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How Max Missed the Mark on Healthcare

Senate Finance Committee Chairman Max Baucus has not disclosed the actual language of his proposed healthcare bill that the Senate is considering. Instead he released an outline known as the "Chairman's Mark" for "America's Healthy Future Act of 2009," to summarize what a Senate bill would entail. A link to the Mark is posted on the Finance Committee website at: http: //www.finance.senate.gov/sitepages/leg/LEG%202009/091609%20Americas_Healthy_Future_Act.pdf

The following provides highlights and brief commentary on some provisions that are "summarized" by the 223-page Mark:

- Pg. 13: Creates national plans that preempt state benefit mandates in order to create a "single, uniform benefit package" for individuals who do not have single, uniform health concerns.

- Pg. 17: Offers only FOUR PLANS from which to choose. You do not get to freely choose the services you want covered in your health insurance plan.

- Pg. 25-27: Federal funds may be used to pay for abortions! The Secretary of Health and Human Services is charged with ensuring that at least one plan in every state provides COVERAGE OF ABORTIONS.

- Pg. 28: MANDATES health insurance for every U.S. citizen and legal resident and requires individuals to REPORT on their income tax form each month that the individual maintained insurance for himself and his dependents under age 18.

- Pg. 29: If you do not maintain insurance for yourself or your dependents, you will be TAXED from $750 to $1,500 per person.

- Pg. 29: Employers are required to automatically enroll employees into health insurance plans offered by the employer. Employees may only opt out if the employee can prove he has insurance through another source!

- Pg. 36-38: Instead of reducing the deficit, the government will actually set aside $6 billion for grants and loans to new insurance companies.

- Pg. 39: Instead of reducing the deficit, the government will spend $30 million, or more, if necessary, to help people with "navigating health insurance coverage transitions…" So we can expect this new program to be confusing to the average consumer.

- Pg. 42: Creates a massive expansion of Medicaid to include coverage for "childless adults" who are at or below 133 percent of the Federal Poverty Level (FPL), which, according to the *Federal Register*, was $10,830 for all states, except Alaska and Hawaii, in 2009. (http: //aspe.hhs.gov/poverty/09poverty.shtml)

- Pg. 46: Medicare for children is expanded from covering children in homes that earn between 100 and 150 percent of the Federal Poverty Level to cover children in homes that earn between 134 and 250 percent of the Federal Poverty Level. (http: //aspe.hhs.gov/poverty/09poverty.shtml)

- Pg. 52-53: Requires drug companies who want to sell their products in Medicaid to increase the rebates provided, which may result in pushing those drug companies away from Medicaid and discourage the creation of new drugs.

- Pg. 55: Decreases the federal upper payment limits for Medicaid payments for prescriptions drugs so the payment is 75% of the average manufacturer price.

- Pg. 56: Creation of a trigger that decreases funding of hospitals that serve a disproportionate share of low-income individuals, when the state's rate of noninsured individuals decreases by 50 percent.

- Pg. 60: Prohibits Medicaid payments for conditions that were acquired by the patient during the provision of other health care services. Thus, presumably Medicaid will not pay for the treatment of Staph infection or MRSA if it is acquired while the patient is in the hospital being treated for unrelated symptoms.

- Pg. 61: Creates a new 11 million dollar bureaucracy: the Medicaid and CHIP Payment and Access Commission.

- Pg. 68: Establishes a new state grant program that establishes standards for maternal and child health, childhood injury prevention, school readiness, juvenile delinquency, family economic factors, and coordination with resources, and if the standards are not met, "expert technical assistance" is provided. 1.5 billion dollars is appropriated for this program in which the government tells families how to operate.

- Pg. 72-73: Appropriates $100 million for incentives for Medicare beneficiaries who successfully complete "healthy lifestyle programs."

- Pg. 74: Authorizes $25 million for a new federal program, the "Childhood Obesity Demonstration Project."

- Pg. 79: Establishes a new Physician Quality Reporting Initiative that incentivizes the completion of practice assessments. The amount of funds that will be designated to pay for the incentives and pay the people who review all of the reports is not specified.

- Pg. 85-87: Delegates the duty of establishing a national strategy to improve health care quality to the Secretary of Health and Human Services and allocates $50 million per year to carry out the plan.

- Pg. 90-93: Creates a $10 billion "Innovation Center" to test, evaluate, and expand payment structures. Spending money to track money.

- Pg. 99-100: Establishes $500 million Community Care Transitions Program for Medicare patients to reduce preventable readmissions.

- Pg. 105: More regulations for residency programs.

- Pg. 107: Establishes a new Workforce Advisory Committee to assess the healthcare workforce. No funding is appropriated for this committee, but that does not mean it will not be costly.

- Pg. 108: More government handouts at a cost of $85 million: A demonstration project to provide financial aid, childcare, case management, and supportive services for low-income individuals entering a healthcare field with labor shortages, when these individuals may already be eligible for welfare and the handouts are not considered income for tax purposes. Additionally, the project would provide grants to up to six states to develop training programs. Who would decide which states deserve funding?

- Pg. 109: Program determines cost-effectiveness of treatment of children with disabilities and special healthcare needs. Should the government really be asking whether your child is worth saving?

- Pg. 112: Limits payments on outpatient therapy services.

- Pg. 116: DECREASES MEDICARE funding by $22.29 billion.

- Pg. 123: For Medicare to cover a drug, the drug manufacturer must sign a document allowing the Secretary of Health and Human Services to set the price of the drug. This will effectively make some drugs unavailable to Medicare patients.

- Pg. 125: Creates a program that allows the Secretary of Health and Human Services to automatically enroll individuals at a certain income level in order to provide insurance for whatever services the Secretary deems appropriate.

- Pg. 127: Allocates $45 million for "outreach and education activities."

- Pg. 129: Allows the IRS to tell the Social Security Administration about your income, and reduces the subsidy for some Medicare beneficiaries.

- Pg. 132-144: Increases regulation for private insurance plans providing coverage to Medicare Advantage patients, including those with special needs.

- Pg. 148: More red tape for hospice providers.

- Pg. 150: Authorizes the Secretary of Health and Human Services to set Medicare healthcare workers' wages.

- Pg. 153: Limits your option to purchase a power-driven wheelchair.

- Pg. 156: Establishes a Medicare Commission comprised of 15 members appointed by the President. Do we need more bureaucracy?

- Pg. 159-168: Creates a "Patient Centered Outcomes Research Institute" with a 21 member board.

- Pg. 167-168, 199: Raises costs for small business owners. Employers must pay taxes and fees for each person covered by their self-insured plans.

- Pg. 169: Health and Human Services Department can require electronic fund transfers for payment receipt by doctors who treat Medicare patients, which means government access to banking information.

- Pg. 170-174, 183, 189: Regulation of private healthcare plans, including regulation of the referral process.

- Pg. 171: Machine readable HEALTH IDENTIFICATION CARDS will be put into effect by the Secretary of Health and Human Services. This is the national ID card that bureaucrats want!

- Pg. 173: Secretary of Health and Human Services will create another committee, the HIPAA standards review committee.

- Pg. 174: Recommends states test "alternatives to the current civil litigation system" in order to address issues related to medical malpractice, but disregards the fact that states like Texas have already taken serious steps in dealing with medical malpractice issues, and that health care costs decreased in those states as a result of tort reform.

- Pg. 176-177: "Physician Payment Sunshine" rules require more paperwork. Manufacturer of covered drug, device, biological or medical supply must report and transfer to a physician, practice, hospital, or group valued at $10.01 or more, or any investment in the entity, to the Secretary of Health and Human Services. This may monitor doctors' interests, but who is shining the light on government officials?

- Pg. 185, 190-195: Imposes new rules for providers of Medicare and Medicaid providers, including compliance programs, program sanctions, time caps for submitting claims, and

requirements that physicians submit to audits and comply with reporting requirements. This will deter physicians from providing services to Medicare and Medicaid patients.

- Pg. 194: Increases funding to the Health Care Fraud and Abuse Control program by $10 million each year for ten years, but how much can the government control fraud, abuse and waste in its programs?

- Pg. 198: Government sets premiums on health insurance plans.

- Pg. 205: INCREASES THE TAX on distributions from health savings accounts that are not used for "qualified medical expenses" to 20% of the disbursed amount.

- Pg. 211-213: Non-profit hospitals are required to conduct a community health needs assessment and to adopt an implementation strategy to meet community needs.

- Pg. 213: Application of fees on importers of drugs, an aggregate annual fee of $2.3 billion, which will increase drug prices.

- Pg. 215: Imposes a tax on anyone manufacturing or importing medical devices (including everything from breathing machines to wheelchairs) for sale in the United States. The aggregate fee is expected to be $4 billion. This means an increase in costs to patients, an increase in regulation by the government and a decrease in incentives for medical device companies.

- Pg. 216: Imposes a fee (tax) on health insurance providers. The aggregate fee is $6 billion. This will result in the LOSS OF PRIVATE INSURANCE PROVIDERS FROM THE MARKET!

- Pg. 218: Imposition of fees (taxes) on entities offering clinical laboratory services. The aggregate of the fee will be $750 million annually.

- Pg. 219: Revokes the opportunity for some retirees to deduct expenses for prescription drugs from their income taxes, which will cause some retirees to pay higher taxes.