

## **A Brief Summary of the Current Health Care Bills before Congress**

### **What Health Care reform bills are currently proposed in Congress?**

**HR 3200** is currently on the floor of the House of Representatives, having gone through several committees as of July.

**HR 676**, although it has more sponsors and was introduced earlier, has not yet been passed on to the floor by all the requisite committees.

**HR 3200** is based on the premise that we can tweak the current health care system and get different results. **HR 676** assumes that a new system design is necessary to achieve the goals of accessible affordable high quality health care for all.

### **HR 3200 “America’s Affordable Health Choices Act” Authors: Representatives Dingell, Rangel, Waxman, Stark, Pallone, and Andrews, and George Miller of California**

HR 3200 is based on continuing our current employment-based health insurance system, with provisions for self-employed or unemployed individuals to buy into the Health Insurance Exchange that is being created.

As proposed, it creates a public health insurance option alongside private plans (Sec 100). It proposes stricter rules for insurance corporations, while obligating nearly all Americans to buy private insurance. Tax dollars will subsidize insurance companies for coverage of low income people, but will not affect the system of premiums, co-pays, and deductibles, except that co-pays will be limited to \$5000 per individual or \$10,000 per family plan, with yearly increases (Sec 122).

Individuals will have to choose which for-profit insurance company they want from among those offered in their State and/or by their employer. HR 3200 establishes requirements for basic coverage (Sec 122), including mental health services and substance abuse treatment (Sec 114).

Insurance companies will not be allowed to deny insurance coverage due to pre-existing conditions; it is implied that they would have to pay for treatment of pre-existing conditions (Sec 111). Insurance companies will not be allowed to drop insured people or employers as readily (Sec 112) but they may still increase their premiums beyond affordability.

Self-insurance by small and mid-sized business would be de-incentivized (penalized) (Sec 113), thus restricting the choices of small and mid-sized businesses and delivering more enrollees to the insurance corporations. Tax credits authorized for small businesses’ insurance plans for employees are capped for employees earning \$80,000 or more (Sec 45R).

Insurance premiums may be assessed based on age of enrollees within some limitations (Sec 113); this would theoretically make it less expensive to insure a younger workforce than an experienced work force. 30% of the revenue received by an insurance corporation may be used for administration and profits (Sec 122). The insurance industry would still be governed in part by State law rather than providing uniform policies, including costs, across the nation.

A Health Insurance Advisory Board is to be established, consisting of about 30 members, some appointed by the President, some federal employees, others from business (Sec 123). There is no specification that these board members not be tied to the insurance industry.

Sec. 241. Individual Affordability Credits through Health Insurance Exchange  
Individuals may apply for affordability premium credit and/or affordability cost-sharing credit. Determination of eligibility of an individual is made by a Health Insurance Exchange or some other entity approved by the Commissioner of Health Insurance. The government will pay the credits for which the individual qualifies directly to the Health Insurance Exchange. The amount of credits will be based on family income level and percent of income charged by Health Insurance Exchange premiums and co-pays. This section will be particularly beneficial to individuals who are under-employed or are in low-paying jobs.

Sec. 208 provides for establishing STATE-BASED HEALTH INSURANCE EXCHANGES as an alternative to the employer-insurance corporation driven Health Insurance Exchanges. The rules and regulations will be nearly identical to the regular Health Insurance Exchanges.

Sec. 221. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.  
The public option described in Sec 221 has many features of traditional employer-based insurance coverage, including enrollment, premiums, preferred providers, and exclusion of certain providers. The distinguishing feature is that the public option program will be administered by the federal government, such that it will not be a for-profit organization.

### **HR 676 United States National Health Care Act, "Medicare for All"**

**Authors: John Conyers and Dennis Kucinich, has 85 sponsors in the House of Representatives**

HR 676 Provides expansion of Medicare to cover everyone residing in the United States and its territories under a Single Payer System. All basic services included in ordinary health care coverage are included, from primary care to intensive care. Such benefits are available through any licensed health care clinician anywhere in the United States that is legally qualified to provide the benefits. No deductibles, copayments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits. Patients shall have free choice of participating physicians and other clinicians, hospitals, and inpatient care facilities.

No institution may be a participating provider unless it is a public or not-for-profit institution. For-profit institutions may choose to become not-for-profits and therefore become participating providers. The owners of such investor-owned providers shall be compensated for the actual appraised value of converted facilities used in the delivery of care. Individual providers, such as doctors, dentists, physical therapists, whether they practice in a group or as individuals, will be considered participating providers. HR 676 outlines four payment options for providers.

Oversight, quality assessment, and payment would be coordinated through regional and State offices. A National Board of Universal Quality and Access will be appointed by the President, by and with the advice and consent of the Senate. The 15 appointed members will represent all stakeholders, including provider institutions, health care professionals, health care advocacy groups, patient representatives, and representatives of labor unions. The board shall advise the Secretary and the Director to ensure quality, access, and affordability.

HR 676 will be paid for from monies already coming into the federal treasury for health care, and by tax increases. The tax increases, however, will likely not amount to more than individuals and employers are currently paying for their health insurance premiums and co-payments. This part of the bill needs to be spelled out in more detail.

Rationale: We are already paying for full coverage, but we are not receiving it. One third of health care dollars do not go for health care, but rather to insurance company administrative costs and profits. This is compared to the 3% of Medicare dollars that go for administrative costs.

HR 676 does not include provisions for keeping private insurance (from a for-profit corporation) as people's primary insurance. HR 676 would bring about a situation more akin to the health insurance coverage currently extended to members of congress, which is paid for by tax money, and includes as much or more choice of providers than that of most private insurance.

### **On Health Care Reform in General**

Congress has not voted to exempt themselves from the Health Care Reform bills proposed for all Americans, but if they do, it could be a signal of flawed legislation.