

H.R. 3200: *America's Affordable Health Choices Act of 2009*

25 MYTHS AND FACTS

JULY 29, 2009

MYTH # 1

There will be a government committee that will decide what treatments and benefits you will receive.

FACT

Nothing in the bill infringes upon you and your doctor's ability to make medical decisions. The National Health Benefits Advisory Council is not a "government committee" but is made up of providers, consumer representatives, employers, labor, health insurance issuers, independent experts and representatives of government agencies. They will make recommendations about minimum standards of care and covered benefits that insurance companies have to offer, ensuring that everyone has a health plan that provides them with adequate coverage.

MYTH # 2

Your healthcare will be rationed.

FACT

This is a misreading of the bill. The legislation limits the amount of out-of-pocket costs you will face to \$5,000 for an individual and \$10,000 (indexed to CPI) for a family for a basic package of care. This ensures you have access to affordable care and won't go bankrupt paying for it.

MYTH #3

The Health Choices Commissioner will choose your health care benefits for you. You will have no choice.

FACT

The Health Choices Commissioner is charged with ensuring insurance plans are meeting regulations and minimum standards as well as administering affordability credits and monitoring the exchange. Nothing in this bill permits the Health Choices Commissioner to choose your benefits for you.

MYTH # 4

The government will mandate Advance Care Planning Consultation, which means euthanasia for seniors and the government will instruct & consult regarding living wills, durable powers of attorney and it will

be mandatory! The government will provide an approved list of end of life resources, guiding you in death.

FACT

There is no mandate for this sort of counseling. The only mandate is that Medicare must pay for the consultation between patients and practitioners to discuss plans for end-of-life care. These are important individual decisions that take time and consideration. Regarding the instructions and consultations on living wills, etc., these will be consultations between you and your provider, not the government. Creating a living will does not mean you are asking to be euthanized. The Centers for Medicare & Medicaid Services will provide planning resources to discuss with your doctor about how you would like to be treated in your final days.

MYTH # 5

The government will mandate a program for orders for the end of your life. The government will have a say in how your life will end.

FACT

You decide how your life ends- that is the whole point of an advance directive.

MYTH # 6

An "Advanced Care Planning Consultation" will be used frequently as your health deteriorates and the government will decide what level of treatment you will have at end of life.

FACT

YOU will decide with your doctor, the level of treatment you will receive at the end of your life.

MYTH # 7

"Advanced Care Consultation" may include an order for end of life plans from the government and the government will specify which doctors can write an end of life order.

FACT

No, the government will NOT be developing end of life plans and the bill specifies which categories of licensed health care professionals can write them but not which specific doctor – you can still choose your doctor.

MYTH # 8

The government will have real-time access to individuals' finances & a National ID health card will be issued.

FACT

The bill says nothing about a National ID health card, or accessing your personal financial information. This section promotes administrative simplification- for example being able to look up your insurance coverage and determine how much you will pay and which provider your insurance will accept, at the point of service. This saves money and gives you, the consumer information about what you will owe at the front end, rather than being denied or getting a surprise bill from your insurance company weeks after your treatment.

MYTH # 9

The government will have direct access to your bank accounts for electronic fund transfers

The bill encourages the development of standards to encourage electronic payments between providers and insurance companies. Administrative simplification measures like these save billions of dollars. Nothing will give the government access to your bank account.

MYTH # 10

There will be a payoff subsidized plan for retirees and their families in unions & community organizations such as ACORN.

FACT

This section provides a limited reimbursement for participating employment-based private plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. People who have been forced into early retirement in this age group do not qualify for Medicare and this will help them stay on their employer provided, private insurance plan if their employer wants to participate. Participation is voluntary. This is for all early retirees, and no language targets the provision towards unions or ACORN.

MYTH # 11

The government is creating a Health Care Exchange to bring private health care plans under the control of the U.S. government and the government will mandate all benefit packages for private health care plans in the Exchange.

FACT

The bill imposes new regulations on private health care plans that will force them to end unethical practices such as rescissions or denying coverage based on pre-existing conditions. The Exchange will improve the quality of coverage and increase the affordability of private insurers in the Exchange. Insurance companies in the Exchange will have to offer a basic benefit packages in every service area. This package will include basic care such as hospitalization, physician visits, medical equipment, mental health, preventative care, maternity and well baby care, and drugs – services

that anyone would expect a real insurance policy to cover. Private insurers may offer a higher tier of coverage with more benefits that are not mandated by the government if they choose.

MYTH # 12

The government will ration your health care through the Health care Exchange!

FACT

No. The Exchange will determine the minimum standards insurance companies must offer coverage for- it has nothing to do with rationing. Private plans can offer extra benefits like dental or vision coverage for adults, or other non-covered benefits that are not included in the basic level plan.

MYTH # 13

Medicaid eligible individuals will be automatically enrolled in Medicaid. They will have no choice.

FACT

Current law allows individuals to be auto-enrolled in Medicaid if they show up for health services and are eligible, so this is not a radical change. Only individuals that fall under 133% of the poverty level who have not had health insurance for six months will be auto-enrolled.

MYTH # 14

No company can sue the government on price fixing. There will be no "judicial review" against government monopoly.

FACT

There is no judicial or administrative review for the payment rates set for the public option.

MYTH # 15

The government will tell doctors how much money they can make.

FACT

This section outlines payment policies for physicians participating in the public option only. No physician has to take the public option.

MYTH # 16

An Employer MUST automatically enroll employees into the public option plan. They will have no choice.

FACT

No. You get to choose your health insurance from the choices your employer offers you. If you fail to do so, your employer will auto-enroll you in the lowest premium health plan (for employees) unless or until you opt into a different plan. You could not be auto-enrolled into the public option in the vast majority of cases because the public option is not even available outside the Exchange (only to individuals and small businesses). The bill specifically mandates that employers provide employees with info on how to opt out of the auto-enrollment coverage.

MYTH # 17

Employers **MUST** pay for health care for part-time employees **AND** their families, thus allowing for additional bankruptcies among small businesses.

FACT

Employers will only pay a proportion of what they must pay for full-time employees. There is also a tax credit equal to 50% of the amount paid by a small employer for employee health coverage available to help with these costs and other protections to ensure that new requirements don't cause undue hardship for small businesses.

MYTH # 18

Any employer with payroll of 400k & above who does not provide the public option will pay 8% tax on all payroll, allowing again for additional bankruptcies of many small businesses.

FACT

Businesses, except some small businesses that are exempted, must contribute to their employees' health insurance. Most employers that are required to provide coverage under this bill already provide coverage—so little will change for them under this bill. They will continue to offer the coverage that they do today, and will not pay a tax. Some employers may choose to do so through the Exchange, but no employer nor employees will be forced to choose any option. Employers that don't contribute to employees' health care will make a contribution to the Exchange, so their employees can access coverage there.

MYTH # 19

Businesses with payroll between 251k & 400k who do not provide the public option will pay a 2-6% tax on all payroll, ensuring even more bankruptcies of many small businesses.

FACT

All businesses, except certain small businesses that are exempted, must contribute to their employees' health insurance. Small businesses typically pay more for the same insurance than a large employer might offer. Small businesses will benefit from this legislation, because it will help

lower their administrative costs and insurance rating, and increase options available to them. The House legislation helps level the playing field between large and small businesses that want to offer health insurance.

MYTH # 20

Any individual who doesn't have acceptable health care according to the government will be taxed 2.5%, ensuring that the government can collect extra taxes from you anytime they want.

FACT

No, the government can only collect the tax if you don't have insurance and can afford to purchase it. Acceptable coverage includes grandfathered individual and employer coverage (ie, what you have now providing your insurance company complies with new laws), certain government coverage (e.g., Medicare, Medicaid, certain coverage provided to veterans, military employees, retirees, and their families), and coverage obtained pursuant to the Exchange or an employer offer of coverage.

MYTH # 21

The government will set the value of a physician's time, professional judgment, etc., determining the value of humans.

FACT

This section directs the Secretary to regularly review fee schedule rates for physician services paid for by Medicare. It allows the secretary to incorporate all the work that a doctor does outside of the procedure when evaluating fee schedules: such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk, and may include validation of the pre, post, and intra-service components of work. This doesn't have anything to do with the value of human lives.

MYTH # 22

The government will penalize hospitals for what they deem preventable readmissions and doctors treating a patient during an initial admission that results in a readmission will be subject to a penalty.

FACT

Preventable readmissions are never desirable. Hospitals are dangerous places, and the more time spent in one, the greater risk of infection or harm to the patient. Right now, hospitals are paid for quantity of care, so the more you are readmitted, the more they get paid. This provision will provide incentives for preventative measures and post-treatment coordination of care to keep you healthier.

MYTH # 23

The government will mandate the establishment of outcome based measures which will lead to rationing.

FACT

This section creates an incentive system to increase payments to high quality Medicare advantage plans and plans that demonstrate improvement and better outcomes such as reduced readmissions, and better outcomes of its enrollees. This is about better quality care, not rationed care. A plan that cuts back on care and produces worse outcomes would not receive any extra payment.

MYTH # 24

The government has the authority to disqualify Medicare Advantage Plans, HMOs, etc., forcing people into the government plan.

FACT

This only says it can disqualify participating plans from Medicare Advantage. This would not result in seniors being forced into the public option. They would remain on Medicare, which is a government plan.

MYTH # 25

The government will RESTRICT the enrollment of people with special needs.

FACT

This ensures that chronic condition special needs plans (SNPs) enroll beneficiaries only during their eligibility periods and extends the SNP program through 2012, and extends certain fully integrated dual eligible SNPs through 2015.

Source: Ohio OFA health insurance reform talking points and fact check on H.R. 3200

Also, to access The Medicare Rights Center's E-Letter which discusses the health reform bills and "Medicare Realities", click

http://www.medicarerights.org/issues-actions/asclepios/2009_32.html