and Abuse Control (HCFAC) program. Activities financed by this funding are used to detect and prevent heath care fraud, waste and abuse through investigations, audits, educational activities, and data analysis. For the HCFAC program, the return on investment of fraud reduction spending is 4-to-1.

Section 602: Prohibiting taxpayer funded abortions and conscience protections.

Explicitly prohibits any federal funding from being used to pay for abortions. The legislation also includes a conscience protection clause that ensures individual and institutional health care providers are protected from being forced to participate in procedures such as abortion to which they have a moral or religious objection.

Section 603: Improved enforcement of the Medicare and Medicaid secondary payer provisions.

Under current law, in instances where a Medicare or Medicaid beneficiary has private insurance coverage, the government plays a secondary role, paying only for procedures and services that are not covered by the private insurance. Studies have shown that Medicare and state Medicaid offices are not very efficient at recovering money that was erroneously paid in secondary payer claims. This provision requires Medicare to improve enforcement of the Medicare Secondary Payer Act and also requires states to improve compliance with Medicaid Secondary Payer requirements.

Section 604: Strengthen Medicare provider enrollment standards and safeguards.

This would require the HHS Secretary to thoroughly screen new Medicare providers and suppliers via criminal background checks, licensure checks, site-visits, etc. Penalties for false statements on enrollment applications are toughened and new applicants.

Section 605: Tracking banned providers across State lines.

Too often providers banned from participating in Medicare are able to find their way back into the program by setting up shop in another state. This provision directs the Secretary, working in coordination with the HHS Office of the Inspector General, to expand Medicare and Medicaid databases to make it easier to track the movement of banned providers. The provision also permits the Social Security Administration, the VA, Defense Department and Justice Department to access the databases so as to ensure banned providers do not target other federal programs.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

Improving Americans Access to Affordable Therapies

Sections 701-703: Creating an FDA approval pathway.

Under current law there is no pathway for FDA approval of a biosimilar, thereby patients do not have access to more affordable biologics at the end of an innovator product's term of patent protection. This bipartisan provision would create an approval process at FDA for biosimilar products with appropriate patent and market protections to continue to encourage innovation. This provision will provide Americans with access to affordable biologics, which often times can be the most expensive therapies, and will lower the cost of health insurance by making them readily available.