

2009



Pennsylvania  
U.S. Senator Bob Casey



## ***HEALTH REFORM IN PENNSYLVANIA***

**ENSURING CHOICE & COMPETITION, CONTROLLING COSTS  
AND PROTECTING CONSUMERS**

 **RESPONSIBLE REFORM**  
FOR THE MIDDLE CLASS  
DEMOCRATS.SENATE.GOV/REFORM





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### HEALTH INSURANCE REFORM IN PENNSYLVANIA

During my travels around Pennsylvania this year and over the past few years, one of the top issues that I am always asked about is health care. I have heard countless stories from people who lost coverage because they couldn't afford to pay for premiums or who were denied care by an insurance company because of a preexisting condition.

This is why one of my top priorities this year has been helping to draft health insurance reform legislation to increase stability and security for Pennsylvania families. As a member of the Health, Education, Labor, and Pensions Committee, I spent over sixty hours debating and drafting legislation with my colleagues that passed the Committee last month.

Before and during that debate I read letters that were sent to my office from constituents and traveled around the state talking to workers, employers, doctors and nurses. In July, I visited health clinics in Bucks County. In June, I hosted a health care roundtable at the College of Physicians in Philadelphia. All of these experiences are invaluable as we continue to debate a health insurance reform bill that makes great strides to improve health care and increase consumer protections.



Health insurance reform will provide a sense of security for families who are worried about losing their coverage due to unemployment or if they or their employer can no longer afford coverage. Reform will add consumer protections to make sure that insurance companies do the right thing and serve consumers to the best of their ability.

Many Pennsylvanians have expressed strong feelings on the health reform debate, and I have urged my colleagues in Washington to avoid jumping to the conclusion that every bit of opposition above a certain decibel level is organized and contrived. This issue is simply too important to cast aspersions or question motives. Our country deserves to have a robust, yet respectful, discussion on the most appropriate way to move forward.

This packet is an effort to set forth the key reasons why maintaining the status quo is not an option. The following pages contain a wealth of information regarding the current state of health care in the Commonwealth of Pennsylvania, as well as specific details about many of the key issues surrounding the reform effort.

I am committed to enacting health insurance reform legislation that protects what works about health care and fixes what is broken. Simply stated, doing nothing is not an option.



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**A NATIONAL PROBLEM THAT AFFECTS US ALL:** If Congress doesn't take action now, Pennsylvanians, including those who currently have health insurance, can be assured of one thing: **you will be forced to spend more on your health care.**

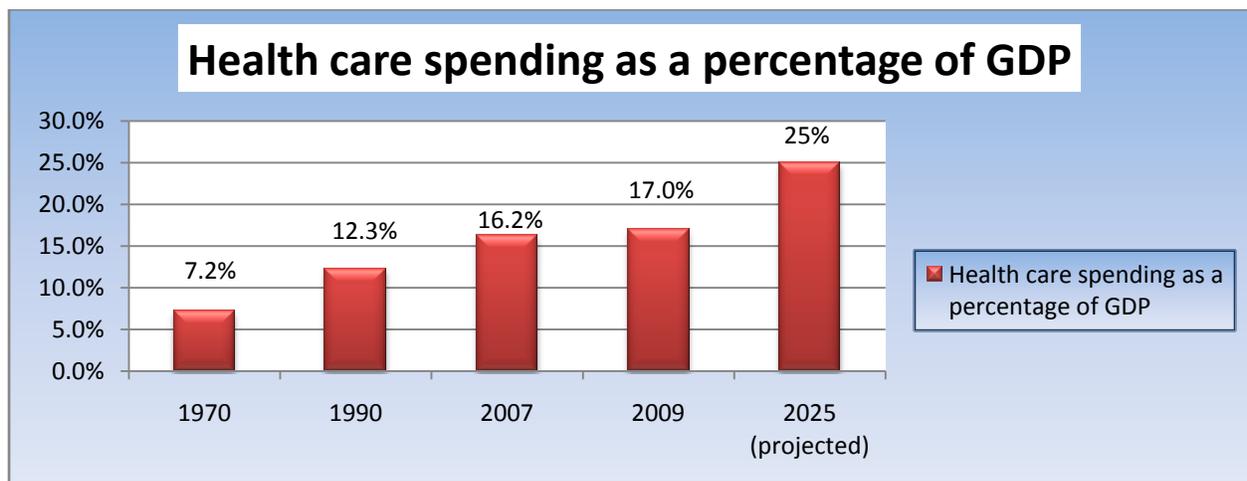
According to the non-partisan Congressional Research Service, costs "are rising for nearly everyone, and the country now likely spends over \$2.5 trillion, more than 17% of gross domestic product (GDP), on health care services and products, far more than other industrialized countries. For all this spending, the country scores average or somewhat worse on many indicators of health care quality, and many may not get appropriate standards of care."<sup>1</sup>

The non-partisan Congressional Budget Office (CBO) summed the problem up this way:

**"As health care spending consumes a greater and greater share of the nation's economic output in the future, Americans will be faced with increasingly difficult choices between health care and other priorities."**<sup>2</sup>



According to the U.S. Department of Health and Human Services, spending on health care in the United States increased from 7.2% of GDP in 1970 to 12.3% in 1990 and 16.2% in 2007.<sup>3</sup> It has likely reached more than 17% in 2009.<sup>4</sup> Barring changes in law, the CBO projected in 2008 that health care spending would rise to 25% of GDP by 2025 and to much higher levels beyond.<sup>5</sup>



Source - U.S. Department of Health and Human Services



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### **THE NEED FOR REFORM IN PENNSYLVANIA AND ACROSS THE COUNTRY IS CLEAR.**

Pennsylvania families simply can't afford the status quo and deserve better. Senator Casey is working to reform our nation's health system in order to reduce costs for families, businesses and government; protect people's choice of doctors, hospitals and health plans; and assure affordable, quality health care for all Americans.

#### A SNAPSHOT OF THE STATUS QUO IN PENNSYLVANIA

- Roughly **7.9 million** people in Pennsylvania get health insurance on the job<sup>6</sup>, where **family premiums average \$13,646**, about the annual earning of a full-time minimum wage job.<sup>7</sup>
- Since 2000 alone, average **family premiums have increased by 103 percent** in Pennsylvania.<sup>8</sup>
- Household budgets are strained by high costs: **19 percent of middle-income Pennsylvania families** spend more than 10 percent of their income on health care.<sup>9</sup>
- High costs block access to care: **10 percent of people in Pennsylvania** report not visiting a doctor due to high costs.<sup>10</sup>
- Pennsylvania businesses and families shoulder a **hidden health tax of roughly \$900 per year on premiums** as a direct result of subsidizing the costs of the uninsured.<sup>11</sup>



#### AFFORDABLE HEALTH COVERAGE: INCREASINGLY OUT OF REACH IN PENNSYLVANIA

- **10 percent of people in Pennsylvania are uninsured** (approximately 1.2 million people), and **65 percent** of them are in families with at least one full time worker.<sup>12</sup>
- The **percent of Pennsylvanians with employer coverage** is declining: from 71 to 64 percent between 2000 and 2007.<sup>13</sup>
- Much of the decline is among workers in small businesses. While **small businesses make up 71 percent of Pennsylvania businesses**,<sup>14</sup> only **51 percent of them offered health coverage benefits in 2006** – down 7 percent since 2000.<sup>15</sup>
- Choice of health insurance is limited in Pennsylvania. Highmark and Independence Blue Cross alone constitute **72 percent** of the health insurance market share in Pennsylvania.<sup>16</sup>
- Choice is even more limited for people with pre-existing conditions. In Pennsylvania, premiums can vary based on demographic factors and health status, and coverage can exclude pre-existing conditions or even be denied completely.<sup>17</sup>



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### **WHAT DOES HEALTH INSURANCE REFORM MEAN FOR PENNSYLVANIANS?**

The health reform effort will (1) reduce costs for families and small businesses; (2) protect your choice of doctors, hospitals and insurance plans; (3) assure stability and security in health care; (4) increase access to health care for the more than one million uninsured Pennsylvanians.

#### *Reduced Health Care Costs for Families and Small Businesses:*

- Lower Costs Through Competition: Premiums for residents of Pennsylvania have risen **103 percent since 2000.**<sup>18</sup> Through health insurance reform, **approximately 1.1 million to 1.3 million** middle class Pennsylvania residents will be eligible for premium credits to ease this burden.<sup>19</sup> Without reform, insurance premiums and prescription drug costs will continue to soar; small businesses in particular would inevitably face rising premiums.

#### *Protecting Choice of doctors, hospitals, and insurance plans:*

- If you like your current plan, the government will not force you to change it: The proposed legislation will not force individuals and families to drop their doctor or insurer. To the contrary, reform will expand your choices, not eliminate them. If your current plan does not meet your needs, the power of the market will present you with the opportunity to seek out coverage that does. The reform plan also includes several new consumer protections relating specifically to the health insurance industry.

#### *Assuring Stability and Security:*

- Preventive Care for Better Health: 37 percent of Pennsylvania residents have not had a colorectal cancer screening, and 21 percent of women have not had a mammogram in the past 2 years.<sup>20</sup> By requiring health plans to cover preventive services for everyone, investing in prevention and wellness, and promoting primary care, health insurance reform will work to create a system that prevents illness and disease instead of just treating it when it's too late and costs more.<sup>21</sup>
- Improving Care for Children and Seniors: 17 percent of children in Pennsylvania have not visited a dentist in the past year,<sup>22</sup> and 28 percent of seniors did not receive a flu vaccine.<sup>23</sup> Health reform will ensure coverage for kids' dental, vision, and hearing needs, and will promote quality coverage for America's seniors, including recommended immunizations.

#### *Increasing Access to Health Care for the uninsured*

- Over one million Pennsylvanians current lack health insurance: The reform effort will significantly reduce this number, which will in turn help control the cost of health care for everyone. Under the status quo, the insured pay for the health care that is received



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by the uninsured in the form of a **hidden tax of roughly \$900<sup>24</sup>** for the cost of caring for people without insurance. As more Americans become insured, that hidden tax will begin to disappear. In addition, covering everyone will put downward pressure on costs.<sup>25</sup>

***Long-Awaited Consumer Protections Now Within Reach:*** The Health Insurance Reform effort is focused on establishing new consumer protections against abusive practices that are permitted under current law. Some of the new protections include:

- No Discrimination for Pre-Existing Conditions: Insurance companies will be prohibited from refusing you coverage because of your medical history.
- No Exorbitant Out-of-Pocket Expenses, Deductibles or Co-Pays: Insurance companies will have to abide by yearly caps on how much they can charge for out-of-pocket expenses.
- No Charge for Preventive Care: Insurance companies must fully cover, without charge, regular checkups and tests that help you prevent illness, such as mammograms or eye and foot exams for diabetics.
- No Dropping of Coverage for Seriously Ill: Insurance companies will be prohibited from dropping or watering down insurance coverage for those who become seriously ill.
- No Gender Discrimination: Insurance companies will be prohibited from charging you more because of your gender.
- No Annual or Lifetime Caps on Coverage: Insurance companies will be prevented from placing annual or lifetime caps on the coverage you receive.
- Extended Coverage for Young Adults: Children would continue to be eligible for family coverage through the age of 26.
- Guaranteed Insurance Renewal: Insurance companies will be required to renew any policy as long as the policyholder pays their premium in full. Insurance companies won't be allowed to refuse renewal because someone became sick.<sup>26</sup>



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### **THE LEGISLATIVE PROCESS TO DATE**

Over the course of the past several weeks and months, both chambers of the United States Congress have been considering bills that would reform our nation's health insurance system.

In the United States Senate, two committees have jurisdiction over issues relating to health care: (1) the Health, Education, Labor and Pensions Committee, commonly referred to as HELP. Senator Casey is a key member of the Senate Committee on Health, Education, Labor and Pensions (HELP) and (2) the Senate Committee on Finance. A summary of the jurisdiction of these committees is as follows:

- The HELP Committee has jurisdiction over healthcare delivery reform, including issues such as prevention, quality improvement, and other related issues.
- The Senate Finance Committee has jurisdiction over programs like Medicaid and Medicare and payment provisions of the bill.

Both the HELP and Finance Committees are developing separate but coordinated health care bills which will be merged so that the entire Senate can then vote upon one Senate bill. The HELP Committee has voted its bill, the Affordable Health Choices Act, out of committee. Once the Finance Committee passes its bill, the two bills will be merged. The Senate floor vote will take place when the Finance Committee has completed its work and its bill is merged with the HELP bill.

In the United States House of Representatives, three separate committees have jurisdiction over health care issues: the Education and Labor Committee, the Ways and Means Committee and the Energy and Commerce Committee. These committees have developed a bill (H.R. 3200) and the House Leadership has publicly stated that a floor vote in the House will likely take place sometime in September. The Senate floor vote may take place when the Finance Committee has completed its work and its bill is merged with the HELP bill.

When these bills finally pass each respective Chamber, members of the House and Senate committees that worked on the bills will meet in a conference committee to develop a final version of this legislation. The conference committee's job is to iron out differences between the bills and agree upon one version of the bill which will then go back and be voted upon in both the House and the Senate. Thus, at the final vote, each Chamber is voting upon an identical bill which, if passed, will go to the President for signature.

Several steps in the legislative process therefore remain, and Senator Casey will continue to work with his colleagues in both parties to produce a bill that will improve our nation's health care system.



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## **THE SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR & PENSIONS: AN OVERVIEW OF THE AFFORDABLE HEALTH CHOICES ACT**

After more than a month of committee mark-up in which over 160 Republican amendments were accepted, the HELP Committee approved the Affordable Health Choices Act. This legislation lays the foundation for comprehensive national health reform. This bill, which will be combined with the work being done by the Senate Finance Committee, will make health care affordable and available to all Americans. Fully 97 percent of Americans will have coverage, which is a major achievement. Key elements of the bill include (NOTE: the final pages of this document includes a comprehensive summary of the legislation):

- **Guaranteeing quality, affordable health coverage for all Americans.**
- **Making coverage fairer and more comprehensive.**
- **Protecting Americans against ruinous medical costs.**
- **Giving immediate assistance to retirees to help with the high cost of coverage.**
- **Providing an immediate benefit for evidence-based preventive services.**
- **Creating a new voluntary insurance program for long term services and supports.**
- **Transforming health quality through delivery system reform.**
- **Improving the health of all Americans through prevention and wellness.**
- **Building a health care workforce to meet the needs of the 21st century.**
- **Fighting health care fraud and abuse.**
- **Improving access to innovative medical therapies.**
- **A new health insurance credit for businesses with 50 or fewer workers will cover up to half of the cost to employers for providing health insurance for their workers.**



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## MYTH VERSUS REALITY ON HEALTH INSURANCE REFORM



As health care reform legislation continues to be written in Washington, there is a lot of misinformation about the intent of reform. Senator Casey's committee has passed a bill, but there is not yet a final proposal. There are, however, plenty of myths that can be dispelled.

**MYTH:** The current health care system is fine and doesn't need to be changed.

**REALITY:** Unless you are an insurance company CEO, the answer is false. Rising health care costs jeopardize family budgets, state budgets and the federal budget. Premiums have doubled in the last nine years. By 2016, premiums for family coverage in Pennsylvania are estimated to consume 51.7% of the median Pennsylvania family income. According to Families USA, 2.8 million Pennsylvanians under age 65 – 27.3% of the population – did not have health insurance at some point in the last two years

**MYTH:** The bill will lead to a government takeover of our nation's health care system.

**REALITY:** Reform will actually increase competition and offer consumers more choices. If you like your current coverage, the government will not force you to change it. If you want to change coverage, you will have more options than before.

A public option would achieve those goals and give the American people more choices. It would foster greater competition; lower costs; and give consumers a greater variety of affordable choices. NBC News recently reported that those most likely to purchase health care via the public plan include: (1) individuals who currently have no health insurance; (2) individuals who buy their own insurance; and (3) workers employed by small businesses where no health insurance is provided.<sup>27</sup> The CBO estimated that the public plan would offer premiums about 10 percent lower than private plans. The government coverage would be available alongside private plans.

Opponents of reform have asserted that a public option would result in a mass exodus from the private market. The objective facts simply do not support this assertion. First, the non-partisan Congressional Budget Office estimates that only 11 million to 12 million people would sign up for the public plan--making it a



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much smaller player in the market.<sup>28</sup> Second, the reform bill specifically includes a combination of mandates and tax incentives that will ensure the continued viability of the private insurance market.

**MYTH:** Health insurance reform will lead to the rationing of health care.

**REALITY:** Health insurance reform will END current forms of rationing, not expand it.

First, there is widespread rationing in today's system. Right now, decisions about what doctor you can see and what treatment you can receive are made by insurance companies, which routinely deny coverage because of cost or the insurance company rules. Health reform will do away with many of those rules that result in rationing today.

Health insurance reform will prevent insurance companies from denying coverage because you have a pre-existing condition; prevent them from canceling coverage because you get sick; ban annual and lifetime limits on coverage, which often force people to pay huge sums out of pocket if they develop a serious illness; and prevent discrimination based on gender. With health insurance reform, we will also put treatment decisions back into the hands of doctors in consultation with their patients.

One of the reasons we spend too much on health care today is that our incentives are perverse: Doctors are paid by the procedure, rather than for quality. We want reform that rewards quality of care, not the quantity of procedures. Having dozens of procedures doesn't necessarily make you better. In fact they can make you worse. Right now roughly 100,000 Americans die every year from medical errors, which, in many cases, were the result of treatments that were wrong for them. We want to reduce preventable hospital re-admissions that are frequently caused because patients are not getting the right care in the first place. We want to give doctors the ability to make the best treatment decisions for you and your family.<sup>29</sup>

**MYTH:** The current health system does not permit insurance companies to discriminate.

**REALITY:** Under current law, insurance coverage can exclude pre-existing conditions or even deny coverage completely. The reform bill will eliminate discrimination for pre-existing conditions, health status or gender. A pre-existing condition is a medical condition that existed before someone applies for or enrolls in a new health insurance policy. It can be something as prevalent as heart disease – which affects one in three adults – or something as life-changing as cancer, which affects 11 million Americans. But a pre-existing condition does not have to be a serious



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disease like cancer or heart disease. Even relatively minor conditions like hay fever, asthma, or previous sports injuries can trigger high premiums or denials of coverage.

The ability to deny coverage has real-world consequences for Pennsylvanians. For instance, an estimated 9 percent of people in Pennsylvania have diabetes<sup>9</sup> while an estimated 28 percent have high blood pressure.<sup>10</sup> Under current law, insurance companies could use these conditions as a reason to deny you health insurance. Health insurance reform will prevent insurance companies from denying coverage based on your health, and it will end discrimination that charges you more if you're sick or a woman.

**MYTH:** Medical malpractice costs are the primary reason why health care premiums are skyrocketing.

**REALITY:** False. The independent Kaiser Family Foundation notes on its website that the non-partisan Congressional Budget Office (CBO) estimates that "malpractice costs account for less than 2 percent of national health spending and that even significant reductions these costs would only modestly affect the growth in overall health spending."<sup>30</sup>

**MYTH:** Small businesses are already struggling. Health care reform will make it worse.

**REALITY:** False. The reform effort will benefit, not burden, small businesses. 175,745 employers in Pennsylvania are small businesses.<sup>6</sup> Small businesses will receive tax credits to help them cover costs if they already offer coverage or to help them offer their employees health care for the first time. One study found that without reform, small businesses across the country will spend \$2.4 trillion on health care over the next ten years. With reform, they would save \$855 billion. With tax credits and a health insurance exchange where they can shop for health plans, insurance coverage will become more affordable for small businesses.

**MYTH:** Health insurance reform will increase the deficit.

**REALITY:** The reform effort will NOT increase the deficit AND will be fully paid for. The majority of the initiatives that would pay for reform will come from cutting waste, fraud and abuse within existing government health programs; ending big subsidies to insurance companies; and increasing efficiency with such steps as coordinating care and streamlining paperwork. We want to take money that is already being spent on health care and re-allocate it toward reforms that lower costs and assure quality affordable health care for all Americans.



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The cuts we are talking about involve spending that currently does not improve care for Americans. For example, we would save \$177 billion in unwarranted subsidies to the insurance industry in the next ten years and put that money into actual care for people. These and other reforms will strengthen and stabilize Medicare. But it's not enough to stop there. Health insurance reform must also encourage the kinds of reforms we know will save money in the long run: preventive care; computerized record-keeping; and comparative effectiveness studies to expose wasteful procedures and hospitalizations and give doctors the tools to make the right treatment decisions for you.<sup>31</sup>

**MYTH:** Health care reform will mandate euthanasia in order to cut health care costs.

**REALITY:** This is **absolutely false** and a disturbing example of the type of misinformation being perpetuated to put the brakes on health care reform.

The reform bill under consideration in the U.S. House of Representatives (H.R. 3200) contains a provision that would require Medicare to pay physicians to counsel patients once every five years. During those voluntary counseling sessions, doctors could discuss how patients can plan for such end-of-life decisions as setting up a living will, obtaining hospice care or establishing a proxy to make their health decisions when they are unable to do so. This concept was first introduced several years ago by then-Representative (now Senator) Johnny Isakson, Republican from Georgia, who was recently quoted as saying that the provision “empowers you to be able to make decisions at a difficult time rather than having the government making them for you.”<sup>32</sup> The bill under consideration in the Senate Committee on Finance does not, at this point, contain a similar provision.

According to the House leadership, the primary goal of this provision is to improve the delivery of health care services toward the end of a patient's life. Under current federal law, Medicare does not reimburse providers who provide counseling for end-of-life care. The lack of reimbursement serves as a deterrent to the delivery of such counseling. As a result, patients sometimes receive end-of-life medical care that they do not want. More generally, the current system's failure to reimburse the cost of counseling leaves patients with inadequate or incomplete information regarding their options for end-of-life care. The provision allows *patients*, not doctors or the federal government, to decide whether to seek out such counseling. Any assertion to the contrary is simply untrue.

**MYTH:** Health care reform will raise taxes on the middle class.

**REALITY:** False. The President has made clear that he won't raise taxes on the middle class.



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### **THE SENATE AFFORDABLE HEALTH CHOICES ACT IN DETAIL**

The following pages provide a comprehensive summary of the provisions of the Affordable Health Choices Act, which was approved by the Senate Committee on Health, Education, Labor, and Pensions on July 15, 2009. Senator Casey is a member of this Committee and participated in over sixty hours of debate on this legislation.

This brief summary outlines the key features of the legislation:

- Guaranteeing quality, affordable health coverage for all Americans.
- Making coverage fairer and more comprehensive.
- Protecting Americans against ruinous medical costs.
- Giving immediate assistance to retirees to help with the high cost of coverage.
- Providing an immediate benefit for evidence-based preventive services.
- Creating a new voluntary insurance program for long term services and supports.
- Transforming health quality through delivery system reform.
- Improving the health of all Americans through prevention and wellness.
- Building a health care workforce to meet the needs of the 21st century.
- Fighting health care fraud and abuse.
- Improving access to innovative medical therapies.

#### **Title I. Guaranteeing Quality, Affordable Coverage for All Americans**

**Building on what works.** Everyone who likes his or her current health insurance – whether employer, individual or government-sponsored – can keep it.

**Fixing what's broken: the American Health Benefit Gateway.** The American Health Benefit Gateway is a new federally sponsored and state run way for individuals and small employers to find and purchase quality, affordable health insurance. Each Gateway will create new and accessible health insurance markets in each state to make purchasing health insurance easy and reliable. Gateways will make sure coverage is high quality and there when consumers need it the most. Plans will have new incentives to keep enrollees healthy. For eligible individuals and families, signing up will be consumer friendly. Enrollees will be able to fill out applications in many locations and be enrolled in the insurance coverage appropriate for them.

Only insurance plans meeting high standards for quality and benefits will sell through the Gateway. For those with incomes up to four times the federal poverty level (\$43,000 in annual income for an individual), premium subsidies will be available on a sliding-scale basis according to family income. Based on their ability to pay, enrollees will be responsible for out of pocket



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expenses with clear limits. One option available to consumers through the Gateway will be a publicly-sponsored plan called the “*Community Health Insurance Option*.”

Gateway plan benefits will be as extensive as those offered to Members of Congress. At a minimum, these benefits will include: outpatient services; emergency services, hospitalization; maternity and newborn care; medical and surgical care; mental health & substance abuse services; prescription drugs, rehabilitative and laboratory services; preventive and wellness services; and pediatric services.

**Fixing what’s broken: Insurance Market Reforms.** Far-reaching changes will be required for new health insurance coverage:

- Guaranteed issue: Insurance companies will be required to take all applicants. For the first time ever, they will not be permitted to deny coverage to anyone.
- No medical underwriting or pre-existing condition exclusions: Insurance companies will be forbidden to write or to price policies based on health status, medical condition, or gender.
- Community rating: Insurance companies will charge everyone premiums that may only vary by family composition, type of plan, geography, tobacco use, participation in wellness programs, and age. Age rating will not vary by a factor more than two to one.
- Medical loss ratios: Insurers will report publicly how much of premium dollars are spent on medical costs versus non-medical costs such as marketing, administration, and profits.
- Coverage for young adults: Insurers will allow young adults extra time to stay on their parents’ coverage plans.
- Elimination of lifetime and annual benefit caps.
- Elimination of insurance policy rescissions.

**Supporting Small Businesses.** A new health insurance credit for businesses with 50 or fewer workers will cover up to half the cost to the employer of providing health insurance for their workers. The credits phase out as the firm size increases, and the assistance is most generous for firms with lower-wage workers.

**Sharing Responsibility – Individuals.** In a voluntary market with guaranteed issue, many healthy people wait until they get sick to purchase coverage, driving the price of insurance beyond most people’s reach. That is why the HELP bill sets a new requirement for all individuals to purchase health insurance. Just as failing to obtain car insurance carries a penalty, so too the HELP bill requires those who fail to fulfill this requirement to pay a fine. Those who do not have affordable coverage available to them will receive a hardship waiver. An exemption is also provided for those who have religious objections to health care coverage.

**Sharing Responsibility – Employers.** Shared responsibility requires everyone to help solve America’s health care crisis. That includes government, insurance companies, medical



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providers, individuals and employers. Except for small employers with 25 or fewer workers, those businesses not providing coverage for their workers will be asked to contribute to the cost of providing publicly-sponsored coverage for those workers. The maximum assessment will be \$750 annually for full-time and \$375 for part-time workers.

**Creating a new voluntary insurance program for long term services and supports.** The HELP legislation creates a new national insurance program to help adults who have or develop functional impairments to remain independent, employed and stay a part of their communities. Financed through voluntary payroll deductions, this program will remove barriers to independence and choice (e.g., housing modifications, assistive technologies, personal assistance services, transportation) by providing a cash benefit to individuals unable to perform two or more functional activities of daily living. The large risk pool created will make added coverage more affordable and reduce incentives for people with severe impairments to spend down to Medicaid.

**Improving access to critical health care services.** The AHCA legislation expands funding authorizations for federally qualified health centers, the National Health Services Corps, and community-based mental and behavioral health services. The legislation also reauthorizes the Wakefield Emergency Medical Services for Children Program.

**Immediate assistance with the soaring cost of health care for retirees.** Retirees not yet eligible for Medicare face extraordinary challenges in receiving affordable, quality health care. Costs for coverage are soaring, but businesses face more and more pressure to cut back on retiree coverage. To help retirees keep the coverage they have, the legislation establishes a reinsurance fund for retiree health coverage that is estimated by the nonpartisan Urban Institute to reduce premiums by over \$1,200 a year for a family policy.

### **Title II. Improving Health Quality through Delivery System Reform**

**A National Quality Strategy.** The United States lacks a coherent strategy to improve the quality of our health care system. Consequently, health outcomes and quality initiatives vary widely. As President Obama has said, these activities have been haphazardly left to “Islands of Excellence.” This title requires the Secretary of Health and Human services to establish a new national strategy and infrastructure to improve the quality and performance of the U.S. health care system. The strategy will target priority areas, use health information technology, and focus on health outcomes and population health. An interagency working group will coordinate and implement health care quality improvement initiatives. Quality measures will be identified, developed and endorsed. A streamlined and integrated quality reporting process will minimize the burden on providers. Key initiatives include:

- Developing a national strategy for quality improvement.
- Establishing an interagency working group on health care quality.



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- Setting comprehensive quality measure development.
- Creating a quality measure endorsement and public reporting system.
- Forming a Patient Safety Research Center at the Agency for Healthcare Research and Quality.
- Supporting and developing Community Health Teams.
- Implementing Medication Management Services in treating chronic disease.
- Improving regionalized systems for Emergency Care, including acute trauma.
- Reporting and reducing preventable readmissions.
- Facilitating shared decision making.
- Evaluating the presentation of prescription drug information.
- Establishing a new Center for Health Outcomes, Research and Evaluation.
- Meeting the promise and opportunity of Administrative Simplification.

### **Title III. Improving the Health of the American People through Prevention & Wellness**

In clinical medical settings, in communities, in health care training, in our workplaces – there are significant barriers to leading a healthy lifestyle. The incentives are misplaced and encourage unhealthy behavior. As President Obama has said, preventive care is “one of the best ways to keep our people healthy and our costs under control.” The key Prevention and Wellness provisions in the HELP Committee legislation include:

- Establishing a federal Prevention and Public Health Council to coordinate federal agencies and to develop a national strategy with public health goals and objectives for the nation.
- Changing medical school and residency curricula to teach the next generation of health care professionals how to prevent unnecessary disease.
- Removing barriers to preventive services.
- Creating a Prevention and Public Health Investment Fund to expand the nation’s investment in prevention and public health.
- Establishing the Right Choices program to give uninsured adults access to preventive services until full insurance coverage is made available through the Gateway.
- Authorizing the development and expansion of School-based Health Clinics.
- Setting up an oral healthcare prevention and education campaign.
- Awarding community transformation grants to prevent and reduce chronic disease.
- Developing a “health aging, living well” program to improve the health status of the pre-Medicare eligible population.
- Improving immunization coverage of children, adolescents, and adults through evidence-based interventions.
- Requiring chain restaurants to disclose calories on menus and menu boards.
- Encouraging a healthy start by requiring employers to provide break times and locations for breastfeeding mothers to express milk.



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- Expanding opportunities for employers to reward employees for participating in wellness programs from the current 20 percent to a 30 percent premium discount.
- Sets up a Coordinated Environmental Public Health Network to track incidence, prevalence and trends in priority chronic conditions.
- Requiring reimbursement for essential preventive services to provide incentives for preventive services such as screenings for diabetes, depression and colorectal cancer, tobacco cessation, and nutrition counseling.

### **Title IV. Building a health care workforce to meet the needs of the 21st century**

A strong health care workforce is essential for successful health reform. The Affordable Health Choices Act will improve access to and delivery of health care services for all Americans by increasing the supply of a qualified health care workforce, enhancing workforce education and training, and providing support to the existing workforce.

Key provisions include:

- Increase the supply of qualified health care workers by providing low-interest student loans, loan repayment programs, and scholarships for students and mid-career health care providers.
- Establishing a National Health Care Workforce Commission to determine current and projected workforce needs, and to advise Congress and the Administration how to align workforce resources with national needs.
- Create state health care workforce development grants to enable state partnerships to support innovative activities to increase the numbers of skilled health care workers.
- Setting up new loan programs for nurses, mental and behavioral health providers, and allied health professionals.
- Developing a Ready Reserve Corps for service in times of national emergency.
- Supporting advanced training for family medicine physicians, pediatricians, nurses, physician assistants, pediatric and general dentists, direct care workers, geriatricians, mental and behavioral health professionals, community health workers, public health professionals, and nurse faculty.
- Forms a Centers of Excellence program to encourage and mentor minority applicants for healthcare workforce positions.
- Creates a Primary Care Extension Program to education and provide assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

### **Title V. Preventing Fraud and Abuse**



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The National Health Care Anti-Fraud Association estimates that three percent of all health care spending – or \$72 billion – is lost to health care fraud perpetrated against public and private health plans. Fraud committed against public and private plans increases the cost of medical care and health insurance for employers, families, and taxpayers, and undermines public trust in our health care system. Our legislation will ramp up efforts to combat fraud, especially in the private health insurance market, giving new tools to states and federal agencies to stop and prevent fraudulent activities.

### **Title VI. Improving Access to Innovative Medical Therapies**

**Follow-on Biologics.** Patients now face extraordinary costs for innovative new medical therapies based on the techniques of biotechnology. The legislation will establish a way for FDA to approve new or “follow-on” versions of these lifesaving medicines. Just as generic drugs have lowered the costs of health care, so too these new biologics can bring the cost of these new medicines within the reach of the patients who need them. The legislation also includes a balanced way to resolve the patent disputes that can stall approval of follow on biologics. Finally, the legislation includes incentives for innovation, by giving manufacturers of innovative biologics a 12-year period of market exclusivity for their products.

**Expanded Participation in 340B Program:** Section 340B of the Public Health Service Act enables safety-net hospitals and other providers serving a large volume of low-income and uninsured patients to access discounts on pharmaceuticals. Among other changes, the HELP legislation expands the drug discount program to allow participation by free-standing children's hospitals, free-standing cancer hospitals, rural referral centers, sole community hospitals with a disproportionate share hospital percentage greater than eight percent, and all critical access hospitals.



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<sup>2</sup> Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November, 2007, <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>.

<sup>3</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Care Expenditures, 2007. Table 1. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

<sup>4</sup> Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. National Health Expenditure Projections 2008 – 2018, Table 1, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.

<sup>5</sup> Congressional Budget Office, *Growth in Health Care Costs*, CBO Testimony before the Committee on the Budget United States Senate, January 31, 2008, <http://www.cbo.gov/ftpdocs/89xx/doc8948/01-31-HealthTestimony.pdf>

<sup>6</sup> U.S. Census Bureau, Current Population Survey. HIA-4 Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007, 2007.

<sup>7</sup> Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table X.D. Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at <http://www.cms.hhs.gov/nationalhealthexpenddata/>.

<sup>8</sup> Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1. Projected 2009 premiums based on Centers for Medicare and Medicaid Services, "National Health Expenditure Data," available at <http://www.cms.hhs.gov/nationalhealthexpenddata/>.

<sup>9</sup> Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2006.

<sup>10</sup> Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

<sup>11</sup> Furnas, B., Harbage, P. (2009). "The Cost Shift from the Uninsured." Center for American Progress.

<sup>12</sup> U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

<sup>13</sup> U.S. Census Bureau, Current Population Survey. HIA-4 Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007, 2007.

<sup>14</sup> Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2006, Table II.A.1a.

<sup>15</sup> Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2001, 2006, Table II.A.2.

<sup>16</sup> Health Care for America Now. (2009). "Premiums Soaring in Consolidated Health Insurance Market." Health Care for America Now.



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<sup>17</sup> <http://www.statehealthfacts.org/>

<sup>18</sup> Center for Financing, Access and Cost Trends, AHRQ, Medical Expenditure Panel Survey - Insurance Component, 2000, Table II.D.1.

<sup>19</sup> U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2007 and 2008.

<sup>20</sup> Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

<sup>21</sup> <http://www.healthreform.gov/reports/statehealthreform/pennsylvania.html>

<sup>22</sup> Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health, Data Resource Center for Child and Adolescent Health.

<sup>23</sup> Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007.

<sup>24</sup> Furnas, B., Harbage, P. (2009). "The Cost Shift from the Uninsured." Center for American Progress.

<sup>25</sup> <http://www.whitehouse.gov/realitycheck/faq#u1>.

<sup>26</sup> <http://www.whitehouse.gov/health-insurance-consumer-protections/>

<sup>27</sup> NBC Nightly News with Brian Williams, 'Public Option' provokes strong reaction, aired Tuesday, August 18, 2009.

<sup>28</sup> Congressional Budget Office: 'Public option' plan would not drive private health insurance out of business by Ricardo Alonso-Zaldivar, The Associated Press Monday July 27, 2009, [http://www.nola.com/news/index.ssf/2009/07/congressional\\_budget\\_office\\_pu.html](http://www.nola.com/news/index.ssf/2009/07/congressional_budget_office_pu.html)

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<sup>30</sup> Medical Malpractice Policy – Background Brief, The Henry J. Kaiser Family Foundation, [http://www.kaiseredu.org/topics\\_im.asp?id=226&imID=1&parentID=59](http://www.kaiseredu.org/topics_im.asp?id=226&imID=1&parentID=59).

<sup>31</sup> <http://www.whitehouse.gov/realitycheck/faq#r1>

<sup>32</sup> Ezra Klein, Washingtonpost.com, *An Interview With Sen. Johnny Isakson*, [http://voices.washingtonpost.com/ezra-klein/2009/08/is\\_the\\_government\\_going\\_to\\_eut.html#more](http://voices.washingtonpost.com/ezra-klein/2009/08/is_the_government_going_to_eut.html#more)