HEALTH CARE BILLS: SOME COMPARISONS

The Telmarc Group, WHITE PAPER No 74

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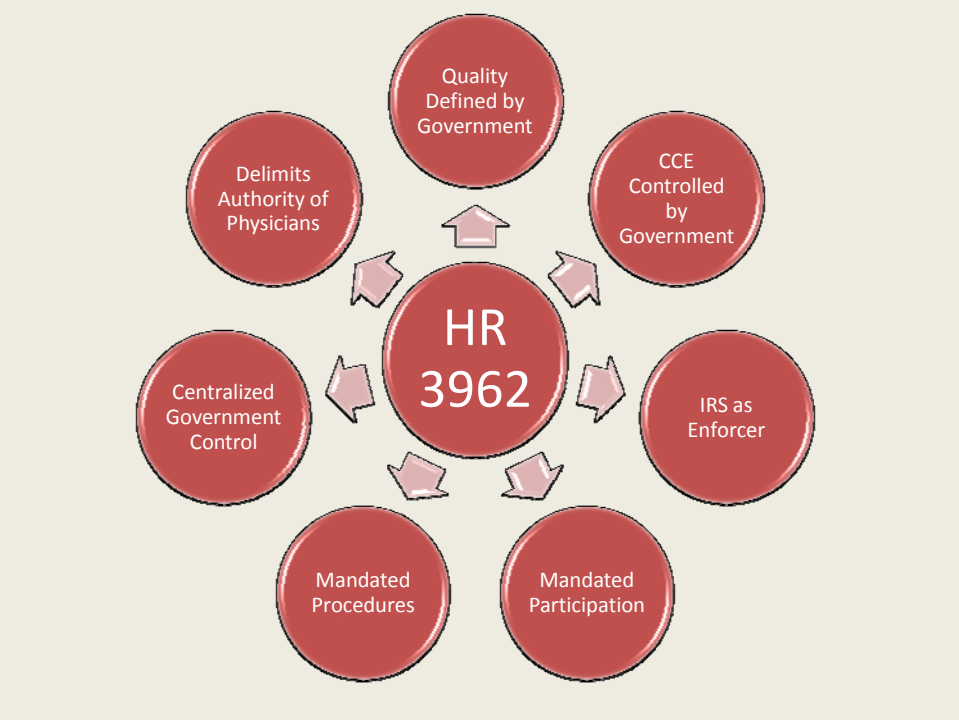
The Telmarc Group - November 2009

1 INTRODUCTION

This report is a compilation of what we written on HR 3200 and its progeny HR 3962. We felt that based on comments that it would be useful to have these postings in a single document and back to back for comparison.

It should be noted that we have looked at different parts of some of the Bills but the overall discussion provides an adequate understanding of where Congress is going.

We have written about several of the concerns of HR 3962 in the past days and we depict them below. Albeit that these are but a few, they are typical of what we have seen. Let me go over them one more time and I suggest that you can review them in prior entries.



1. Government Control: There is generated a massive new infrastructure of centralized Government control of all aspects of medicine. It takes away autonomy and reduce this to an erstwhile government agency. The model for this is in Galbraith's book on

American Capitalism written in the early 1950s where he is prescribing how the Government is the only benign and loving care giver to control the evil large corporations. One should remember that the physicians are in many ways just small business people in the market.

2. Defining Quality: We have written extensively on this issue but the last entity one would want to define what quality is would be the Federal Government. Just look at the job they did with H1N1, Katrina, and the like. This is not a party sensitive issue, they just cannot do it.

3. CCE: The Comparative Clinical Effectiveness issue is one where the Government controlled entity would define the research, fund the research, analyze the research and then dictate medical care. This is just insane.

4. Defined Benefits: The Government is insisting that the basic plan include everything and the kitchen sink for all insurance carriers as well as itself. It has taken universal coverage to the extreme. The basic package should have some catastrophic coverage, no one should go to their death bed broken, yet there is no reason to insist on everything.

5. The IRS as Enforcer: This is a real problem. First the IRS is not prepared for this and second it opens the window for criminal attacks on individuals.

6. Delimits Autonomy of Physician: Every patient is different and every physician cares for their patients differently. The matching up of a good physician and an involved patient is essential for humane care. This law will break that bond and set the parties adrift if not at each others' throat.

Perhaps the Countervailing Power of the people will do something to reduce the negative effects of this legislation. We need health care reform, we need universal care, yet we do not need such massive Government involvement with the most critical parts of our lives. It will destroy freedom.

2 INCLUSION

This is the issue of who is to be included in the coverage and the law, both people and entities.

2.1 HR 3962

HR 3962 defines the standard package of coverage for every possible basic plan. We discuss some of these issues herein. As with other discussions we use the words of the Bill as backdrop.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.

(a) IN GENERAL.—A qualified health benefits plan shall provide coverage that at least meets the benefit standards adopted under section 224 for the essential benefits package described in section 222 for the plan year involved.

This wording means that what follows shall apply to any and all plans. Thus the ability to purchase a catastrophic coverage plan only is no longer acceptable. No matter what you must buy and pay for what shall be required for all plans. This one condition will perforce of the increased coverage requirements drive up the cost of all other plans.

(b) CHOICE OF COVERAGE.—

(1) NON-EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of a qualified health benefits plan that is not an Exchange-participating health benefits plan, such plan may offer such coverage in addition to the essential benefits package as the QHBP offering entity may specify.

(2) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS.—In the case of an Exchange-participating health benefits plan, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium plus level of benefits, provide additional benefits.

(3) CONTINUATION OF OFFERING OF SEPARATE EXCEPTED BENEFITS COVERAGE.—Nothing in this division shall be construed as affecting the offering outside of the Health Insurance Exchange and under State law of health benefits in the form of excepted benefits (described in section 202(b)(1)(B)(ii)) if such benefits are offered under a separate policy, contract, or certificate of insurance.

The above merely states the minimum but does not limit the maximum. This creates a disincentive to have to pay for your own care out of pocket and creates the perception that you can get as much as you want. Yet as we have shown before that will be capped by the CCE efforts. This is a squeeze play with a great amount of ambiguity of expectations.

(c) CLINICAL APPROPRIATENESS.—Nothing in this Act shall be construed to prohibit a group health plan or health insurance issuer from using medical management practices so long as such management practices are based on valid medical evidence and are relevant to the patient whose medical treatment is under review.

This above statement is the fox in the hen house. Read this slowly. It says a plan can do whatever it wants as long as it based on valid medical evidence, later defined in the Government controlled CCE plan. This is the most deadly statement in this Bill!

(d) PROVISION OF BENEFITS.—Nothing in this division shall be construed as prohibiting a qualified health benefits plan from subcontracting with stand-alone health insurance issuers or insurers for the provision of dental, vision, mental health, and other benefits and services.

SEC. 222. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term essential benefits package means health benefits coverage, consistent with standards adopted under section 224, to ensure the provision of quality health care and financial security, that—

(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

(2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);

(3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;

(4) complies with section 215(a) (relating to network adequacy); and

(5) is equivalent in its scope of benefits, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage in Y1. In order to carry out paragraph (5), the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Health Benefits Advisory Committee and to the Secretary of Health and Human Services.

The above is filled with many small and large landmines. For example they have removed lifetime limits. Typically all plans have a lifetime limit unless one seeks a re-insurer plan. Removing that now creates a potential for unlimited care despite the CCE constraints.

(b) MINIMUM SERVICES TO BE COVERED.—Subject to subsection (d), the items and services described in this subsection are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinic services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

The above well baby care for children up to 21 is unbelievable. This is a very expensive clause. The limit of 18 was an old standard. Clause (7) for mental care is also very costly and that means anyone seeking to dry out or whatever to do so at the expense of those

taking care of themselves. Perhaps it will also pay for fat farms. The other issue will be just who are the other professionals. That becomes another backdoor.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for—

(A) preventive items and services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention; or

(B) well-baby and well-child care.

This means that the person has no out of pocket for preventative care. Thus if one is a tubby you get all the care you need to get in shape. There is no stick just lots of M&Ms, I mean carrots.

(2) ANNUAL LIMITATION.—

(A) ANNUAL LIMITATION.—The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).

(B) APPLICABLE LEVEL.—**The applicable level specified in this subparagraph for Y1 is not to exceed $5,000 for an individual and not to exceed $10,000 for a family.** Such levels shall be increased (rounded to the nearest $100) for each subsequent year by the annual percentage increase in the enrollment-weighted average of premium increases for basic plans applicable to such year, except that Secretary shall adjust such increase to ensure that the applicable level specified in this subparagraph meets the minimum actuarial value required under paragraph (3).

This appears to be beneficial. It means that in the event of a problem you are maxed out at $10,000 per family per year. That may be costly but is not unreasonable. One must remember that the cap is gone.

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in sub paragraph (B).

(B) REFERENCE BENEFITS PACKAGE DE SCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) ASSESSMENT AND COUNSELING FOR DOMESTIC VIOLENCE.—The Secretary shall support the need for an assessment and brief counseling for domestic violence as part of a behavioral health assessment or primary care visit and determine the appropriate coverage for such assessment and counseling.

This is new and is not in any current plan that I have seen. It clearly is someone's favorite cause.

(e) ABORTION COVERAGE PROHIBITED AS PART OF MINIMUM BENEFITS PACKAGE.—

(1) PROHIBITION OF REQUIRED COVERAGE.— **The Health Benefits Advisory Committee may not recommend under section 223(b), and the Secretary may not adopt in standards under section 224(b), the services described in paragraph (4)(A) or (4)(B) as part of the essential benefits package and the Commissioner may not require such services for qualified health benefits plans to participate in the Health Insurance Exchange.**

This does not expressly prohibit anything.

(2) VOLUNTARY CHOICE OF COVERAGE BY PLAN.—In the case of a qualified health benefits plan, the plan is not required (or prohibited) under this Act from providing coverage of services described in paragraph (4)(A) or (4)(B) and the QHBP offering entity shall determine whether such coverage is provided.

Thus if you go private you can get whatever you want.

(3) COVERAGE UNDER PUBLIC HEALTH INSURANCE OPTION.—The public health insurance option shall provide coverage for services described in para graph (4)(B). Nothing in this Act shall be construed as preventing the public health insurance option from providing for or prohibiting coverage of services described in paragraph (4)(A).

(4) ABORTION SERVICES.—

(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(B) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

Unless I missed something this is the "allowed" paragraph and there is nothing here.

(f) REPORT REGARDING INCLUSION OF ORAL HEALTH CARE IN ESSENTIAL BENEFITS PACKAGE.—Not later than 1 year after the date of the enactment of this Act, the

Secretary of Health and Human Services shall submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package.

SEC. 223. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

(2) CHAIR.—The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee. (3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) Nine members who are not Federal employees or officers and who are appointed by the President.

(B) Nine members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which

the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint. Such initial appointments shall be made not later than 60 days after the date of the enactment of this Act.

(4) TERMS.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term on the Committee, except that the terms of the initial members shall be adjusted in order to provide for a staggered term of appointment for all such members.

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, patient representatives, employers (including small employers), labor, health insurance issuers, experts in health care financing and delivery, experts in oral health care, experts in racial and ethnic disparities, experts on health care needs and disparities of individuals with disabilities, representatives of relevant governmental agencies, and at least one practicing physician or other health professional and an expert in child and adolescent health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the Secretary benefit standards (as defined in para graph (5)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health dis parities.

(2) DEADLINE.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(3) STATE INPUT.—The Health Benefits Advisory Committee shall examine the health coverage laws and benefits of each State in developing recommendations under this subsection and may incorporate such coverage and benefits as the Committee determines to be appropriate and consistent with this Act. The Health Benefits Advisory Committee shall also seek input from the States and consider recommendations on how to ensure quality of health coverage in all States.

(4) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this sub section.

(5) BENEFIT STANDARDS DEFINED.—In this subtitle, the term benefit standards means standards respecting—

(A) the essential benefits package described in section 222, including categories of covered treatments, items and services within benefit classes, and cost-sharing consistent with subsection (d) of such section; and (B) the cost-sharing levels for enhanced plans and premium plans (as provided under section 303(c)) consistent with paragraph (5).

(6) LEVELS OF COST-SHARING FOR ENHANCED AND PREMIUM PLANS.—

(A) ENHANCED PLAN.—The level of cost sharing for enhanced plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 85 percent of the actuarial value of the benefits provided under the reference benefits package described in section 222(c)(3)(B).

(B) PREMIUM PLAN.—The level of cost sharing for premium plans shall be designed so that such plans have benefits that are actuarially equivalent to approximately 95 percent of the actuarial value of the benefits provided under the reference benefits package described in section 222(c)(3)(B).

This group may have very far reaching and costly powers. This Bill like all that the Democrats seem to develop create a centralized Government plan to control each corner of one's life. It truly assumes that they are the anointed ones!

2.2 HR 3200

3 QUALITY

Quality has been a major concern and we had written a separate white paper on the topic. This compares the two plans in detail.

3.1 HR 3962

I have had a gnawing concern that the Quality rubric of HR 3200 and now of HR 3962 is a wolf in sheep's closing for rationing in the Medicare Section of the Bill. Let me

reiterate what the current Bills states, and it is worth comparing with what I said last July on the same matter.

The Bill states:

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT. Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

PART E—QUALITY IMPROVEMENT ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT

SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stake holders.

(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic dis eases;

(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

(3) have the greatest potential for improving the performance, affordability, and patient centeredness of health care, including those due to variations in care;

(4) address health disparities across groups and areas; and

(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

(d) DEFINITIONS.—In this part:

(1) CONSENSUS-BASED ENTITY.—The term 'consensus-based entity' means an entity with a contract with the Secretary under section 1890.

(2) **QUALITY MEASURE.—The term 'quality measure' means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.**

Yet when one looks at who gets to opine on quality it is:

SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.

(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

(3) RECOMMENDATIONS OF CONSENSUS BASED ENTITY.—In carrying out this section, the Secretary shall—

(A) seek public input; and

(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

and it continues:

(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a voluntary collaborative

of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

(A) Hospitals and other institutional providers.

(B) Physicians.

(C) Health care quality alliances.

(D) Nurses and other health care practitioners.

(E) Health plans.

(F) Patient advocates and consumer groups.

(G) Employers.

(H) Public and private purchasers of health care items and services.

(I) Labor organizations.

(J) Relevant departments or agencies of the United States.

(K) Biopharmaceutical companies and manufacturers of medical devices.

(L) Licensing, credentialing, and accrediting bodies.

Thus again no direct involvement of patients. If all else fails please listen to your customer. They have every possible influencing group in this mix! Pork anyone?

3.2 HR 3200

I have written about quality in health care a few weeks ago and have just published a White Paper on health care quality. In reading HR 3200 I see that they too have included quality. In fact the Bill is called:

H. R. 3200 ''America's Affordable Health Choices Act of 2009'' *"To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes."*

Now as we have said before quality is truly in the eye of the beholder, in this case the patient. If one has prostate cancer, quality care is not lots of morphine and just letting it met to the bone. Quality is engaging the patient in the process of managing his disease. Each patient is different, each patient has a different world view. Some dread incontinence, some sexual dysfunction, some pain. Thus the treatment of a patient, quality treatment, is a personalized interaction between patient and physician.

In HR 3200 they introduce sections defining as best as a politician can the idea of quality. It starts as follows:

"***H. R. 3200 ‘‘America’s Affordable Health Choices Act of 2009’’.***

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE IV—QUALITY

Subtitle C—Quality Measurements

SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES FOR QUALITY IMPROVEMENT.

Title XI of the Social Security Act, as amended by section 1401(a), is further amended by adding at the end the following new part:

‘‘PART E—QUALITY IMPROVEMENT ‘‘ESTABLISHMENT OF NATIONAL PRIORITIES FOR PERFORMANCE IMPROVEMENT‘‘ SEC. 1191.

(a) ESTABLISHMENT OF NATIONAL PRIORITIES BY THE SECRETARY.—The Secretary shall establish and periodically update, not less frequently than triennially, national priorities for performance improvement.

‘‘(b) RECOMMENDATIONS FOR NATIONAL PRIORITIES.—In establishing and updating national priorities under subsection (a), the Secretary shall solicit and consider recommendations from multiple outside stakeholders.

‘‘(c) CONSIDERATIONS IN SETTING NATIONAL PRIORITIES.—With respect to such priorities, the Secretary shall ensure that priority is given to areas in the delivery of health care services in the United States that—

‘‘(1) contribute to a large burden of disease, including those that address the health care provided to patients with prevalent, high-cost chronic dis eases;

‘‘(2) have the greatest potential to decrease morbidity and mortality in this country, including those that are designed to eliminate harm to patients;

‘‘(3) have the greatest potential for improving the performance, affordability, and patient centeredness of health care, including those due to variations in care;

‘‘(4) address health disparities across groups and areas; and

‘‘(5) have the potential for rapid improvement due to existing evidence, standards of care or other reasons."

It then goes on to define quality as follows:

"*‘‘(d) DEFINITIONS.—In this part:*

‘‘(1) CONSENSUS-BASED ENTITY.—The term ‘consensus-based entity’ means an entity with a contract with the Secretary under section 1890. ‘

*‘(2) QUALITY MEASURE.—**The term ‘quality measure’ means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services**....*"

This is a deadly definition of quality. It is akin to what the Brits have in their national system where they use the QALY approach to the rationing of health care. The QALY approach looks at a disease and looks at the average quality of life for a variety of treatments. For example we consider prostate cancer. There are three treatments; do nothing, prostatectomy, radiation therapy. Each of these has an outcome and has a patient result in quality of life measurements. Thus is we consider the quality measures some weighted average of pain, sexual dysfunction and incontinence, then we get a quality measure for each treatment for each period of time after diagnosis. We then obtain the average across the country and see that for example doing nothing may have the least impact, the patient has longer time with no sexual dysfunction and incontinence and they die faster so the time with pain is less. Then we assign a cost. Doing nothing is cheap, just lots of morphine if the Government even allows that. The Brits then rank each treatment by the $/QALY and permit the lowest cost treatment only! That means often doing nothing!

But what is wrong with this you may ask, for Congress has in effect placed this in the new Bill! What is wrong is that every patient is different and we are assuming the

average. If you are average then you get the correct treatment. If you are not then you are mistreated.

Parsing the above definition is telling. Let us proceed:

1. "***national consensus***": this means an average across all and disregard to the individual. Medicine is a profession which deals with persons, individuals, and not large groups. Each person with prostate cancer is different. However the Congress drives this to an average. The Brit's QALY approach is just that, an average. God forbid if your disease is one sigma either way, the plan drives to the mean.

2. "***performance and improvement of population health"*** This is NOT individual health, not individual quality, but the population as a whole, as an average. This takes the practice of Medicine and throws it out the door. Why take patient histories, just do a test, diagnose the disease, and use what is in column A. Why perhaps we do not need physicians, that good old obese GS 10 can handle it all on their own!

3. "***or of institutional providers of services, physicians, and other health care practitioners"*** This again focuses on the delivery, and one suspects the costs of the delivery. If we make them all size 10. I remember the tale a fellow grad student told me at MIT. He lived on a Kibbutz and he was 6" 5" and had a size 14 shoe. The Kibbutz only had size 6 thru 10 shoes. He never got shoes because he was outside the range that was acceptable in the Kibbutz. Thus he move to the States where he could get shoes. In the HR 3200 plan it assumes that the delivery will be those size 6-10 shoes and God forbid if you have a 14 foot, You die!

The Bill then continues:

‘‘***SEC. 1192. DEVELOPMENT OF NEW QUALITY MEASURES.***

(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

‘‘(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

‘‘(2) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

‘‘(3) RECOMMENDATIONS OF CONSENSUS BASED ENTITY.—In carrying out this section, the Secretary shall—

''(A) seek public input; and

''(B) take into consideration recommendations of the consensus-based entity with a contract with the Secretary under section 1890(a).

''(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.

—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

''(c) DEVELOPMENT OF QUALITY MEASURES.—

''(1) PATIENT-CENTERED AND POPULATION BASED MEASURES.—Quality measures developed under agreements under subsection (a) shall be designed—

''(A) to assess outcomes and functional status of patients;

''(B) to assess the continuity and coordination of care and care transitions for patients across providers and health care settings, including end of life care;

''(C) to assess patient experience and patient engagement;

''(D) to assess the safety, effectiveness, and timeliness of care;

''(E) to assess health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language;

''(F) to assess the efficiency and resource use in the provision of care;..."

Finally the Bill defines the Stakeholders who will assist in the definitions. It states:

"***SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES****....*

''(6) MULTI-STAKEHOLDER GROUPS.—For purposes of this subsection, the term 'multi-stakeholder groups' means, with respect to a quality measure, a voluntary collaborative of organizations representing persons interested in or affected by the use of such quality measure, such as the following:

‘‘(A) Hospitals and other institutional providers.

‘‘(B) Physicians.

‘‘(C) Health care quality alliances.

‘‘(D) Nurses and other health care practitioners.

‘‘(E) Health plans.

‘‘(F) Patient advocates and consumer groups.

‘‘(G) Employers.

‘‘(H) Public and private purchasers of health care items and services.

‘‘(I) Labor organizations.

‘‘(J) Relevant departments or agencies of the United States.

‘‘(K) Biopharmaceutical companies and manufacturers of medical devices.

‘‘(L) Licensing, credentialing, and accrediting bodies."

Does anyone notice who is missing from this list? The patient. There should be one and only one advocacy group and that should and must be the patient. The patient along with their physician should decide. Not some gang from Washington or the south side of Chicago!

Who (what) is a patient advocacy group? It is some political organization whose sole purpose is its own continuation. They, the Government, have all of these "stakeholders", entities interested in lining their own nests and pockets, but the poor patient is left out in the cold. Remember this bill looks at the average patient, not even plus or minus one standard deviation. The arrogance of assembling this group of people is an insult to the American patients who as taxpayers are paying for this collections of lobbyists. This Bill is a full employment Bill for Lobbyists!

Finally the Bill advocates the use of these measures as follows:

"***SEC. 1444. APPLICATION OF QUALITY MEASURES.***

(a) INPATIENT HOSPITAL SERVICES.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:...

‘‘(x)..

(I) Subject to subclause (II), for purposes of reporting data on quality measures for inpatient hospital services furnished during fiscal year 2012 and each subsequent fiscal year, ***the quality measures specified under clause (viii) shall be measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary*** *under section 1890(a).*

‘‘(II) In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical quality measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. The Secretary shall submit such a non-endorsed measure to the entity for consideration for endorsement. If the entity considers but does not endorse such a measure and if the Secretary does not phase-out use of such measure, the Secretary"

Finally we have the Secretary of HHS selecting the quality measures! Health care is now a fully political process! You cannot make this up. The poor patient is thrown onto the ash heap of politics and their health care is reduced to political whims!

4 COMPARATIVE CLINICAL EFFECTIVENESS

This is one of my classic concerns. It truly represents a Government takeover of the practice of medicine.

4.1 HR 3962

As we have written many times before, there is an ongoing process of CCE in the medical community. It is a day to day exercise as now means and methods are used to do studies and report on them. The journals are filled with the results and the Government for the most part funds them now. So why set up a Government controlled effort.

Let us look at HR 3962 and see what it says. First this is in the Medicare section and that seems to be the backdoor approach to establishing this center. The Bill section is:

TITLE IV—QUALITY Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.

Now the specific words are:

(2) DUTIES.—The Center shall—

(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for highly credible research;

(F) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

(**G) appoint clinical perspective advisory panels for research priorities under this section, which shall consult with patients and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.**

The three key points above are the establishment of a massive Government controlled infrastructure to control the CCE effort, then the establishment of national registries of results, and these are not delimited to Medicare, and then to send the recommendations to physicians as to how they should practice medicine. It is akin to my ongoing fear that the Government will take over the writing of Harrison's.

The it continues:

(B) DATA COLLECTION.—In order to carry out its functions, the Center shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(iii) adopt procedures allowing any interested party to submit information for the use by the Center in making reports and recommendations. In carrying out clause (ii), the Center may award grants or contracts (or provide for intergovernmental transfers, as applicable) to private entities and governmental agencies with experience in conducting comparative effectiveness research, such as the National Institutes of Health and other relevant Federal health agencies.

Thus the Government is empowered with great authority to seek out and obtain whatever it needs for whatever purposes it deems appropriate. It does all of this with a CER Commission as follows:

(b) COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

(2) DUTIES.—The Commission shall—

(A)(i) **recommend to the Center national priorities for research described in subsection (a) which shall take into account—**

(I) disease incidence, prevalence, and burden in the United States;

(II) evidence gaps in terms of clinical outcomes;

(III) variations in practice, delivery, and outcomes by geography, treatment site, provider type, disability, variation in age group (including children, adolescents,

adults, and seniors), racial and ethnic background, gender, genetic and molecular subtypes, and other appropriate populations or subpopulations; and

(IV) the potential for new evidence concerning certain categories, health care services, or treatments to improve patient health and well-being, and the quality of care; and

(ii) in making such recommendations consult with a broad array of public and private stakeholders, including patients and health care providers and payers;

(B) monitor the appropriateness of use of the CERTF described in subsection (g) with respect to the timely production of comparative effectiveness research recommended to be a national priority under subparagraph (A);

(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

(D) review the methodologies developed by the center under subsection (a)(2)(C);

(E) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance methods and standards that promote highly credible research;

(F) make recommendations to the Center for policies that would allow for public access of data produced under this section, in accordance with appropriate privacy and proprietary practices, while ensuring that the information produced through such data is timely and credible;

Thus unlike the current mode of medical research where researchers and practicing physicians are motivated by what they see in situ as the major issue to be studied, this approach is a centralized Government selection process whereby the Commission will decide in a fully centralized manner what needs to be studied. It thus can select what it sees as important. In many ways it is reminiscent of the old Soviet system of research where such things as genetics were not studied because it was viewed as anti Marxian.

It continues:

(I) make recommendations to the Center for the broad dissemination, consistent with subsection (e), of the findings of research con- ducted and supported under this section that enables clinicians, patients, consumers, and payers to make more informed health care decisions that improve quality and value; and

This is the critical element because it them gets to not only choose the research issues but also it gets to tell the physicians what the results are and then tie the results to how they are to practice medicine.

The Commission is composed as follows:

(A) IN GENERAL.—The members of the Commission shall consist of—

(i) the Director of the Agency for Healthcare Research and Quality or their designee;

(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services or their designee;

(iii) the Director of the National Institutes of Health or their designee; and

(iv) 16 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, and consumers of Federal and State beneficiary programs. Of such members, at least 10 shall be practicing physicians, health care practitioners, consumers, or patients.

The Commission is specifically to be composed of:

(I) Epidemiology.

(II) Health services research.

(III) Bioethics.

(IV) Decision sciences.

(V) Health disparities.

(VI) Health economics.

and

(I) Patients.

(II) Health care consumers.

(III) Practicing Physicians, including surgeons.

(IV) Other health care practitioners engaged in clinical care.

(V) Organizations with proven expertise in racial and ethnic minority health research.

(VI) Employers.

(VII) Public payers.

(VIII) Insurance plans.

(IX) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

This should be a real get together. One need not imagine too far as to how the agenda will be agreed to. It will be a tower of Babel with this collection of interests all chosen is a highly political manner. Politicians will pack this with friends and useful associates.

This is not the way that medical research or any research for that matter is conducted. At best if it even holds together a few Nobel Peace Prizes should be awarded.

The fear is that the structure of this entity may take good research funds away from where they are being productively used today and place them in politically correct areas where they will be wasted. The true fear is that the results obtained therefrom will be used to mandate medical practice methods which will create harm on the people.

4.2 HR 3200

In evaluating parts of HR 3200 as we did yesterday we have now begun to delve into the more arcane parts. Let us address the parts of the bill that refer to CCE. There appear to be two. and they are:

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

SEC. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

(1) IN GENERAL.—The Secretary shall establish within the ***Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research*** *(in this section referred to as the "Center") to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.*

Thus the Secretary of HHS shall establish another Government Agency to do this CCE effort. Amongst its duties will be:

"(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;"

Yet it does not end here for it further states:

"*(1) IN GENERAL.—The Secretary shall establish an independent* ***Comparative Effectiveness Research Commission*** *(in this section referred to as the "Commission") to oversee and evaluate the activities carried out by the Center under subsection (a), subject to the authority of the Secretary, to ensure such activities result in highly credible research and information resulting from such research...*"

Thus we have a new Government body plus an oversight group. Its purpose is:

"*(A)* ***determine national priorities for research*** *described in subsection (a) and in making such determinations consult with a broad array of public and private stakeholders, including patients and health care providers and payers*;"

Thus this group will decide what the research priorities should be. This is a bit backwards to say the least. There is a well established infrastructure in the US and elsewhere where such research is being done in a peer review manner on a daily basis. Why do we need a Government entity and oversight. As far as one can see this is acting as the guiding light. Research is NOT done that way, it is highly distributed and combative. Ideas and data are thrown into the arena and allowed to be digested and the truth, whatever it may be, is supposed to emerge. I continue to come back to the

prostate studies and the rebuttals. This can be done and is done daily in NEJM and the other professional journals. Why have the Government do what is already being done, and done well.

Then the Bill continues as follows:

"*DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT*

TITLE IV—QUALITY AND SURVEILLANCE

Subtitle D—Adapting Workforce to Evolving Health System Needs

SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE.

''PART D—IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE

''SEC. 931. CENTER FOR QUALITY IMPROVEMENT."

It is to create:

"(*a) IN GENERAL.—There is established the* ***Center for Quality Improvement*** *(referred to in this part as the 'Center'), to be headed by the Director*."

Its function is to:

''*(1) identify existing best practices under sub section (e);*

''(2) develop new best practices under sub section (f);

''(3) evaluate best practices under subsection (g);

''(4) ***implement best practices*** *under subsection (h);*

''(5) ***ensure that best practices are identified, developed, evaluated, and implemented under this section consistent with standards adopted by the Secretary***..."

Now in reading the above one sees that implementing under subsection (h) is most critical. This states:

"*(h) IMPLEMENTATION OF BEST PRACTICES.—*

*‘‘(1) IN GENERAL.—The Director shall enter into **voluntary arrangements** with health care providers (including hospitals and other health facilities and health practitioners) in a State or region to implement best practices identified or developed under this section. Such implementation—*

‘‘(A) may include forming collaborative multi-institutional teams; and

‘‘(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.

‘‘(2) PREFERENCES.—In carrying out this sub section, the Director shall give priority to health care providers implementing best practices that—

‘‘(A) have the greatest impact on patient outcomes and satisfaction;

‘‘(B) are the most easily adapted for use by health care providers across a variety of health care settings;

‘‘(C) promote coordination....""

Thus as best we can see, there are now two new CCE institutions and several committees but the implementation is **voluntary**.

This question is why is this necessary since it is being done and done well already, and why does the Government believe that it can not only do this but do it better! This is centralizing medical research and the results when the process is naturally a distributed process. No one study is ever definitive, no two patients are the same, and no Government plan ever works as anticipated.

5 THE IRS

The most interesting issue has been the use of the IRS as the enforcer. Here we compare the two Bills.

5.1 HR 3962

As I read through HR 3962 it is clear that Congress, the Democrats, have made this ever so more severe. In this not we provide the IRS as collector Section, Namely Title V of Division A which applies to non Medicare and VA taxpayers.

The following is the Bill and its related IRS clauses. This may require some heavy slogging but it may be worth it in the end.

TITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART 1—SHARED RESPONSIBILITY

Subpart A—Individual Responsibility

SEC. 501. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

PART VIII—HEALTH CARE RELATED TAXES

SUBPART A. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

Subpart A—Tax on Individuals Without Acceptable Health Care Coverage

Sec. 59B. Tax on individuals without acceptable health care coverage.

SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) TAX IMPOSED.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, ***there is hereby imposed a tax equal to 2.5 percent of the excess of—***

(1) the taxpayer's modified adjusted gross income for the taxable year, over

(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

This is the tax for not having signed up. I suspect that fraud and other criminal issue still apply and that if one makes a deliberate and material false statement then one could be in significant difficulty.

One of my questions is how much work will the IRS have to do to enforce this. It requires more people, major computer changes, increased observation. And where are the costs associated with this? There are many issues which these folks may have just neglected to see.

(b) LIMITATIONS.—

(1) TAX LIMITED TO AVERAGE PREMIUM.—

(A) IN GENERAL.—The tax imposed under subsection (a) with respect to any tax payer for any taxable year shall not exceed the applicable national average premium for such taxable year.

(B) APPLICABLE NATIONAL AVERAGE PREMIUM.—

(i) IN GENERAL.—For purposes of subparagraph (A), the 'applicable national average premium' means, with respect to any taxable year, the average premium (as determined by the Secretary, in coordination with the Health Choices Commissioner) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

(ii) FAILURE TO PROVIDE COVERAGE FOR MORE THAN ONE INDIVIDUAL.—In the case of any taxpayer who fails to meet the requirements of subsection (d) with respect to more than one individual during the tax able year, clause (i) shall be applied by substituting 'family coverage' for 'self-only coverage'.

(2) PRORATION FOR PART YEAR FAILURES.— The tax imposed under subsection (a) with respect to any taxpayer for any taxable year shall not exceed the amount which bears the same ratio to the amount of tax so imposed (determined without regard to this paragraph and after application of para graph (1)) as—

(A) the aggregate periods during such taxable year for which such individual failed to meet the requirements of subsection (d), bears to

(B) the entire taxable year.

(c) EXCEPTIONS.—

(1) DEPENDENTS.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to

another taxpayer for any tax able year beginning in the same calendar year as such taxable year.

(2) NONRESIDENT ALIENS.—Subsection (a) shall not apply to any individual who is a non resident alien.

(3) INDIVIDUALS RESIDING OUTSIDE UNITED STATES.—Any qualified individual (as defined in section 911(d)) (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1), whichever is applicable.

(4) INDIVIDUALS RESIDING IN POSSESSIONS OF THE UNITED STATES.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

(5) RELIGIOUS CONSCIENCE EXEMPTION.—

(A) IN GENERAL.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sector division as described in such section.

(B) EXEMPTION.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such form and manner as the Secretary may prescribe. The Secretary may treat an application for exemption under section 1402(g)(1) as an application for exemption under this section, or may otherwise coordinate applications under such sections, as the Secretary determines appropriate. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

There are some exemptions. For example if your spouse has custody of your child, up to 27, well I guess we are dealing with the current generation, they get to pay. The religious exemption is stricter than it looks, and I suspect it covers Christian Scientists who pay for their own care already.

(d) ACCEPTABLE COVERAGE REQUIREMENT.—

(1) IN GENERAL.—The requirements of this subsection are met with respect to any individual for any period if such individual (and each qualifying child of such individual) is covered by acceptable coverage at all times during such period.

(2) ACCEPTABLE COVERAGE.—For purposes of this section, the term 'acceptable coverage' means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the).

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER GRAND FATHERED EMPLOYMENT-BASED HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202 of the) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage under the veteran's health care program under chapter 17 of title 38, United States Code.

(G) MEMBERS OF INDIAN TRIBES.— Health care services made available through the Indian Health Service, a tribal organization (as defined in section 4 of the Indian Health Care Improvement Act), or an urban Indian organization (as defined in such section) to members of an Indian tribe (as defined in such section).

(H) OTHER COVERAGE.—Such other health benefits coverage as the Secretary, in co ordination with the Health Choices Commissioner, recognizes for purposes of this sub section.

(e) OTHER DEFINITIONS AND SPECIAL RULES.—

(1) QUALIFYING CHILD.—For purposes of this section, the term 'qualifying child' has the meaning given such term by section 152(c). With respect to any period during which

health coverage for a child must be provided by an individual pursuant to a child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

We will get back to the child issue but I believe that that will be a matter of concern. What if your child leaves home at 18?

(2) BASIC PLAN.—For purposes of this section, the term 'basic plan' has the meaning given such term under section 100(c) of the .

(3) HEALTH INSURANCE EXCHANGE.—For purposes of this section, the term 'Health Insurance Exchange' has the meaning given such term under section 100(c) of the , including any State-based health insurance exchange approved for operation under section 308 of such Act.

(4) FAMILY COVERAGE.—For purposes of this section, the term 'family coverage' means any coverage other than self-only coverage.

(5) MODIFIED ADJUSTED GROSS INCOME.— For purposes of this section, the term 'modified adjusted gross income' means adjusted gross income increased by—

(A) any amount excluded from gross income under section 911, and

(B) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(6) NOT TREATED AS TAX IMPOSED BY THIS CHAPTER FOR CERTAIN PURPOSES.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 55.

(f) REGULATIONS.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes of this section, including regulations or other guidance (developed in co ordination with the Health Choices Commissioner) which provide—

(1) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

(2) a waiver of the application of subsection (a) in cases of hardship, including a process for applying for such a waiver.

. (b) INFORMATION REPORTING.— (1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after section 6050W the following new section:

S**EC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.**

(a) REQUIREMENT OF REPORTING.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

(1) is in such form as the Secretary may pre scribe, and

(2) contains—

(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

(C) such other information as the Secretary may require.

(c) **STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—**

(**1) the name and address of the person required to make such return and the phone number of the information contact for such person, and**

(2) the information required to be shown on the return with respect to such individual. The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

This means that the return opens and links your tax and health information. They claim HIPPA compliance but that is a major risk issue.

(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any govern mental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

(2) PENALTY FOR FAILURE TO FILE.—

(A) RETURN.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking or at the end of clause (xxii), by striking and at the end of clause (xxiii) and inserting or, and by adding at the end the following new clause: (xxiv) section 6050X (relating to re turns relating to health insurance coverage), and

(B) STATEMENT.—Paragraph (2) of section 6724(d) of such Code is amended by striking or at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting , or, and by inserting after subparagraph (FF) the following new sub paragraph: (GG) section 6050X (relating to returns relating to health insurance coverage).

(c) RETURN REQUIREMENT.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.

(d) CLERICAL AMENDMENTS.— (1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

PART VIII. HEALTH CARE RELATED TAXES.

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item: Sec. 6050X. Returns relating to health insurance coverage.

(e) SECTION 15 NOT TO APPLY.—The amendment made by subsection (a) shall not be treated as a change in a rate of tax for purposes of section 15 of the Internal Revenue Code of 1986. (f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

(**2) RETURNS.—The amendments made by sub section (b) shall apply to calendar years beginning after December 31, 2012.**

This all begins in three years. This is a major change in Tax Law. It will make tax filing ever so more complex. Imagine having to prove to the State that you have auto insurance on your State Tax filing!

5.2 HR 3200

I have often admired the intelligence and persistence of Talmudic Scholars, those wise men who dedicate their lives to understanding the law, Hebrew Law, the law of God. The writings are presented and then discussed, debated, and interpreted. Then the opinions are recorded. In HR 3200 we need the wisdom of a fine group of such men. This is not a statement meant for humor of any type, it is a statement of sincere respect and of desperate need.

There are many blogs out there which a flailing about making statements that have at best questionable merit. I have been spending time reading this bill, slowly and not as well as any scholar, but having been through this process many times before helps but still leaves much in question.

In today's discussion we talk about the IRS becoming the police force for the Health Care Bill, HR 3200, a fact which seems to have been missed. People speak of getting health care from the motor vehicle bureau, but imaging having the IRS oversee your compliance. One agency more feared than the Taliban is the IRS. Never, never, I repeat, never, get the IRS upset. Overpay taxes, avoid deductions, and do whatever to stay away from their tentacles. But alas this Bill places them in the middle as the enforcer. Let me quote from the Bill.

"*TITLE III—SHARED RESPONSIBILITY*

Subtitle A—Individual Responsibility

SEC. 301. INDIVIDUAL RESPONSIBILITY.

For an individual's responsibility to obtain acceptable coverage, see section 59B of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

SEC. 322. SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) FAILURE TO ELECT, OR SUBSTANTIALLY COMPLY WITH, HEALTH COVERAGE PARTICIPATION REQUIREMENTS.—For employment tax on employers who fail to elect, or substantially comply with, the health coverage participation requirements described in part 1, see section 3111(c) of the Internal Revenue Code of 1986 (as added by section 412 of this Act).

(b) OTHER FAILURES.—For excise tax on other failures of electing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 411 of this Act).

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

SEC. 401. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part: ''Subpart A—Tax on Individuals Without Acceptable Health Care Coverage ''Sec. 59B. Tax on individuals without acceptable health care coverage. ''SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH CARE COVERAGE.

''(a) TAX IMPOSED.—In the case of any individual who does not meet the requirements of subsection (d) at any time during the taxable year, there is hereby imposed a tax equal to 2.5 percent of the excess of—

''(1) the taxpayer's modified adjusted gross income for the taxable year, over

''(2) the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

''(a) REQUIREMENT OF REPORTING.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

''(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

''(C) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual. The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made."

Well, what does this say. I think it simply states that the IRS will become the policeman for compliance. You must report your coverage to the IRS, if you do not have any you them must pay a fine, and if you falsely make statements then you are guilty of tax fraud. Remember that the IRS already has rules and regulations to take your property if you defraud them and in addition you have now added to your tax burden. Our

Secretary of the Treasury has just gathered more power, and one who himself had problems with the taxes.

One must also remember that the Bill from Congress when signed by the President becomes an authorizing legislation. It authorizes HHS and Treasury Secretaries to them create the Administrative law to enforce this. Administrative law is the billions of lines of law which implement the legislation passed. It is controlled by administrative law judges, not judges and juries, who make non-recourse decisions. There are more administrative law judges than civil and criminal judges combined.

This is a shadow judicial system which in many ways flies in the face of the Constitution. The create Star Chambers, a practice which the Constitution eschewed, but via these types of legislation have returned.

It is a shame that we have many bloggers making statements without basis. There are true concerns in this Bill, concerns which need study. Where are the Talmudic Scholars in this realm? It may not be our souls at risk but it is our bodies!

For anyone who has ever been audited, remember, the IRS code is the only US code which assumes you are guilty until you prove you are innocent!

6 MEDICARE

This is a brief summary of the massive changes made to Medicare. We just list them.

6.1 HR 3962

As I continue to slog through HR 3962 I thought it would be educational just to present the Table of Contents of the Medicare section. Remember what our current President said, if you like your current health care you can keep your current health care. Not if you are on Medicare! And those fellows at the AARP, shame of you!

The following is a massive change in Medicare and the seniors just do not know what is happening to them. This Bill goes well beyond HR 3200 in making Medicare a straight jacket for physicians and is a clear example of what will happen to a public plan.

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 1001. TABLE OF CONTENTS OF DIVISION.

The table of contents of this division is as follows:

Sec. 1123. Payments for efficient areas.

Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).

Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES

Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 3—OTHER PROVISIONS

Sec. 1141. Rental and purchase of power-driven wheelchairs.

Sec. 1141A. Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends.

Sec. 1142. Extension of payment rule for brachytherapy.

Sec. 1143. Home infusion therapy report to Congress.

Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data.

Sec. 1145. Treatment of certain cancer hospitals.

Sec. 1146. Payment for imaging services.

Sec. 1147. Durable medical equipment program improvements.

Sec. 1148. MedPAC study and report on bone mass measurement.

Sec. 1149. Timely access to post-mastectomy items.

Sec. 1149A. Payment for biosimilar biological products.

Sec. 1149B. Study and report on DME competitive bidding process.

Subtitle C—Provisions Related to Medicare Parts A and B

Sec. 1151. Reducing potentially preventable hospital readmissions.

Sec. 1152. Post acute care services payment reform plan and bundling pilot program.

Sec. 1153. Home health payment update for 2010.

Sec. 1154. Payment adjustments for home health care.

Sec. 1155. Incorporating productivity improvements into market basket update for home health services.

Sec. 1155A. MedPAC study on variation in home health margins.

Sec. 1155B. Permitting home health agencies to assign the most appropriate skilled service to make the initial assessment visit under a Medicare home health plan of care for rehabilitation cases.

Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.

Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.

Sec. 1158. Revision of medicare payment systems to address geographic inequities.

Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care.

Sec. 1160. Implementation, and Congressional review, of proposal to revise

Sec. 1189. State certification prior to waiver of licensure requirements under Medicare prescription drug program.

Subtitle F—Medicare Rural Access Protections

Sec. 1191. Telehealth expansion and enhancements.

Sec. 1192. Extension of outpatient hold harmless provision.

Sec. 1193. Extension of section 508 hospital reclassifications.

Sec. 1194. Extension of geographic floor for work.

Sec. 1195. Extension of payment for technical component of certain physician

pathology services.

Sec. 1196. Extension of ambulance add-ons.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

Sec. 1201. Improving assets tests for Medicare Savings Program and low-income

subsidy program.

Sec. 1202. Elimination of part D cost-sharing for certain non-institutionalized

full-benefit dual eligible individuals.

Sec. 1203. Eliminating barriers to enrollment.

Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low

income subsidy enrollment.

Sec. 1205. Intelligent assignment in enrollment.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

Sec. 1301. Accountable Care Organization pilot program.

Sec. 1302. Medical home pilot program.

Sec. 1303. Payment incentive for selected primary care services.

Sec. 1304. Increased reimbursement rate for certified nurse-midwives.

Sec. 1305. Coverage and waiver of cost-sharing for preventive services.

Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless

of coding, subsequent diagnosis, or ancillary tissue removal.

Sec. 1307. Excluding clinical social worker services from coverage under the

medicare skilled nursing facility prospective payment system

and consolidated payment.

Sec. 1308. Coverage of marriage and family therapist services and mental

health counselor services.

Sec. 1309. Extension of physician fee schedule mental health add-on.

Sec. 1310. Expanding access to vaccines.

Sec. 1311. Expansion of Medicare-Covered Preventive Services at Federally

Qualified Health Centers.

Sec. 1312. Independence at home demonstration program.

Sec. 1313. Recognition of certified diabetes educators as certified providers for purposes of Medicare diabetes outpatient self-management training services.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Sec. 1401. Comparative effectiveness research.

Subtitle B—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES, NURSING FACILITIES, AND OTHER LONG-TERM CARE FACILITIES

Sec. 1411. Required disclosure of ownership and additional disclosable parties information.

Sec. 1412. Accountability requirements.

Sec. 1413. Nursing home compare Medicare website.

Sec. 1414. Reporting of expenditures.

Sec. 1415. Standardized complaint form.

Sec. 1416. Ensuring staffing accountability.

Sec. 1417. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers.

PART 2—TARGETING ENFORCEMENT

Sec. 1421. Civil money penalties.

Sec. 1422. National independent monitor pilot program.

Sec. 1423. Notification of facility closure.

PART 3—IMPROVING STAFF TRAINING

Sec. 1431. Dementia and abuse prevention training.

Medicare and State health care programs.

Sec. 1620. OIG authority to exclude from Federal health care programs officers and owners of entities convicted of fraud.

Sec. 1621. Self-referral disclosure protocol.

Subtitle C—Enhanced Program and Provider Protections

Sec. 1631. Enhanced CMS program protection authority.

Sec. 1632. Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations.

Sec. 1633. Required inclusion of payment modifier for certain evaluation and management services.

Sec. 1634. Evaluations and reports required under Medicare Integrity Program.

Sec. 1635. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.

Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months.

Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare enrolled physicians or eligible professionals.

Sec. 1638. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.

Sec. 1639. Face-to-face encounter with patient required before eligibility certifications

Bank.

Sec. 1653. Compliance with HIPAA privacy and security standards.

6.2 HR 3200

7 END OF LIFE

This was the Palin "death panel" issue.

7.1 HR 3962

Removed from Bill

7.2 HR 3200

Physicians often have quite difficult tasks to perform as regards to their patients. Some of the most difficult are those of informing parents of the impending death of a child and the dealing with families of older individuals who have failed to leave behind their wishes regarding health care. The latter task often results in the physician taking extreme measures in order to avoid potential litigation from children or other survivors resulting from may be perceived as failing to "take all measures" to save their loved one. Also concomitant with this side of the problem is the side as relates to the patient who is put through many, and often painful, procedures which add significantly to health care costs.

Many people, but not close to a majority, have living wills, powers of attorney, medical directives, and the like which dictate how far medical professional should go and when to just let the patient go in a natural manner, and perhaps with as much dignity as possible. The problem with these directives, also called advance directives, is that they are legal and not medical documents, and they often require a discussion amongst the parties in a calm and rational manner. This is often not what occurs. There are many stories relating to "pulling the plug" and the litigation related thereto.

In an attempt to move the ball forward on this issue the medical bill HR 3200 has included a section on Advance Directives. We discuss this here. At its core it is an essential step forward. Yet it places the issue in the hands of the physician who may not be the best person to address the issues with the patient if they are doing so after

having advised the patient of their condition.

The section in HR 3200 amends the section of the Social Security Act, specifically Sec. 1861. [42 U.S.C. 1395x] which is a set of definitions relating to what services a physician may perform and how they may be compensated.

Now HR 3200 states:

"**DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS**

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle C—Miscellaneous Improvements

SEC. 1233. ADVANCE CARE PLANNING CONSULTATION.

(a) MEDICARE.—(1) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)—(i) by striking ''and'' at the end of subparagraph (DD);
(ii) by adding ''and'' at the end of subparagraph (EE); and (iii) by adding at the end the following new subparagraph: ''(FF) advance care planning consultation (as defined in subsection (hhh)(1));''; and

(B) by adding at the end the following new subsection: ''Advance Care Planning Consultation"

(hhh)(1) Subject to paragraphs (3) and (4), the term 'advance care planning consultation' means a consultation between the individual and a practitioner described in paragraph (2) regarding advance care planning, if, subject to paragraph (3), the individual involved has not had such a consultation within the last 5 years. Such consultation shall include the following:

''(A) **An explanation by the practitioner of advance care planning, including key questions and considerations, important steps, and suggested people to talk to**.

''(B) **An explanation by the practitioner of advance directives, including living wills and durable powers of attorney, and their uses**.

''(C) **An explanation by the practitioner of the role and responsibilities of a health care proxy**.

‘‘(D) **The provision by the practitioner of a list of national and State-specific resources to assist consumers and their families with advance care planning**, including the national toll-free hotline, the advance care planning clearinghouses, and State legal service organizations (including those funded through the Older Americans Act of 1965).

‘‘(E) An explanation by the practitioner of the continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports that are available under this title.

This is a difficult task for the physician since in many ways the physician must diagnose, inform the patient, and then proceed to tell the patient about the details of an advance directive. If however this is accomplished under non life threatening situations perhaps the physician can have such a conversation. However the conversation should involve family members, and often that is where the rub occurs. The Bill does not recognize this problem, nor necessarily should it, but this is often the main concern. The Medicare patient is NOT being asked to execute a DNR, the patient is being informed and hopefully executes a document which expresses the patient's interests which the patient shares with the physician and their family. The problem is many people will just delay this process, as many people die without wills. The Bill continues:

‘‘(F)(i) Subject to clause (ii), an explanation of orders regarding life sustaining treatment or similar orders, which shall include—

‘‘(I) the reasons why the development of such an order is beneficial to the individual and the individual’s family and the reasons why such an order should be updated periodically as the health of the individual changes;

‘‘(II) the information needed for an individual or legal surrogate to make informed decisions regarding the completion of such an order; and

‘‘(III) the identification of resources that an individual may use to determine the requirements of the State in which such individual re sides so that the treatment wishes of that individual will be carried out if the individual is unable to communicate those wishes, including requirements regarding the designation of a surrogate decision maker (also known as a health care proxy).

The Bill continues in a quite rational manner and expresses the intent to have the patient express their wishes. Hopefully if this is done then the issue of excess treatment and excess costs may be mitigated for fear of not adhering to the patient's unspoken wish. The problem here is that the issue related to subsequent malpractice litigation is

still open. Even with a proxy, and an advance, there may be family problems and litigation which the physician may fear. The Bill had the opportunity to clearly address this but it failed. I believe that this would have made a significant improvement. Namely giving the physician a "safe harbor" from litigation by following and advance directive.

The Bill continues:

‘‘(ii) The Secretary shall limit the requirement for explanations under clause (i) to consultations furnished in a State—

‘‘(I) in which all legal barriers have been addressed for enabling orders for life sustaining treatment to constitute a set of medical orders respected across all care settings; and

‘‘(II) that has in effect a program for orders for life sustaining treatment described in clause (iii).

‘‘(iii) A program for orders for life sustaining treatment for a States described in this clause is a program that—

‘‘(I) ensures such orders are standardized and uniquely identifiable throughout the State;

‘‘(II) distributes or makes accessible such orders to physicians and other health professionals that (acting within the scope of the professional’s authority under State law) may sign orders for life sustaining treatment;

‘‘(III) provides training for health care professionals across the continuum of care about the goals and use of orders for life sustaining treatment; and

‘‘(IV) is guided by a coalition of stake holders includes representatives from emergency medical services, emergency department physicians or nurses, state long-term care association, state medical association, state surveyors, agency responsible for senior services, state department of health, state hospital association, home health association, state bar association, and state hospice association.

There is the issue of a patient having an advance directive in one state and being treated in another and there being a conflict of laws. This has always been a problem in law and there is an immense body of law on conflict of laws. Yet since time is of the essence here was another opportunity for Congress to thread the needle but they passed. Perhaps it is just too steep a hill to climb?

The Bill continues:

‘‘(2) A practitioner described in this paragraph is— ‘‘(A) a physician (as defined in subsection (r)(1)); and ‘‘(B) a nurse practitioner or physician’s assist ant who has the authority under State law to sign orders for life sustaining treatments.

‘‘(3)(A) An initial preventive physical examination under subsection (WW), including any related discussion during such examination, shall not be considered an advance care planning consultation for purposes of applying the 5-year limitation under paragraph (1).

‘‘(B) An advance care planning consultation with respect to an individual may be conducted more frequently than provided under paragraph (1) if there is a significant change in the health condition of the individual, including diagnosis of a chronic, progressive, life-limiting disease, a life-threatening or terminal diagnosis or life-threatening injury, or upon admission to a skilled nursing facility, a long-term care facility (as defined by the Secretary), or a hospice program.

‘‘(4) A consultation under this subsection may include the formulation of an order regarding life sustaining treatment or a similar order.

The above just covers procedural issues. It continues:

‘‘(5)(A) For purposes of this section, the term ‘order regarding life sustaining treatment’ means, with respect to an individual, an actionable medical order relating to the treatment of that individual that—

‘‘(i) is signed and dated by a physician (as defined in subsection (r)(1)) or another health care professional (as specified by the Secretary and who is acting within the scope of the professional’s authority under State law in signing such an order, including a nurse practitioner or physician assistant) and is in a form that permits it to stay with the individual and be followed by health care professionals and providers across the continuum of care;

‘‘(ii) effectively communicates the individual’s preferences regarding life sustaining treatment, including an indication of the treatment and care desired by the individual;

‘‘(iii) is uniquely identifiable and standardized within a given locality, region, or State (as identified by the Secretary); and

‘‘(iv) may incorporate any advance directive (as defined in section 1866(f)(3)) if executed

by the individual.

‘‘(B) **The level of treatment indicated under subparagraph (A)(ii) may range from an indication for full treatment to an indication to limit some or all or specified interventions. Such indicated levels of treatment may include indications respecting, among other items—**

‘‘(i) the intensity of medical intervention if the patient is pulse less, apneic, or has serious cardiac or pulmonary problems;

‘‘(ii) the individual’s desire regarding transfer to a hospital or remaining at the current care set ting;

‘‘(iii) the use of antibiotics; and

‘‘**(iv) the use of artificially administered nutrition and hydration.’’.**

The above details the advance notice and it follows generally accepted and used standards. Finally there are details on payments and the like.

(2) PAYMENT.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ‘‘(2)(FF),’’ after ‘‘(2)(EE),’’.

(3) FREQUENCY LIMITATION.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)— (i) in subparagraph (N), by striking ‘‘and’’ at the end; (ii) in subparagraph (O) by striking the semicolon at the end and inserting ‘‘, and’’; and (iii) by adding at the end the following new subparagraph: ‘‘(P) in the case of advance care planning consultations (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;’’; and

(B) in paragraph (7), by striking ‘‘or (K)’’ and inserting ‘‘(K), or (P)’’.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to consultations furnished on or after January 1, 2011.

(b) EXPANSION OF PHYSICIAN QUALITY REPORTING INITIATIVE FOR END OF LIFE CARE.—

(1) PHYSICIAN’S QUALITY REPORTING INITIATIVE.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)) is amended by adding at the end the following

new paragraphs: ‘‘(3) PHYSICIAN’S QUALITY REPORTING INITIATIVE.—

‘‘(A) IN GENERAL.—For purposes of re porting data on quality measures for covered professional services furnished during 2011 and any subsequent year, to the extent that measures are available, the Secretary shall include quality measures on end of life care and advanced care planning that have been adopted or endorsed by a consensus-based organization, if appropriate. Such measures shall measure both the creation of and adherence to orders for life sustaining treatment.

‘‘(B) PROPOSED SET OF MEASURES.—The Secretary shall publish in the Federal Register proposed quality measures on end of life care and advanced care planning that the Secretary determines are described in subparagraph (A) and would be appropriate for eligible professionals to use to submit data to the Secretary. The Secretary shall provide for a period of public comment on such set of measures before finalizing such proposed measures.’’.

(c) INCLUSION OF INFORMATION IN MEDICARE & YOU HANDBOOK.— (1) MEDICARE & YOU HANDBOOK.—

(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall update the online version of the Medicare & You Handbook to include the following:

(i) An explanation of advance care planning and advance directives, including— (I) living wills; (II) durable power of attorney; (III) orders of life-sustaining treatment; and (IV) health care proxies.

(ii) A description of Federal and State resources available to assist individuals and their families with advance care planning and advance directives, including— (I) available State legal service organizations to assist individuals with advance care planning, including those organizations that receive funding pursuant to the Older Americans Act of 1965 (42 U.S.C. 93001 et seq.); (II) website links or addresses for State-specific advance directive forms; and (III) any additional information, as determined by the Secretary.

(B) UPDATE OF PAPER AND SUBSEQUENT VERSIONS.—The Secretary shall include the information described in subparagraph (A) in all paper and electronic versions of the Medicare & You Handbook that are published on or after the date that is 1 year after the date of the enactment of this Act.

The strange issue here is the quality issue. We have written on that extensively and

although it related obliquely to real patient care here it is just a hanging reminder that to the author's of HR 3200 the term quality seems to be purely quantitative measure and reports.

In an NEJM paper by Bloche in 2005 after the Schiavo case he states:

"*Anger, denial, and other nonrational influences can lock family members into warring stances over whether to treat a devastating illness aggressively or discontinue life-sustaining measures. What is remarkable, given the intensity of the feelings at stake, is how rarely such conflicts make their way to court. It is a measure of how discreetly such squabbles are handled that we know little about how often they arise. And it is a measure of people's character under this pressure that families usually come together to make these judgments or to honor the preferences their loved ones have expressed*."

It is for this reason that one can say "Prior planning prevents poor performance"

This portion of the bill, HR 3200, is in my opinion a well written, well directed, and needed step. It will be a difficult step to take for the physicians and even more difficult for compliance. There does not appear to ban anything new or striking in this section. It contains what physicians have been seeking for many years now, yet the human factor on the patient side will be a barrier. It will have a strong cultural and psychological element. It most likely will not be achieved as quickly as one would like. It also benefits the patient, it is not a threat to any patient, it allows them to maintain control over their lives and to do so with dignity and respect.

8 THE EXCHANGE

This details the structure of the Exchange.

8.1 HR 3962

Not reviewed again.

8.2 HR 3200

The Health Insurance Exchange is a major part of the HR 3200 Bill. Simply stated, the Exchange is a co-op wherein a group is established and then negotiates some "good" deals for its members. The AMA and many other professional groups have exchange type functions and they work reasonably well.

The problem with health care today is the residual of company provided plans and many being gold plated and not taxed. This is particularly true of Union members and Government employees whose benefits have exploded over the years and the benefits are compounded by the lack of taxation. The benefits then extend to their early retirement resulting is ever so much more explosive costs. Just look at GM and the State of California!

Along comes HR 3200 and it says that the Government and ONLY the Government can do exchanges. It takes it one step further and creates a public plan that will drive out all other players, level playing field notwithstanding. We will examine this in detail.

Just to put our opinions on the table. We believe in the following:

1. Universal coverage, no leakage, no scamming the system

2. Individual and not corporate or employer coverage

3. Taxation of coverage on an before-tax basis

4. Catastrophic coverage mandate for all

5. Out of pocket expenses expected unless you want to pay for the added benefit, and

6. Exchanges are an ideal platform to accomplish this. By exchanges we mean private and group based exchanges, and not a public Federal Government managed exchange.

We detailed this in our most recent book on Health Care Policy.

Now Exchanges for the purpose of purchasing health insurance may be a structure whose time is coming. In the recent NEJM article by Frank and Zeckhauser they state:

"*Exchanges focus on the purchase of insurance for individuals, households, and groups of small employers — all of which will be more likely to obtain coverage if it is made more affordable or more available, and certainly if it is made mandatory. Exchanges mimic some functions that are performed by large employers as purchasers, including assembling, organizing, and disseminating information about competing health plans; enacting policies that promote risk pooling; specifying benefit packages; negotiating premiums; limiting the number and types of plans that may be marketed; and structuring the enrollment and plan selection process. They thus seek to extend to all consumers the benefits of having a large employer purchase one's insurance.*"

They continue as follows:

"*Should exchanges play a similarly active role in structuring and managing the health insurance market, so as to guide people to appropriate plans, enhance competition, and thereby improve quality and reduce price? A few decades ago, the conventional wisdom in economics was that individuals could make effective choices in markets, even when the options were numerous and complex. Extensive research in behavioral economics calls this belief into question. In many circumstances, particularly when uncertainties and high stakes are involved, consumers have trouble making good decisions. The purchase of health insurance presents just such challenges. Hence the potential benefits of exchanges.*

"Consumers facing complex, uncertain, and consequential choices may also rely on simple rules of thumb. An analysis of Medicare recipients choosing among PDPs suggests that they used such rules to their detriment5 — for example, by overweighting premium outlays and slighting the total expected out-of-pocket costs. As a result, many chose a plan that was expected to be more costly and offered no advantages in terms of features or quality. "

These experiences suggest that exchanges should be structured to foster effective consumer choices, and thereby efficient outcomes, by providing consumer-friendly information about the coverage, cost, and quality of different plans. Ironically, one way to enhance the prospect of informed choices is to limit the number of options. Plans then compete on price, quality, or both in order to be included. Requiring plans to offer identical features would promote competition and facilitate decisions but limit choice. The trade-off between these objectives should be carefully weighed by officials legislating, designing, and operating exchanges."

HR 3200 is filled with elements of creating exchanges. Unlike many of the other exchange ideas floating about the HR 3200 is a Government controlled Exchange including a public plan. We feel that it is worth the while to look at this legislation is some detail. By deconstructing the law as written one gets to see what is in the mind of those who wrote it. They clearly despise private enterprise and demand ultimate Government control. We will see this play out as we go through the key sections on the Exchange. Let us start the process.

In HR 3200 the details about an exchange are in Title II and the three following subtitles. These are shown below.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

Subtitle B—Public Health Insurance Option

Subtitle C—Individual Affordability Credits

In subtitle A we have the details of the exchange. The full set of elements are shown below.

Subtitle A—Health Insurance Exchange

Sec. 201. Establishment of Health Insurance Exchange; outline of duties; definitions.

Sec. 202. Exchange-eligible individuals and employers.

Sec. 203. Benefits package levels.

Sec. 204. Contracts for the offering of Exchange-participating health benefits plans.

Sec. 205. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.

Sec. 206. Other functions.

Sec. 207. Health Insurance Exchange Trust Fund.

Sec. 208. Optional operation of State-based health insurance exchanges.

Subtitle B—Public Health Insurance Option

Sec. 221. Establishment and administration of a public health insurance option

as an Exchange-qualified health benefits plan.

Sec. 222. Premiums and financing.

Sec. 223. Payment rates for items and services.

Sec. 224. Modernized payment initiatives and delivery system reform.

Sec. 225. Provider participation.

Sec. 226. Application of fraud and abuse provisions.

Subtitle C—Individual Affordability Credits

Sec. 241. Availability through Health Insurance Exchange.

Sec. 242. Affordable credit eligible individual.

Sec. 243. Affordable premium credit.

Sec. 244. Affordability cost-sharing credit.

Sec. 245. Income determinations.

Sec. 246. No Federal payment for undocumented aliens.

Now let us detail several of the key parts of this Title. First, the establishment of the Exchange as follows:

(a) ESTABLISHMENT.—There is established within the **Health Choices Administration** and **under the direction of the Commissioner a Health Insurance Exchange** in order to **facilitate access of individuals and employers**, through a transparent process, to a variety of **choices of affordable, quality health insurance coverage**, including a **public health insurance** option.

Thus this statement does the following:

1. Establishes a Health Choice Administration, a new Government Agency

2. Creates a Commissioner

3. Facilitates an exchange for affordable and quality health insurance

4. Creates a public option

The Commissioner now has the authority as stated:

(b) OUTLINE OF DUTIES OF **COMMISSIONER**.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 143(b), the Commissioner shall—

(1) under section 204 **establish standards for, accept bids from, and negotiate and enter into contracts with, QHBP offering entities** for the offering of health benefits …

(2) ….. facilitate **outreach and enrollment** in such plans of Exchange-eligible individuals and employers ….

(3) conduct such activities related to the **Health Insurance Exchange as required, including establishment of a risk …..**

Now the individuals are granted access as follows:

(a) **ACCESS TO COVERAGE.**—In accordance with this section, all individuals are eligible to obtain coverage through enrollment in an Exchange…

(b) **DEFINITIONS**.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term ''Exchange-eligible individual'' means an individual who is eligible …

(2) **ACCEPTABLE COVERAGE**.—For purposes of this division, the term ''acceptable coverage'' means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN…

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, …

Thus you have to must be in the exchange unless you are poor, old, or grandfathered. Thus as written it will eventually drive all out of the grandfathered plans into the Exchange Plans. The benefits are as described below:

SEC. 203. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall specify the benefits to be made available under Exchange-participating health benefits plans during each plan year, consistent with subtitle C of title I and this section.

(b) LIMITATION ON HEALTH BENEFITS PLANS OFFERED BY OFFERING ENTITIES.—The **Commissioner may not enter into a contract** with a QHBP offering entity under section 204(c) for the offering of an Exchange-participating health benefits plan in a service area **unless the following requirements are met**:

(1) REQUIRED OFFERING OF **BASIC PLAN**.—The entity offers only one basic plan for such service area.

(2) OPTIONAL OFFERING OF **ENHANCED PLAN**.—If and only if the entity offers a basic plan 0 for such service area, the entity may offer one enhanced plan for such area.

(3) OPTIONAL OFFERING OF **PREMIUM PLAN**.— If and only if the entity offers an enhanced plan for such service area, the entity may offer one premium plan for such area.

(4) OPTIONAL OFFERING OF **PREMIUM-PLUS PLANS**.—If and only if the entity offers a premium plan for such service area, the entity may offer one or more premium-plus plans for such area. All such plans may be offered under a single contract with the Commissioner.

Now the law starts to specify the minimum and maximum plan offerings in statutory law. This is very dangerous because as all plan administrators well know as medicine changes we want the plans to adapt. But by making this statutory law we make it near impossible to ever change it. These four divisions further make such changes near impossible. Now they detail the options:

(c) **SPECIFICATION OF BENEFIT LEVELS FOR PLANS**.—

(1) IN GENERAL.—The **Commissioner shall establish the following standards** consistent with this subsection and title I:

(A) **BASIC, ENHANCED, AND PREMIUM PLANS**.—Standards for levels of Exchange participating health benefits plans: basic, enhanced, and premium (in this division referred to as a ''basic plan'', ''enhanced plan'', and ''premium plan'', respectively).

(B) **PREMIUM-PLUS PLAN BENEFITS**.— **Standards for additional benefits that may be offered, consistent with this subsection** and sub title C of title I, under a premium plan (such a plan with additional benefits referred to in this division as a ''premium-plus plan'').

(2) **BASIC PLAN**.—

(A) IN GENERAL.—A basic **plan shall offer the essential benefits package required under title I** for a qualified health benefits plan.

(B) TIERED COST-SHARING FOR AFFORD ABLE CREDIT ELIGIBLE INDIVIDUALS…

(3) **ENHANCED PLAN**.—A enhanced plan shall offer, in addition to the level of benefits under the basic plan, a **lower level of cost-sharing** as provided...

(4) **PREMIUM PLAN**.—A premium plan shall offer, in addition to the level of **benefits** under the basic plan, a lower **level of cost-sharing** as provided ...

(5) **PREMIUM-PLUS PLAN**.—A premium-plus plan is a **premium plan** that **also provides additional benefits, such as adult oral health and vision care, approved by the Commissioner**. The portion of the premium that is attributable to such additional benefits shall be separately specified.

Now what are these four levels. Let us start at the end, the Premium Plus. This is the Union Plan, the payback to the Unions for ensuring the election of the current President. They are now immortalized into law! You cannot make this up.

1. Now back to Basic. This is the minimum coverage with the maximum payment.
2. Enhanced is the minimum coverage with a minimum payment.
3. Premium is the maximum coverage with maximum payment.
4. Then we are back to the gold plated Union Plans. Affordable only by companies who will NOT be competing in a world economy, like….well like the Government…and most likely no other company which will survive.

Now how will this be paid for. The answer is as follows:

(4) **DIRECT PAYMENT OF PREMIUMS TO PLANS**.—Under the enrollment process, individuals enrolled in an Exchange-participating health benefits plan shall pay such plans directly, and not through the Commissioner or the Health Insurance Exchange.

Now we are finally at the Public Plan:

SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A PUBLIC HEALTH INSURANCE OPTION AS AN EXCHANGE-QUALIFIED HEALTH BENEFITS PLAN.

(a) ESTABLISHMENT.—For years beginning with Y1, **the Secretary of Health and Human Services (in this sub title referred to as the ''Secretary'') shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the ''public health insurance option'') that ensures choice, competition, and stability of affordable, high quality coverage throughout the United States in accordance with this subtitle. In designing the option, the Secretary's primary responsibility is to create a low-cost plan without compromising quality or access to care**.

(b) OFFERING AS AN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—

(1) **EXCLUSIVE TO THE EXCHANGE**.—The public health insurance **option shall only be made available through the Health Insurance Exchange**.

(2) ENSURING A LEVEL PLAYING FIELD.—Consistent with this subtitle, the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—

(A) shall offer **basic, enhanced, and premium plans**; and

(B) **may offer premium-plus plans**...

(g) **ACCESS TO FEDERAL COURTS**.—The provisions of Medicare (and related provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, **shall apply to the public health insurance option** and individuals enrolled under such option under this title in the same manner as such provisions apply to Medicare and Medicare beneficiaries.

Thus the Public Plan will have elements like private plans, shall be run by the Government, people will be allowed to sue, and the Secretary and reporting Commissioner will decide what to offer and at what price.

In addition there is nothing in the Bill, HR 3200, to make this self supporting. Namely the Government may easily subsidize this Plan. The "level playing" field statement is ambiguous at the least and open to continuous litigation at the worst.

Now what does the Public Plan charge? The following details that:

SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) RATES ESTABLISHED BY SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish payment rates for the public health insurance option for services and health care providers consistent with this section and may change such payment rates in accordance with section 224.

(2) INITIAL PAYMENT RULES.—

(A) IN GENERAL.—Except as provided in subparagraph (B) and subsection (b)(1), during Y1, Y2, and Y3, the Secretary shall base the payment rates under this section for services and providers described in paragraph (1) on the p**ayment rates for similar services and providers under parts A and B of Medicare**.

(B) EXCEPTIONS.—

(i) PRACTITIONERS' SERVICES.—Payment rates for practitioners' services otherwise established under the fee schedule under section 1848 of the Social Security Act shall be applied without regard to the provisions under subsection (f) of such section and the update under subsection (d)(4) under such section for a year as applied under this paragraph shall be not less than 1 percent.

(ii) ADJUSTMENTS.—The Secretary may determine the extent to which Medicare adjustments applicable to base payment rates under parts A and B of Medicare shall apply under this subtitle.

(3) FOR NEW SERVICES.—The Secretary shall modify payment rates described in paragraph (2) in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.

(4) PRESCRIPTION DRUGS.—Payment rates under this section for prescription drugs that are not paid for under part A or part B of Medicare shall be at rates negotiated by the Secretary.

(b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

(1) INITIAL INCENTIVE PERIOD.—

(A) IN GENERAL.—The Secretary shall provide, in the case of services described in sub paragraph (B) furnished during Y1, Y2, and Y3, for payment rates that are 5 percent greater than the rates established under subsection (a).

(B) SERVICES DESCRIBED.—The services described in this subparagraph are items and professional services, under the public health insurance option by a physician or other health care practitioner who participates in both Medicare and the public health insurance option.

(C) SPECIAL RULES.—A pediatrician and any other health care practitioner who is a type of practitioner that does not typically participate in Medicare (as determined by the Secretary) shall also be eligible for the increased payment rates under subparagraph (A).

(2) SUBSEQUENT PERIODS.—Beginning with Y4 and for subsequent years, the Secretary shall continue to use an administrative process to set such rates in order to promote payment accuracy, to en sure adequate beneficiary access to providers, and to promote affordability and the efficient delivery of medical care consistent with section 221(a). Such rates shall not be set at levels expected to increase overall medical costs under the option beyond what would be expected if the process under subsection (a)(2) and paragraph (1) of this subsection were continued.

(3) **ESTABLISHMENT OF A PROVIDER NET WORK.**—Health care providers participating under **Medicare are participating providers in the public health insurance option unless they opt out in a process established by the Secretary**.

(c) ADMINISTRATIVE PROCESS FOR SETTING RATES.—Chapter 5 of title 5, United States Code shall apply to the process for the initial establishment of payment rates under this section but not to the specific methodology for establishing such rates or the calculation of such rates.

(d) CONSTRUCTION.—Nothing in this subtitle shall be construed as limiting the Secretary's authority to correct for payments that are excessive or deficient, taking into account the provisions of section 221(a) and the amounts paid for similar health care providers and services under other Exchange-participating health benefits plans.

(e) CONSTRUCTION.—Nothing in this subtitle shall be construed as affecting the authority of the Secretary to establish payment rates, including payments to provide for

the more efficient delivery of services, such as the initiatives provided for under section 224.

(f) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate or methodology established under this section or under section 224.

Finally the Public Plan will introduce many ways to practice Medicine such as bundling and the Medical Home construct. The opening part of the enabling legislation in HR 3200 is the most telling here. This is accomplished in the following parts:

SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(a) IN GENERAL.—For plan years beginning with Y1, the **Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option**. **The payment mechanisms and policies under this section may include patient-centered medical home and other care management payments, accountable care organizations, value based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers**.

The above goes to the heart of the Government taking control over health care. They do:

1. Medical Home: This may have value for chronic patients.

2. Accountable Care Organizations

3. Value Based Purchasing

4. Bundling: This places hospitals in charge as we have argued before.

5. Differential Payments

6. Capitation: This was the procedure which HMOs used to ration and deny care!

These are the worst of the worst of the HMO era! They will in my opinion and in the opinion of many other practicing physicians destroy health care. It continues:

(b) **REQUIREMENTS FOR INNOVATIVE PAYMENTS**.— The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficient and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

(2) promotes care that is integrated, patient centered, quality, and efficient.

(c) **ENCOURAGING THE USE OF HIGH VALUE SERVICES**.—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

(d) **NON-UNIFORMITY PERMITTED**.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as ac countable care organizations and medical homes) under the public health insurance option for different geographic areas.

Well that is it. Let us review the HR 3200 Exchange proposals:

1. Controlled by a Commissioner

2. Forces everyone to ultimately participate

3. Specifies what services are provided at what price.

4. Establishes a public plan with no parity with private plans, namely the Government can underwrite

5. Results in the elimination of Private Plans by word of law

6. Restructures any and all medical compensation into Government specified, controlled, prices, and allocated processes and procedures.

Exchange are worthwhile. They work well in free and open markets. Government controlled exchanges working under the letter of the law are a disaster. The overhead will cause irreparable harm to the citizens and destroy the US Medical community as we know it. Please just read the words. They were in my opinion written by an evil mind!

9 THE MEDICAL HOME

This is the medical home concept.

9.1 HR 3962

Remains unchanged.

9.2 HR 3200

HR 3200 is rant with Government controls. I did not realize how much until I have spent days reading it. Every special interest, every wacko Congressperson, every fringe player have had their chance at throwing something in this festering soup. Today we talk of the Medical Home. Nice sounding name, is it not? But beware.

In a CNN, of all places, web piece by Shawn Tully, the author lists five areas of major concern in the health bills. Some are spot on and some are open for interpretation. Yet hidden in the middle of the article is the following:

"*The Senate bill requires that Americans buying through the exchanges -- and as we've seen, that will soon be most Americans -- must get their care through something called "medical home." Medical home is similar to an HMO. You're assigned a primary care doctor, and the doctor controls your access to specialists. The primary care physicians will decide which services, like MRIs and other diagnostic scans, are best for you, and will decide when you really need to see a cardiologists or orthopedists.*

Under the proposals, the gatekeepers would theoretically guide patients to tests and treatments that have proved most cost-effective. The danger is that doctors will be financially rewarded for denying care, as were HMO physicians more than a decade ago. It was consumer outrage over despotic gatekeepers that made the HMOs so unpopular, and killed what was billed as the solution to America's health-care cost explosion."

Before commenting let us present the Bill and its wording. We use HR 3200 since I have been studying that at length. The Bill states:

"DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS Sec. 1302. Medical home pilot program.

SEC. 1302. MEDICAL HOME PILOT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 1301, the following new section:

‘‘MEDICAL HOME PILOT PROGRAM ‘‘SEC. 1866E.

(a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

‘‘(1) ESTABLISHMENT OF PILOT PROGRAM.— The **Secretary shall establish a medical home** pilot program (in this section referred to as the ‘pilot program’) **for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes** for **furnishing medical home services** (as defined under subsection (b)(1)) **to high need beneficiaries** (as defined in subsection (d)(1)(C)) and to **targeted high need beneficiaries** (as defined in subsection (c)(1)(C))."

Now you must begin to parse the words. They are important. We will get to defining a Medical Home in a moment but read the enabling legislation. It is:

1. a pilot program

2. Targeted, and that I believe is an operative word, to (i) high need beneficiaries and (ii) targeted high need beneficiaries. Frankly I do not see the difference other than the word targeted, but wait, the Bill defines these terms.

The Medical Home pilot will do the following:

"‘‘(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models: ‘‘(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient centered medical home model under subsection (c). ‘‘(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d)."

Now to the Definitions:

‘‘*(b) DEFINITIONS.—For purposes of this section: ‘*

‘(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term ‘patient-centered medical home services’ means services that—

‘‘(A) provide beneficiaries with direct and ongoing access to a primary care or principal care by a physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

‘‘(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

‘‘(C) provide for all the patient’s health care needs or take responsibility for appropriately arranging care with other qualified providers for all stages of life;

‘‘(D) provide continuous access to care and communication with participating beneficiaries;

‘‘(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

‘‘(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

‘‘(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

‘‘(2) PRIMARY CARE.—The term ‘primary care’ means health care that is provided by a physician or nurse practitioner who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

‘‘(3) PRINCIPAL CARE.—The term ‘principal care’ means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist’s expertise, and for whom the subspecialist assumes care management."

"‘‘(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term ‘community-based medical home’ means a nonprofit community-based or State-based organization that is certified under paragraph (2) as meeting the following requirements:

‘‘(i) The organization provides beneficiaries with medical home services.

‘‘(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician or nurse practitioner designated by the beneficiary as his or her community-based medical home provider.

‘‘(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician or nurse practitioner in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area."

In some ways this is starting to sound like the old Public Health system of the 1920s and 1930s. Now to the high need beneficiary we spoke about above:

‘‘(C) **HIGH NEED BENEFICIARY**.—In this section, the term ‘high need beneficiary’ means an individual who **requires regular medical monitoring, advising, or treatment**. "

In a way this is the chronically ill, the Type 2 Diabetic, the congestive heart failure, the patient with COPD. It seems not to include the cancer patient, the broken leg, or even the day to day practice of medicine. It seems targeted at those who frankly use most of the health care facilities by their continuing return to them.

The program will be evaluated on the following:

‘‘(e) EXPANSION OF PROGRAM.—

‘‘(1) EVALUATION OF COST AND QUALITY.— The Secretary shall evaluate the pilot program to determine—

‘‘(A) the extent to which medical homes result in—

‘‘(i) **improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients**;

‘‘(ii) improvement in reducing health disparities;

‘‘(iii) reductions in preventable hospitalizations;

‘‘(iv) prevention of readmissions;

‘‘(v) reductions in emergency room visits;

‘‘(vi) improvement in health outcomes, including patient functional status where applicable;

‘‘(vii) **improvement in patient satisfaction;**

‘‘(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

‘‘(ix) reductions in health care expenditures..."

The patient concerns is seventh. But frankly the intent is not bad. It takes those patient who often dominate the costs, in almost all cases there is an existing diagnosis and course of the disease, and manages it. This is a patient management system. If you have Type 2 Diabetes they will try to manage you. If you have COPD the same applies. You may live a long time but the way it is managed now you may be seeing dozens of physicians and wasting resources. Is this rationing? Frankly I think not. It is good sense. It also is a trial.

And now how much will this cost? Well the Bill states:

‘‘(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

‘‘(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the **Secretary for the Centers for Medicare & Medicaid Services**, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

‘‘(A) **$200,000,000 for each of fiscal years 2010 through 2014** for payments for medical home services under subsection (c)(3); and

‘‘(B) **$125,000,000 for each of fiscal years 2012 through 2016,** for payments under subsection (d)(5). Amounts available under this paragraph for a fiscal year shall be available until expended."

That is only a bit shy of $2 billion. Peanuts!

So let's go back to the CNN article. Our approach has been to deal with the facts. The Medical Home is a Medicare Trial, and a worthwhile one indeed if it stays to the chronically ill. The author of the CNN article seems to imply that this Trial applies to all! I cannot find that in HR 3200. This continues a problem I have with the media, they fail to reference the specific statement, the words, and then they go off in a screaming tangent. Upon my first reading of the CNN piece I thought there would be fire here amongst the smoke. No, sorry, it may even be a great idea!

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