

 **NATIONAL
BLACK
CHURCH
INITIATIVE**
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Innovative Health Policy Plan for Our Nation

*In Response to the House and Senate Health
Reform Legislation*





"Bringing people together to serve humanity"

P.O. Box 65177
Washington, DC 20035
202 • 744 • 0184
debc2002@gmail.com

To:

THE HONORABLE MEMBERS OF THE UNITED STATES SENATE

The Honorable Paul Ryan, House Speaker
The Honorable Nancy Pelosi, House Minority Leader
The Honorable Mitch McConnell, Senate Majority Leader
The Honorable Charles Schumer, Senate Minority Leader
The Honorable Lamar Alexander, Senate Committee on Health, Education, Labor and Pensions
Chair
The Honorable Patty Murray, Senate Committee on Health, Education, Labor and Pensions
Ranking Member
The Honorable Orrin Hatch, Senate Committee on Finance Chair
The Honorable Ron Wyden, Senate Committee on Finance Ranking Member

From:

The Most Right Rev. Anthony Evans, President of the National Black Church Initiative

Through:

Church of God in Christ
African Methodist Episcopal Church
African Methodist Episcopal Zion Church
Christian Methodist Episcopal Church
Full Gospel Baptist Church Fellowship International
National Baptist Convention, USA, Inc.
National Baptist Convention of America, Inc.
Progressive National Baptist Convention, Inc.
Pentecostal Assemblies of the World, Inc.
The Union of Black Episcopalians
National Council of Churches
International Council of Community Churches
Unity Fellowship Church Movement
Mount Calvary Holy Churches of America
Greater Mount Calvary Holy Church
American Baptist Churches
Berean Missionary Baptist Church
The Potter's House

Re: The National Black Church Initiative's Innovative Health Policy Plan for Our Nation (IHPPON) In Response to the Senate and House Health Reform Legislation

The National Black Church Initiative is pleased to present you a copy of its innovative health policy plan for our nation. We have observed the proceedings of Congress, who we have elected to represent our interests. Suffice to say, those proceedings representing our health care since 2000 have painful to watch in a nation as rich and prosperous as ours. We have watched Congress and their deliberations as they doll out inefficient means that do not meet our healthcare needs.

This is why we are morally compelled as the black church to stand up and provide substantial solutions based on the science and numbers of our plan. We have this right as Americans to put forth our directive not because the black church wants to punish or ally with any political party. We take this mandate because we are compelled morally to do so. The National Black Church Initiative's Innovative Health Policy Plan for Our Nation calls for the combining of the best practices that have been put forth by both parties.

Let it be very clear that we are standing on the ethics and teaching of Jesus, not the principle of either the Republican or Democratic parties. We call for

1. Correcting the onerous taxes and regulations of the Affordable Care Act,
2. Mean testing some of our rich seniors without abandoning them,
3. A limit on liability
4. Responsibility on those who use the system to most,
5. A lowering of health care premiums to 15% of income for working individuals and families,
6. A lowering or prescription drug prices without hindering innovative new drug and therapy development,
7. A complete analysis of—and game plan for—the most expensive health care conditions of this nation, namely cancer, diabetes, and heart diseases, and
8. A five-billion-dollar plan to eradicate health disparities and focus on cultural competencies

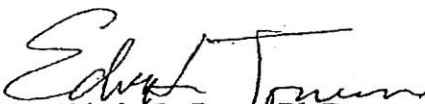
We have not dodged our moral commitment to providing healthcare for all. This plan is deeply written with compassion and love for everyone and does not favor anyone. Most importantly, this plan calls for the restoration of the 800-billion-dollar redirection of funding by the American Health Care Act and the Better Reconciliation and Care Act. The redirecting is morally incomprehensible.


If the National Black Church Initiative Innovative's Health Policy Plan for Our Nation is implemented in our existing health care system, the 23 million who are slated to lose their coverage will not lose their coverage and our nation will be more happy and vibrant.

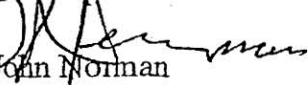
We will embrace God's promise for our nation as stated in our Declaration of Independence that "we hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

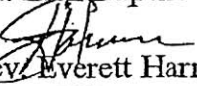
You Humble Servant in Christ,

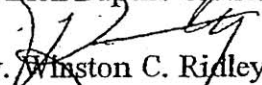
The Right Most Reverend Anthony Evans
President

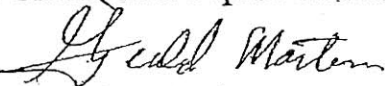

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Faith Christian University Church


Rev. Amos Ballenger
Mt. Zion Baptist Church

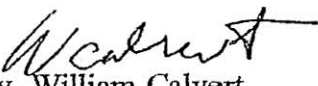

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Mt. Zion Baptist Church



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Mt. Zion Baptist Church

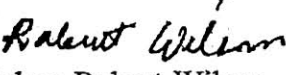

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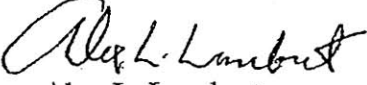

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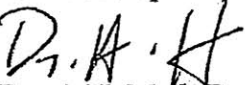

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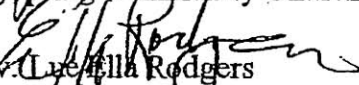

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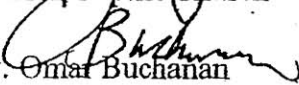

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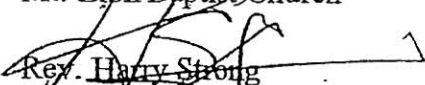

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All For Jesus Scripture Art

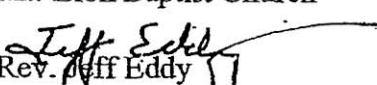

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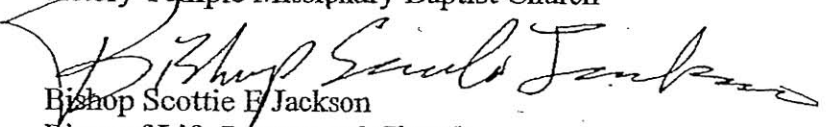

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Mt. Zion Baptist Church

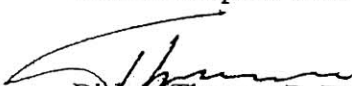

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Rev. Jeff Eddy
National Lay leader

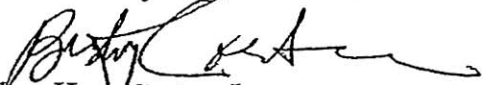

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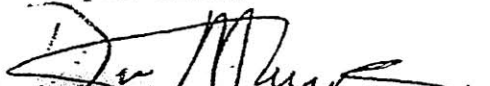

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Breakthrough Bible College



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New Community Church of God In Christ

TABLE OF CONTENTS

1	Explanation on why the National Black Church Initiative is writing a structural outline of essential components in the next Healthcare Bill	1
2	The House and Senate Healthcare Plans	5
3	Overview of the Patient Protection and Affordable Care Act’s Failings	10
4	National Health Groups’ Views	13
5	Health Economists’ Views	35
6	Congressional Budget Analysis of AHCA	41
7	The National Black Church Initiative’s Five Billion Dollar Health Disparities and Cultural Competency Focus.....	49
8	The National Black Church Initiative’s National Healthcare Plan	54
9	Financing the Healthcare Plan.....	57
10	Bibliography	58

THE NATIONAL BLACK CHURCH INITIATIVE'S INNOVATIVE HEALTH POLICY PLAN FOR OUR NATION

In Response to the House and Senate Health Reform Legislation

1 EXPLANATION ON WHY THE NATIONAL BLACK CHURCH INITIATIVE IS WRITING A STRUCTURAL OUTLINE OF ESSENTIAL COMPONENTS IN THE NEXT HEALTHCARE BILL

Many systemic issues in the American health care system triggered the need for health care reform. As of 2010, 44 million Americans did not have health insurance, creating an enormous economic liability in this country; many resorted to emergency care as a last recourse, which shifted the expensive burden of their uninsured status onto other taxpayers. The primary reasons for Americans being uninsured are cost and job loss. Poor working families are the most likely to be uninsured. The uninsured are less likely to have a usual source of care outside of the emergency room. Uninsured Americans often go without screenings and preventive care, often delay or go without needed medical care, and pay more for medical care. The uninsured are more likely to die than the insured. Uninsured Americans cost the American healthcare system \$49 billion each year, and only 12% of uninsured families pay their hospital bills in full.

Insurers discriminated and restricted coverage for the most vulnerable Americans: those with pre-existing conditions, disabilities, and lower-income statuses. Older Americans and women also faced obstacles due to their age and sex that include higher costs, incorrect coverage, and coverage denial. Insurers sought to create a difficult health insurance environment in many ways, such as denying coverage and dropping Americans from their insurance due to minor paperwork discrepancies. Many NBCI members and congregants suffered from a health system that not only did not serve their needs, but also puts them at risk economically and worsening their health conditions. Many poor and working-class NBCI members do not have adequate health coverage for themselves or their families.

Prior to the passage of the ACA, America was suffering from a national health crisis that was characterized by:

- Growing numbers of uninsured people.
- A growth in personal debt and bankruptcy due to medical costs.
- An ever-increasing cost of health care.
- Ever-growing profit for the health care corporations.
- And a growing national debt and deficit

A 2007 study by the American Journal of Medicine found approximately 62 percent of all personal bankruptcies in the United States were related to medical bills. 78 percent of those involved had health insurance, although many were bankrupted anyway due to gaps in coverage such as co-payments, deductibles, and uncovered services. Other people had private insurance but got so sick that they lost their job and lost their insurance.

Back in 1960, an average of \$147 was spent per person on health care in the United States. By 2009, that number had skyrocketed to \$8,086. National health expenditures will hit \$3.35 trillion in 2017, which works out to \$10,345 for every man, woman and child. The average family of 4 spent about \$20,728 per year on healthcare in 2013 and \$24,671 in 2015.

With all this spending, hospital executives continue to make millions of dollars in profit while consumers struggle to pay their ever-increasing medical costs. According to the *Fortune* 500, the ten largest health insurers' profits reached \$8.3 billion in 2008 and \$15.0 billion in 2015. The nation's largest health insurer, UnitedHealth, claims that Obamacare has reduced its 2016 earnings by \$850 million. However, UnitedHealth announced record-breaking profits in 2015, and in July 2016 celebrated revenues that quarter totaling \$46.5 billion, an increase of \$10 billion since the same time last year. Aetna reported \$15.8 billion in revenue for the three months that ended Sept. 30, 2016. UnitedHealth reported a 12 percent jump in revenue to \$46.3 billion for that period compared with the previous year. The company collected \$36.1 billion in insurance premiums, a sum 11% higher than for the year-ago quarter, while profits increased 29 percent to \$1.98 billion as the company signed up 955,000 more health insurance customers through its employer and individual plans.

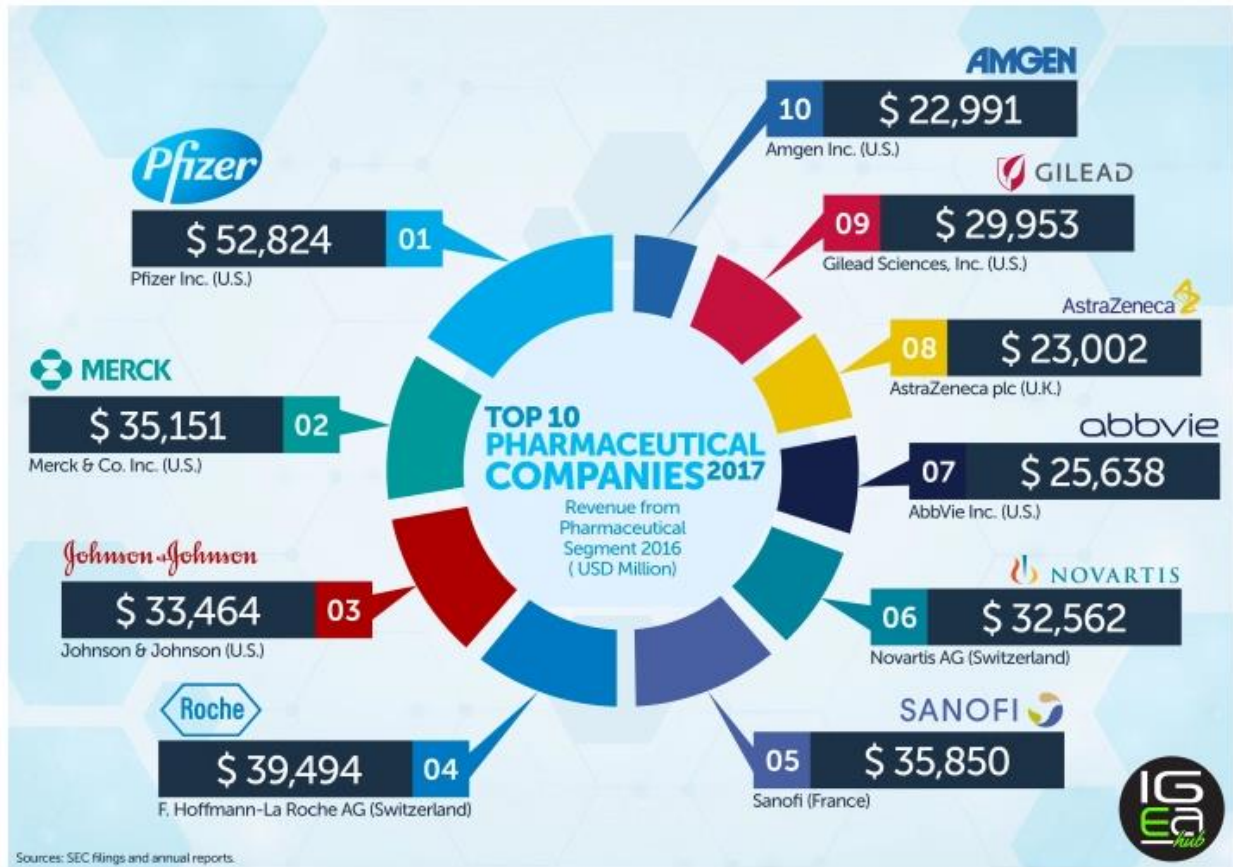
The top executives at the five largest for-profit health insurance companies in the United States combined personally made nearly \$200 million in total compensation for 2009. And company filings show that UnitedHealth's CEO Stephen J. Hemsley made over \$20 million in 2015. To be fair, that is a pay cut. The previous year, in 2014, Hemsley took home \$66 million in compensation. A Salon analysis of regulatory filings found that the top five health insurers — UnitedHealth, Anthem, Aetna, Humana and Cigna — have doled out nearly \$30 billion in stock buybacks and dividends from 2013 to 2015. The pharmaceutical companies have not been left behind either; in fact, they are doing exceptionally well under Obamacare despite what they would have the public believe.

World's largest pharmaceutical firms					
Company	Total revenue (\$bn)	R&D spend (\$bn)	Sales and marketing spend(\$bn)	Profit (\$bn)	Profit margin (%)
Johnson & Johnson (US)	71.3	8.2	17.5	13.8	19
Novartis (Swiss)	58.8	9.9	14.6	9.2	16
Pfizer (US)	51.6	6.6	11.4	22.0	43
Hoffmann-La Roche (Swiss)	50.3	9.3	9.0	12.0	24
Sanofi (France)	44.4	6.3	9.1	8.5	11
Merck (US)	44.0	7.5	9.5	4.4	10
GSK (UK)	41.4	5.3	9.9	8.5	21
AstraZeneca (UK)	25.7	4.3	7.3	2.6	10
Eli Lilly (US)	23.1	5.5	5.7	4.7	20
AbbVie (US)	18.8	2.9	4.3	4.1	22

Source:
GlobalData

The health care system has sufficient monies from health insurers, pharmaceutical companies, and the government to cover every man, woman and child in this country. However, none of these entities have the moral integrity or will to do so. And we, including NBCI's 15.7 million members, and the American people are asked to shoulder the financial burden in a scaled down system that does not meet our needs. This unfair arrangement is morally reprehensible in every sense of the word, and the church will not be a pawn in this game anymore.

In 2016, despite many reports and analyses claiming that pharmaceutical companies are performing sub-optimally, these companies continue to earn in the tens of billions. Many have even profited from health care reform.



The National Black Church Initiative (NBCI) is a coalition of 34,000 African American and Latino churches working to eradicate racial disparities in healthcare, technology, education, housing, and the environment. NBCI's mission is to provide critical wellness information to all its members, congregants, churches and the public. Our methodology is utilizing faith and sound health science.

NBCI's purpose is to partner with major organizations and officials whose main mission is to reduce racial disparities in the variety of areas cited above. NBCI offers faith-based, out-of-the box and cutting-edge solutions to stubborn economic and social issues. NBCI's programs are governed by credible statistical analysis, science based strategies and techniques, and methods that work.

As an economic and moral imperative, NBCI demands that the next health care reform bill serve the American people better than the Affordable Car Act has and better than the America Health Care Act and the Better Care Reconciliation Act in its current form will.

We are offering our own health analysis and solutions because we are being royally used both by the government and the private sector. Our nation's next health care plan should be driven by sound health data as well as cost savings methods. There should not be a battle between these two important aspects.

The following structural outline contains the National Black Church Initiative's (NBCI) stance for the next health care reform bill that (1) improves what the ACA does right, (2) corrects what the ACA does wrong, and (3) addresses other health care deficits in this country. NBCI seeks to incorporate our own non-negotiable health care plan principles that aims to achieve all three of these endeavors. These principles are as follows:

1. Mandated child health care
2. Health care decisions driven by hard science, data collection and statistical evaluation of procedures, theories and innovative practices
3. Prohibition of discrimination
4. Emphasis on education, testing and early diagnosis, prevention and data collection
5. Emphasis on physical exercise and nutrition program block grants
6. Commitment to cultural competency in health care workforce
7. Emphasis on voluntary data collection and research data
8. Encouragement of African Americans and other diverse populations to voluntary clinical trial participation
9. Universal access to affordable care
10. Comprehensive review on cost saving, streamlining, upgrading technology, rooting out corruption and providing comprehensive education of system procedures in Medicaid and Medicare.
11. Removal of the IRS from the health care plan, and the individuals mandate/tax and penalties

(Consult Non-Negotiable Principles of The National Black Church Initiative Affordable Health Care Plan for more details.)

The proposed House bill, known as the *American Health Care Act of 2017*, and the proposed Senate Bill, titled the *Better Care Reconciliation Act of 2017*, and the self-serving recommendations from the pharmaceutical industry, hospitals, and health plan organizations are in stark violations to our Bills of Rights when it states that, "we hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

Where is the life in these bills? Where is the liberty? And where is the happiness? For those who set with their backs against the wall in this society when there is so much to be shared, we are the first to die and the last to receive any form of happiness. This is a moral disgrace for the country and for its government and private sector.

2 THE HOUSE AND SENATE HEALTHCARE PLANS

The first proposed healthcare plan, the American Health Care Act (AHCA), does improve some important aspects of the ACA. The AHCA gets rid of the penalty for not having insurance and

keeps some ACA provisions such as the key essential health benefits, and preexisting conditions exclusions. The bill helps those making over the 400% poverty level by expanding HSAs and providing a tax credit based on age, eases requirements, and lets insurers sell across state lines which might reduce the cost of plans.

However, the AHCA also has many drawbacks for most of NBCI members and many in the public. Per numerous experts, the AHCA will hurt the sick, poor, and women and help the upper tiers, large employers, and industry. The uninsured rate will increase over time under the AHCA. The bill charges people 30% more for 12 months if they have a lapse in coverage for more than 63 days. The bill doesn't incentivize healthy people to enter the market which means that coverage will be expensive for the sick who need insurance. The bill gets rid of the employer mandate, which means that more employees may go uninsured and the state will have to provide assistance to more people.

This bill repeals the definitions of plan levels deregulating that insurers need to meet specific actuarial values and repeals the requirement for Medicaid to provide minimal essential coverage, leading to inadequate coverage for millions of Americans in need. The AHCA changes tax credits to age-based credits, gets rid of out-of-pocket assistance, and freezes Medicaid Expansion. Poor, older Americans would be hit especially hard. The average 64-year-old earning just above the poverty line would have to pay about 9 times more in premiums. After premiums increasing in 2018 and 2019, there will be significant variation depending on whether someone lives in a state that opts out of key Obamacare insurance rules.

According to a 2017 CBO Report on the American Health Care Act: In 2026, an estimated 52 million people would be uninsured [under the AHCA], compared with 28 million who would lack insurance that year under current law. The current all-time low uninsured rate (8.6% for ages 0-65) and is projected to double by 2026 if AHCA is passed as written.

The AHCA saves \$30 billion by taking coverage options away from those who benefited from assistance: the sick, poor, seniors, and women, and redistributes the savings to the healthy, the rich, industries, and big businesses via tax cuts.

Conversely, the bill overall may deepen the deficit. The largest increases in the deficit would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage such as repealing a surtax on net investment income, repealing annual fees imposed on health insurers, and reducing the income threshold for determining the tax deduction for medical expenses.

Many will struggle under the law as tax credits will be based on age while out-of-pocket assistance is cut. This means seniors and the poor will see very large increases in personal costs. Under the AHCA, premiums could decline by about 20% on average over a decade compared to current law in states that currently waive some of the ACA rules. In short, people will pay less but get fewer benefits. 1 out of 6 Americans will live in an area with an unstable insurance market in 2020 where sick people could have trouble finding coverage. That means that the problem of plan selection

under the ACA will continue under the AHCA instead of being addressed and fixed. This time it will target the sick. Also, Small businesses will lose their tax credit under the AHCA.

The second proposed healthcare plan to repeal and replace the Affordable Care Act, tilted the “Better Care Reconciliation Act of 2017” (BCRA), contains key difference from the AHCA. Namely, it is a slower phased repeal of the ACA.

While the AHCA proposes a system of age-based tax credits, the BCRA instead relies on the existing ACA system of federal tax credits but base the tax credits on age, income and geographic location. Eligibility for the subsidies is scaled back to include households with incomes under 350 percent of the federal poverty level from 400 percent. The BCRA benchmark (which is like the ACA) provides much less coverage than the ACA; the ACA benchmark plan’s actuarial value is 70 percent while the BCRA benchmark plan would have an average actuarial value of 58 percent.

The BCRA would maintain three Health Savings Account (HAS) expansion provisions from the AHCA, including (1) increasing contribution limits from the current \$3,400 for individuals and \$6,750 for families in 2017 to \$6,550 for an individual and \$13,100 for a family; (2) allowing both spouses to make catch-up contributions to the same HSA; and (3) allowing individuals up to 60 days to establish an HSA upon enrolling in HSA-eligible coverage to be reimbursed from their accounts for medical expenses. These changes would be effective in January 2018.

The BCRA repeals all forms of penalties for not purchasing coverage. Unlike the AHCA, the BCRA does not address the ACA’s actuarial value standards and extends cost-sharing subsidy payments, which reduce premiums and deductibles for low-income individuals, until December 31, 2019.

State innovation waivers – The BCRA seeks to provide states with better and more efficient access to the ACA’s Section 1332 state innovation waivers by eliminating the requirement that waivers be codified in state law. Section 1332 waivers include waivers of ACA requirements like essential health benefits, actuarial values and exchange requirements. The BCRA would allow states to waive these provisions if the state describes how it would “provide for alternative means of, and requirements for, increasing access to comprehensive coverage, reducing average premiums, and increasing enrollment,” a lower standard than under the ACA.

The BCRA also appropriates \$2 billion for 2017 through 2019 to allow states to submit waiver applications and to use the long-term stability fund to carry out innovation waiver plans. The BCRA allows for an expedited approval process if the Secretary of Health & Human Services (HHS) determines that it is necessary and requires all waivers to be approved, unless they will increase the federal deficit. Waivers are granted for an eight year period, unless a state requests a shorter period, with automatic renewals upon application. Finally, the BCRA provides that 1332 waivers approved prior to enactment will be governed under the ACA parameters.

The ACA’s prohibition on charging higher premiums or denying coverage based on existing medical conditions seems to remain intact under the BCRA. However, this does not guarantee that someone will not be denied coverage for a preexisting condition. The discussion draft grants states

more flexibility with respect to other insurance rules, such as the establishment of basic benefits packages and minimum payments that insurers must make toward medical bills. To the extent that states modify essential health benefits under a waiver, this could weaken pre-existing condition protections if certain benefits are not included. However, the Senate does not maintain the AHCA provision that allowed states to request a waiver to engage in health-status underwriting for individuals who did not maintain continuous coverage.

The BCRA would amend the Employee Retirement Income Security Act of 1974 (ERISA) to allow for the creation of small-business health plans, which means “a fully insured group health plan, offered by a health insurance issuer in the large group market” whose sponsor meets specified requirements. The BCRA would require the Secretary of HHS to establish a certification process no later than six months after the date of enactment.

The BCRA appropriates \$2 billion in 2018 for the Secretary of HHS to distribute grants to states to support substance-use-disorder treatment and recovery support services. This is different from the AHCA, which earmarked \$15 billion over 10 years for mental health, substance abuse and maternity care.

Like the AHCA, the BCRA would end the ACA’s \$1 billion in funding for the Prevention and Public Health Fund, but one year earlier than the AHCA on October 1, 2017

Unlike the AHCA’s “Patient and State Stability Fund,” the BCRA would create two funds geared toward stabilizing insurance markets. First, the short-term stability fund would appropriate \$50 billion over four years (\$15 billion annually in 2018 and 2019 and \$10 billion annually for 2021 and 2022) to the Centers for Medicare and Medicaid Services (CMS) to “fund arrangements with health insurance issuers to address coverage and access disruption and respond to urgent health care needs” with no state 4 matching requirement. Insurers would be required to apply for the short-term stability fund, with applications for 2018 due within 35 days of the BCRA’s enactment.

The BCRA proposes many of the Medicaid changes included in the AHCA, such as the sunset of the essential health benefits requirements for Medicaid plans effective January 1, 2020. The BCRA also retains the conversion of Medicaid to a per capita cap system with optional block 5 grants for certain populations, as well as the AHCA’s optional work requirement. Key differences between the BCRA and the House-passed bill are:

Like the AHCA, the BCRA would allow state Medicaid plans to conduct eligibility determinations every six months, and it provides a 5 percent increase in the federal medical assistance percentage (FMAP) for states that elect this option. However, the BCRA gives states more flexibility by allowing them to make eligibility redeterminations after fewer months.

The AHCA would freeze Medicaid expansion after March 1, 2017, by eliminating the state option to expand and receive enhanced FMAP payments. By contrast, the BCRA would not freeze Medicaid expansion, allowing states to enroll and cover individuals up to 133 percent FPL through December 31, 2017. States that had not expanded their programs as of March 1, 2017, could opt to do so, but would receive their regular matching rate to cover new enrollees.

Unlike the AHCA, the BCRA would provide a prolonged phaseout of enhanced federal Medicaid funding for states. Under the AHCA, states that have already expanded could keep the enhanced match for expansion enrollees until December 31, 2019, but, after that, they would receive an enhanced FMAP for only individuals enrolled as of December 31, 2019, who do not become disenrolled for more than a month (“grandfathered expansion enrollees”). The BCRA maintains the enhanced FMAP for the Medicaid expansion population until December 31, 2020, after which enhanced funding would be phased down from 85 percent to 75 percent over three years (2021-2023). No enhanced funding would be available to states after December 31, 2023.

Like the AHCA, the BCRA would convert federal funding for Medicaid to a per capita cap model, unless a state chooses to receive block grant funding for children and non-expansion adult enrollees, beginning in FY 2020. The BCRA also would maintain the five enrollee categories established by the AHCA: (1) elderly; (2) blind and disabled; (3) children; (4) expansion enrollees; and (5) other non-elderly, non-disabled, non-expansion adults. However, the BCRA includes several key differences:

- Medically complex children would be carved out from the cap.
- The baseline for the cap would no longer be based on state FY 2016 spending trended forward by the medical consumer price index (CPI-M) to 2019 in each enrollee category. Instead, the BCRA cap baseline is a period of eight consecutive quarters between 2014 and the second quarter of 2017 selected by the state.
- The growth factor for the cap is altered. Under the BCRA, from FY 2020 to FY 2024, the per capita cap would increase annually by the CPI-M for expansion adults, children and other adult enrollee categories. The cap would grow annually by medical inflation plus 1 percent. Then, beginning in FY 2025, the per capita cap would grow more slowly for all enrollee categories at the general consumer price index rate. The BCRA would impose deeper Medicaid cuts than the AHCA because it utilizes a slower annual growth rate for payments made to states.

Similar to the AHCA, the BCRA would give each state the option to receive block grant funding for its “other adult” populations in 2020. Similar to the AHCA, states would be subject to minimum requirements, but they also would retain the ability to set eligibility and minimum benefits, and general funding would remain the same. A key difference is that, under the BCRA, before the Secretary of HHS may approve a block grant proposal, it must be made public for a 30-day notice-and-comment period.

Unlike the AHCA, the BCRA permits states that have grandfathered managed care waivers to continue to implement the managed care delivery system that is subject to the waiver without reapplying to the Secretary, as long as the waiver’s terms and conditions are not modified. A managed care waiver is deemed “grandfathered” if the provisions of the waiver or demonstration project under Section 1115 of the Social Security Act were approved as of January 1, 2017, and have been renewed by the Secretary of HHS no less than one time.

The BCRA directs the Secretary of HHS to implement procedures to encourage states to adopt or extend waivers to make home and community-based services available.

The AHCA would repeal the Medicaid disproportionate share hospital (DSH) payments for non-expansion states in 2018 and for expansion states in 2020. The BCRA instead would exempt non-expansion states from scheduled reductions in DSH payments from FY 2021 through 2024 and provide an increase in DSH payments for non-expansion states in FY 2020 based on each state's Medicaid enrollment.

The BCRA reduces permissible Medicaid provider taxes from 6 percent under the ACA in 0.2 percent increments beginning in 2021 to ultimately reduce the tax to 5 percent in FY 2025. There was no such similar provision in the AHCA.

Unlike the AHCA, the BCRA would provide an \$8 billion pool for bonus payments to state Medicaid and CHIP programs for FY 2023 through 2026. The Secretary of HHS could use these funds to increase federal matching rates for states that have lower-than-expected expenses under the per capita cap allotment, report applicable quality measures and have a plan to use the additional funds on quality improvement.

The BCRA would provide optional state Medicaid coverage of inpatient psychiatric services for individuals between the ages of 21 and 65. The coverage would not exceed 30 days in any month or 90 days in any calendar year. To receive the assistance, a state must maintain its number of licensed psychiatric beds as of the date of the BCRA's enactment, and maintain current 7 levels of funding for inpatient services and outpatient psychiatric services. The BCRA also provides a lower match for such services (50 percent) furnished on or after October 1, 2018.

3 OVERVIEW OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S FAILINGS

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA) for short, is a landmark health care reform bill intended make our health care system more accessible and affordable to more Americans. Signed into law in 2010 under the Obama administration, the ACA is most often referred to as "ObamaCare." This landmark legislation provides reforms in three key imperfect aspects in the American health care system and health insurance industry: protection, accessibility, affordability. The ACA provides news rights, benefits, and protections to all insured Americans and expands access to affordable health care services.

In title I "Quality, affordable health care for all Americans" of the act, the ACA stipulates that "10 essential benefits" are guaranteed to be covered in all insurance plans. These essential 10 health benefits are:

- Ambulatory patient services

- Emergency services
- Hospitalization and surgery
- Laboratory services
- Mental health services and addiction treatment
- Pediatric care, including dental and vision
- Prenatal and postnatal care
- Prescription medication
- Preventive care, including general wellness checkups and chronic disease management
- Rehabilitative care

In addition, the Affordable Care Act addresses 9 other areas and provisions that reform our health care system, including the role of public programs, the quality and efficiency of health care, chronic diseases and public health management, addressing the health care workforce, transparency and program integrity, innovative medical therapies access improvement, community living assistance services and supports, revenue provisions, and reauthorization of the Indian Health Care Improvement Act.

The ACA establishes State-based exchanges (marketplaces) which reduce out-of-pocket costs and premium costs by offering subsidies to low and middle-income families, providing cost assistance, and comparing coverage for consumers. The Supreme Court rules that the Medicaid expansion under the ACA was optional to states. Nevertheless, the Medicaid expansion to the 138% Federal Poverty Level (FPL) allows more qualified working families to get coverage through Medicaid. The ACA also requires large businesses to offer coverage (“employer mandate”) and offers tax credits to small businesses to subsidize employee coverage.

A May 2014 Gallup poll shows that, under the ACA, the number of uninsured Americans is the least it has been since 2008 when Gallup started polling the number of people who were uninsured. Data from HHS on the uninsured in 2007 shows that this could actually be the lowest uninsured rate since before 1998. The uninsured rate for U.S. adults in April was 13.4%, down from 15.0% in March. As of July 2015 the uninsured rate is around 11.4%. The total number of uninsured was 44 million before the ACA.

The biggest winners from the law include people between the ages of 18 and 34; blacks; Hispanics; and people who live in rural areas. The areas with the largest increases in the health insurance rate, for example, include rural Arkansas and Nevada; southern Texas; large swaths of New Mexico, Kentucky and West Virginia; and much of inland California and Oregon.

Other transformative provisions include:

- Prohibition of discrimination based on salary, age, gender, health status, preexisting conditions
- Prohibition of unjustified rate hikes
- Requirement of an appeals process on insurance company decisions.

- Immediate access to insurance for people with a preexisting condition.
- Immediate access to the CHIP
- Prohibition on excessive waiting periods.
- Extension of dependent coverage to the age of 26
- Prohibition on rescissions.
- No lifetime or annual limits.
- Cuts wasteful spending and fraud

Despite all these benefits under the ACA, the bill does come with some substantial shortcomings.

Noncompliance fee—Under the ACA, everyone over a certain income must obtain health insurance or face a fine imposed by the IRS on your annual tax returns. In 2016, the individual mandate requires that noncompliant citizens pay a fine equal to 2.5 percent of their total taxable household income, or \$695 per uninsured adult and \$347.50 per uninsured child, per household, whichever is greater. The fine goes up each year based on inflation. There will be people who can't pay the premiums at any price, even if those prices are much lower than those of private insurance companies or employer-provided health plans. It's estimated that approximately 30 million people, or 10 percent of the U.S. population, will not be able to afford any of the insurance options now available.

No universal coverage—By 2024, when the law is theoretically fully in effect and uninsured is at its lowest, 25% of the uninsured will qualify for Medicaid. They will either be in a non-expansion state (5%), or won't know about, or won't get, free or low-cost coverage despite being eligible (20%).

Rising premiums rates— Before the ACA premiums were rising at an unsustainable rate, and without taking subsidies into account this trend has continued under the Affordable Care Act (in part due to insurers having to cover pre-existing conditions). In 2013, Blue Shield of California announced that it wanted to raise health insurance premiums by up to 20 percent to combat rising health care costs. As of 2015 insurers continue to raise rates to maintain a profit under the increasing cost of the rest of the healthcare system.

Although the ACA regulates insurance, it was not able to regulate costs as well as everyone might have hoped. The ACA left room for insurance companies to raise premiums in order to include the cost of covering pre-existing conditions. Insurance companies raised rates substantially going into 2014 when discrimination against pre-existing conditions was banned under the Affordable Care Act and all plans had to become guaranteed issue. ObamaCare has done a lot to help curb premium growth and many pay less after subsidies, but the base costs of premiums are still growing at unsustainable rates for many families like they did before the law despite cost curbing measures.

Refusing coverage for pre-existing conditions, putting people in high-risk pools, or charging sick people more for coverage was one of the main ways premium rates were artificially kept low before the ACA.

Other rising costs—To add to this problem the underlying healthcare industries like drug makers, device makers, and hospitals continue to raise prices to retain their place in the for-profit market. As the root costs of healthcare go up the costs of treatment and detection go up too. The ACA’s new taxes on the healthcare industry help to fund subsidies which lower costs based on income, but the base costs are still a major issue even under the ACA.

What is still unknown however is how the new reforms will affect long-term growth in healthcare costs. One hope is that by expanding access to preventive services (though regulation and subsidies) chronic illness will be caught early more often saving us all wasteful spending and human suffering. According to the [CDC](#), 75 percent of all healthcare expenditures go toward treating chronic diseases, many of which are preventable.

Other nonexistent protections—Insurers can limit benefits, medical networks, and care, and increase patients’ co-pays, deductibles and other out-of-pocket costs under the ACA. This is true despite new restrictions and regulations like the requirements for plans to provide minimum value and ten essential benefits. Benefits and doctors networks aren’t limited by insurers, and patient costs are replaced by taxes in a single payer system.

4 NATIONAL HEALTH GROUPS’ VIEWS

National Medical Association

“TO THE HONORABLE MEMBERS OF THE UNITED STATES CONGRESS:

You now have before you a BILL, the American Health Care Act, for your consideration which is intended to replace the Patient Protection and Affordable Care Act (ACA) which was signed into law on March 23, 2010. Called Obamacare, the current legislation has led to the provision of healthcare insurance coverage for millions of previously uninsured American citizens, resulting in documented improvement of health status and savings of lives, especially in poor and minority communities.

Obamacare is now under threat of repeal by your august body, which will result in loss of coverage and protection by an estimated 20 to 30 million Americans, with corresponding increases in illness and death.

The BILL that you now have before you would not prevent this catastrophe from happening but would actually be the cause of it, because large numbers of the most vulnerable people in our society will not be able to afford coverage under the AHCA plan, which favors the wealthy and penalizes the poor and under-represented minorities whose interests are served by the NMA.

Specifically, the AHCA has fatal flaws and deficiencies that make it untenable and unacceptable as a measure to replace Obamacare. For example, the tax-credit structure of the bill gives a tax break to the rich while removing the financial support that allows the insurance marketplaces to operate successfully; without such support, middle-class individuals who do not receive health insurance coverage from their employers will have nowhere to turn to shop for affordable plans.

Because of the scarcity of high-quality plans, market forces will drive up the cost of health insurance to unreachable heights for most citizens, resulting in a drastic increase in the numbers of uninsured individuals. Another liability in the AHCA plan is the scrapping of most subsidies which will also put the purchase of health insurance out of the reach of most of the public. Still another flaw is the planned pullout from Medicaid expansion by 2020 which will leave millions more poor people adrift in a dangerous undertow of lack of insurance coverage. A freeze on Federal payments to the states would accompany the withdrawal from Medicaid expansion. This is an absolute violation of the public trust that was given to the 31 states that signed on to expanded Medicaid on behalf of their constituents.

There are other flaws in the AHCA BILL which render it reprehensible and unworthy of the support of your august body. Although there are problems with certain aspects of Obamacare, these are fixable. We trust that your collective wisdom and your interest in the welfare of the American people will move you to REJECT THE AHCA, RETAIN THE ACA, and to take the bipartisan steps necessary to adjust the ACA for the benefit of our citizens.

FOR THE NATIONAL MEDICAL ASSOCIATION,

Richard Allen Williams, MD, FACC, FAHA, FACP
117th President”

Robert Wood Johnson Foundation

“The following statement from the Robert Wood Johnson Foundation is in response to the Congressional Budget Office’s (CBO) score of the Senate’s proposed legislation repealing the Affordable Care Act. The non-partisan estimate concludes 22 million people would lose coverage by 2026 under the [Senate’s] Better Care Reconciliation Act of 2017. The Robert Wood Johnson Foundation has worked for more than 40 years to ensure that everyone in America has access to affordable, high-quality health care.

Being able to obtain affordable health insurance matters, as researchers have shown time and again. The impact of having health insurance is proven. It’s a matter of life and death. Having health insurance affects financial security, the ability to receive care, reductions in chronic disease, and better health outcomes.

This bill puts the protections and peace of mind that come with comprehensive health insurance out of reach for millions of people—including children, the elderly, and those with disabilities. It rolls back expansion of coverage under the Affordable Care Act, which helped millions of people become insured. It shifts responsibility to cash-strapped states for covering health care for the poor. It turns the financial support that made health insurance affordable for millions of people into tax cuts for the wealthiest among us.

Every member of Congress must weigh the policy of taking insurance from 22 million people. This bill would negatively affect the most vulnerable Americans regardless of where they live.

For the most vulnerable, expansion of insurance coverage under the Affordable Care Act has been a lifeline to affordably accessing health care. Cutting a lifeline to affordable health care is a step in the wrong direction.

We recognize there are ways in which current policies could be improved and strengthened, and we look forward to working with others to ensure that everyone in America has access to affordable, high-quality health care.”

AARP, Inc.

“AARP opposes this legislation, as introduced, that would weaken Medicare, leaving the door open to a voucher program that shifts costs and risks to seniors.

Before people even reach retirement age, big insurance companies could be allowed to charge them an age tax that adds up to thousands of dollars more per year. Older Americans need affordable health care services and prescriptions. This plan goes in the opposite direction, increasing insurance premiums for older Americans and not doing anything to lower drug costs.

On top of the hefty premium increase for consumers, big drug companies and other special interests get a sweetheart deal.

Finally, Medicaid cuts could impact people of all ages and put at risk the health and safety of 17.4 million children and adults with disabilities and seniors by eliminating much-needed services that allow individuals to live independently in their homes and communities. Although no one believes the current health care system is perfect, this harmful legislation would make health care less secure and less affordable.

AARP stands ready to work with both parties on legislation that puts Americans first, not the special interests.”

American Medical Association

“The American Health Care Act (AHCA), released by Congress this week, is intended to repeal and replace the Affordable Care Act (ACA). But as introduced, it does not align with the health reform objectives that the AMA set forth in January to protect patients. While the ACA is imperfect, the current version of the AHCA is not legislation we can support.

The replacement bill, as written, would reverse the coverage gains achieved under the ACA, causing many Americans to lose the health care coverage they have come to depend upon.

In a letter sent today to leaders of the House committees that will mark up the AHCA, AMA CEO and Executive Vice President James L. Madara, MD, wrote that the proposed changes to Medicaid would limit states’ ability to respond to changes in service demands and threaten coverage for people with low incomes. Dr. Madara also noted that the proposed changes in tax credits and subsidies to help patients purchase private health insurance coverage are expected to result in fewer Americans with insurance coverage.

It is unclear the exact impact this bill will have on the number of insured Americans, and review by the nonpartisan Congressional Budget Office is still pending. The ratings and analytics firm S&P Global Ratings has already estimated that as many as 10 million Americans could lose coverage if this bill becomes law, saying that between 2 million and 4 million people could lose the insurance they purchased in the individual health exchanges under the ACA, and between 4 million and 6 million could lose their coverage under Medicaid.

That just won't do.

We all know that our health system is highly complex, but our core commitment to the patients most in need should be straightforward. As the AMA has previously stated, members of Congress must keep top of mind the potentially life-altering impact their policy decisions will have.

We physicians often see patients at their most vulnerable, from the first time they set eyes on a newborn child to the last time they squeeze a dying loved one's hand. We don't want to see any of our patients, now insured, exposed to the financial and medical uncertainties that would come with losing that coverage.

That is, above all, why physicians must be involved in this debate.”

American Hospital Association & Federation of American Hospitals

“As lawmakers work to re-examine this law, patients and the caregivers who serve them across America are depending on Congress to make continued coverage a priority. We believe that any changes to the ACA must be guided by ensuring that we continue to provide health care coverage for the tens of millions of Americans who have benefitted from the law. We are pleased that so many in Congress also recognize the need to preserve patient coverage.

We believe the legislation needs to be reviewed through this lens, and carefully evaluated regarding its impact on both individuals and the ability of hospitals and health systems which are the backbone of the nation's health care safety net in terms of our ability to care for all of those who walk through our doors.

Any ability to evaluate The American Health Care Act, however, is severely hampered by the lack of coverage estimates by the Congressional Budget Office (CBO). Lacking that level of analysis and needed transparency, we urge that Congress should wait until an estimate is available before proceeding with formal consideration.

In addition to the lack of a CBO score, we have some additional policy concerns with the proposal.

For example, it appears that the effort to restructure the Medicaid program will have the effect of making significant reductions in a program that provides services to our most vulnerable populations, and already pays providers significantly less than the cost of providing care.

Providing flexibility to the states to expand coverage, and create innovative financing and delivery models to improve care and program sustainability, can be achieved through other alternatives. For instance, the expanded use of waivers -- with appropriate safeguards -- can be very effective

in allowing state flexibility to foster creative approaches and can improve the program more effectively than through imposing per-capita caps.

In addition, the legislation repeals much of the funding currently dedicated to provide coverage in the future. Furthermore, we object to eliminating the funding from some sources, but leaving in reductions to payments for hospitals services. If coverage is not maintained at the current level, those resources need to be returned to hospitals and health systems in order to provide services to what will likely be an increased number of uninsured Americans.

At the same time, while we commend the recent actions by the Congress to address behavioral health issues, as well as the drug epidemic that is impacting virtually every community we serve, it is important to recognize that significant progress in these areas is directly related to whether individuals have coverage. And, we have already seen clear evidence of how expanded coverage is helping to address these high-priority needs.

Health care coverage is vitally important to working Americans and their families. They rely on hospitals and health systems to provide them with access for their essential health care needs in a manner that is of the highest quality, not to mention the full range of critical life-saving services, including preventive benefits, that will further improve the quality of their lives and the health of the communities in which they live.

We recognize this measure represents the first step in a process. It is critical that this process be thoughtful and focused on finding ways to improve our health care system, particularly for the poor, elderly and disabled.

We ask Congress to protect our patients, and find ways to maintain coverage for as many Americans as possible. We look forward to continuing to work with the Congress and the Administration on ACA reform, but we cannot support The American Health Care Act in its current form.”

American Cancer Society Cancer Action Network

“The bills released by the House Energy and Commerce Committee and the House Ways and Means Committee retain key patient protections prohibiting insurers from charging more based on health status and prohibiting pre-existing condition exclusions. However, these protections are hollow if patients and survivors can’t afford insurance that covers the health care services they need to treat their cancer diagnosis.

ACS CAN has long advocated that any changes to the health care law should provide equal or better coverage for cancer prevention, treatment and follow-up care than what is currently available. These bills have the potential to significantly alter the affordability, availability and quality of health insurance available to cancer patients and survivors. Changing the income-based subsidy to a flat tax credit, combined with reducing the standards for quality insurance could return cancer patients to a world where many are unable to afford meaningful insurance or are left to buy coverage that doesn’t meet their health needs.

In 2015, approximately 1.5 million people with a history of cancer between 18-64 years old relied on Medicaid for their insurance. Nearly one-third of childhood cancer patients are insured through Medicaid at the time of diagnosis. The proposed repeal of Medicaid expansion along with significant federal funding changes could leave the nation's lowest income cancer patients without access to preventive, curative and follow-up health care.

Moreover, reduced federal funding combined with state-specific eligibility and enrollment restrictions will likely result in fewer cancer patients accessing needed health care. For low-income individuals these changes could be the difference between an early diagnosis when outcomes are better and costs are less or a late diagnosis where costs are higher and survival less likely.

According to multiple independent analyses, 30 million individuals, including many cancer patients and survivors, now have insurance facilitated by current law. ACS CAN will continue to urge lawmakers to strengthen and improve the law in a way that reduces the national cancer burden.”

American Health Care Association (AHCA)

“Long term care providers across the country are disappointed that cuts to Medicaid are included in the Obamacare repeal and replace bill released yesterday. The current Medicaid system underfunds nursing center care by \$22.46 per day, resulting in a shortfall of nearly \$7 billion annually. The bill released yesterday will sharply reduce Medicaid funds across the board for all beneficiaries, making it harder than ever to maintain access to care for the most vulnerable in our society.

The residents in long term care centers are uniquely vulnerable. More than one million individuals call nursing centers their home and most rely on Medicaid for their care. This bill will cut Medicaid funding for seniors and individuals with disabilities, jeopardizing access to the care they need.

We strongly encourage Congress to protect Medicaid access for seniors and people with disabilities in the Obamacare repeal and replace effort.”

America's Essential Hospitals

“We appreciate that House Republicans offer the safety net some support in today's reconciliation bill, including an eventual end to disproportionate share hospital cuts. Nevertheless, America's Essential Hospitals remains deeply concerned about the legislation in its current form.

We are particularly disappointed lawmakers seem willing to consider this bill in committee without a Congressional Budget Office score and an estimate of how the bill might impact health care coverage. A score is crucial, as this legislation could place a heavy burden on the safety net by reducing federal support for Medicaid expansion over time and imposing per-capita caps on the program.

These changes alone could result in deep funding cuts for essential hospitals, which now operate with little or no margin. Our hospitals could not sustain such reductions without scaling back services or eliminating jobs.

Individuals and families — especially the vulnerable — could suffer. Communities could suffer, as well: Our hospitals are a key source of costly, lifesaving services, including trauma and neonatal intensive care, disaster response, and infection control. Without a CBO score, there are too many unknowns and too great a risk of coverage losses without affordable alternatives for many Americans.

Congress must work with all stakeholders to ensure that those who have coverage now do not lose it, that entitlement reform does not shift costs to states and providers, and that reform sustains a strong and secure safety net. Lawmakers must halt action on this bill until the CBO scores it and stakeholders can fully evaluate its provisions with that score in hand.”

America’s Hospitals and Health Systems

“On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners —including more than 270,000 affiliated physicians, 2 million nurses and other caregivers —and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is writing to express our views on The American Health Care Act, legislation to repeal and replace the Affordable Care Act (ACA).

As lawmakers work to re-examine this law, patients and the caregivers who serve them across America are depending on Congress to make continued coverage a priority. We believe that any changes to the ACA must be guided by ensuring that we continue to provide health care coverage for the tens of millions of Americans who have benefitted from the law. We are pleased that so many in Congress also recognize the need to preserve patient coverage.

We believe the legislation needs to be reviewed through this lens, and carefully evaluated regarding its impact on both individuals and the ability of hospitals and health systems which are the backbone of the nation's health care safety net in terms of our ability to care for all of those who walk through our doors.

Any ability to evaluate The American Health Care Act, however, is severely hampered by the lack of coverage estimates by the Congressional Budget Office (CBO). Lacking that level of analysis and needed transparency, we urge that Congress should wait until an estimate is available before proceeding with formal consideration. In addition to the lack of a CBO score, we have some additional policy concerns with the proposal.

For example, it appears that the effort to restructure the Medicaid program will have the effect of making significant reductions in a program that provides services to our most vulnerable populations, and already pays providers significantly less than the cost of providing care.

Providing flexibility to the states to expand coverage, and create innovative financing and delivery models to improve care and program sustainability, can be achieved through other alternatives. For instance, the expanded use of waivers -- with appropriate safeguards -- can be very effective in allowing state flexibility to foster creative approaches and can improve the program more effectively than through imposing per-capita caps.

In addition, the legislation repeals much of the funding currently dedicated to provide coverage in the future. Furthermore, we object to eliminating the funding from some sources, but leaving in reductions to payments for hospitals services. If coverage is not maintained at the current level, those resources need to be returned to hospitals and health systems in order to provide services to what will likely be an increased number of uninsured Americans.

At the same time, while we commend the recent actions by the Congress to address behavioral health issues, as well as the drug epidemic that is impacting virtually every community we serve, it is important to recognize that significant progress in these areas is directly related to whether individuals have coverage. And, we have already seen clear evidence of how expanded coverage is helping to address these high-priority needs. Health care coverage is vitally important to working Americans and their families. They rely on hospitals and health systems to provide them with access for their essential health care needs in a manner that is of the highest quality, not to mention the full range of critical life-saving services, including preventive benefits, that will further improve the quality of their lives and the health of the communities in which they live.

We recognize this measure represents the first step in a process. It is critical that this process be thoughtful and focused on finding ways to improve our health care system, particularly for the poor, elderly and disabled.

We ask Congress to protect our patients, and find ways to maintain coverage for as many Americans as possible. We look forward to continuing to work with the Congress and the Administration on ACA reform, but we cannot support The American Health Care Act in its current form.”

American Public Health Association

“This proposal would jeopardize the health and lives of many millions of Americans. It would dramatically reverse progress we’ve made in controlling health care costs and assuring quality care, and it would gut patient protections, investments in prevention and access to care for the most vulnerable Americans.

American lives are on the line. It is particularly troubling that legislators plan to consider this proposal without a score from the Congressional Budget Office. We urge House members to oppose this plan and instead strengthen our nation’s commitment to improving the health and safety of all Americans.”

American Nursing Association

“Summary Analysis of the American Health Care Act 2017

The House Energy and Commerce Committee and the House Ways and Means Committee released on March 6, 2017 concurrent budget reconciliation bills, referred to together as the American Health Care Act (AHCA). The legislation grew out of a January House budget resolution instructing the Energy and Commerce and Ways and Means Committees – the two primary committees with jurisdiction over health care – to draft legislative recommendations that the House

Budget Committee would compile into a single reconciliation package. This summary gives details on legislative recommendations included as of Monday March 6, 2017. The concurrent bills:

- Do not align with ANA priorities for health care transformation.
- Slash Medicaid funding, potentially jeopardizing access to health care for millions of Americans. o State budgets will be enormously impacted, as states will be forced to make the stark choice to either replace federal funding with state dollars or to reduce eligibility, services provided or provider payments.
- Change how healthcare is financed, particularly for those without employer-sponsored health care coverage.
- Offers Health Savings Accounts with higher allowable contributions; however, these forms of coverage will only be useful to high earners or those with extra savings to spare. (Read more about Health Savings Accounts here).
- Rollback employer-mandated health insurance by eliminating the ACA's requirement that employers with more than 50 employees pay for coverage.

The provisions under consideration by the House Energy and Commerce Committee will negatively impact the gains achieved under the ACA.

‘The proposal is not in alignment with the American Nurses Association’s core principles.’

ANA has opposed the plan. The bill restricts access to a standard package of essential health care services for all citizens and residents. It gradually eliminates the ACA’s Medicaid expansion and implements a per capita cap funding mechanism for state Medicaid programs, jeopardizing access to health care for the 11 million Americans who gained coverage through expansion. The bill restricts access to critical mental health and substance use disorder services in the midst of the nation’s opioid crisis.

‘Finally, the bill creates a Patient and State Stability Fund with a \$100 billion appropriation through 2026 for states to stabilize their health insurance markets and to create high risk insurance pools. While this will somewhat alleviate the cuts noted above, the funding available is grossly inadequate and will create a separate insurance market for high risk individuals who often have chronic and complex health conditions. The bill reduces the ability to optimize primary, community-based preventive services. While it provides for a \$422 million increase in funding for Federally Qualified Health Centers in FY 2017, it eliminates the Prevention and Public Health Fund and removes its nearly \$1 billion annual appropriation after FY 2018; this includes roughly \$325 million in funding for immunization programs and \$160 million in funding for Preventive Health and Health Services Block Grants..’

The bill also reinstates Disproportionate Share Hospital payments in non-Medicaid expansion states. This provides payments for uncompensated care costs to hospitals which see a high number of uninsured patients but does not replace the Medicaid funds paid to hospitals on behalf of hospitalized patients in the population covered under Medicaid expansion. The bill also moves away from the economic use of health care services and does not provide adequate supports for those who do not have the means to share in costs. It eliminates cost sharing subsidies for low-income individuals and families and replaces premium subsidies with age-based refundable tax

credits. The elimination of cost-sharing subsidies may increase the likelihood that some individuals defer preventive services due to their being unaffordable. This in turn will lead to poor health outcomes and greater reliance on costly emergency care. The age-based refundable tax credits will significantly decrease low-income seniors' financial assistance and impact their ability to receive care. The expanded use of Health Savings Accounts (HSAs), meanwhile, mainly benefits middle- and upper-class individuals and families who have the means to set aside money for these HSAs and who have a higher tax burden.

The bill is largely silent on nursing workforce issues or staffing levels. It does, however, increase federal funding for "safety net providers" in states that did not expand Medicaid. This could presumably include APRNs, though this is not specified in the bill's language. Analysis of the House Ways and Means Committee Bill This summary gives a close review and analysis of the Ways and Means Committee bill. Because the Ways and Means Committee is primarily tasked with tax-related issues, the bill and the content of this document primarily focuses on how the bill would change health care financing, and the implications of those changes if the ACA is repealed.

ANA remains steadfast in its health policy priorities and stands in opposition to the AHCA. AHCA tax provisions benefit wealthy taxpayers, health insurers and providers. State Medicaid programs and Medicaid beneficiaries could face severe cuts in federal funding to Medicaid and potential coverage losses. Seniors and individuals with chronic illnesses or who live in areas where care is costly also have cause for concern. While the AHCA tax credits should help these groups afford low actuarial value health care coverage, they would likely be unable to afford the high deductibles and other out-of-pocket costs that come with those plans. By contrast, individuals with high incomes and younger people stand to gain much under the AHCA's provisions. Tax credits the bill implements would help these groups better afford coverage than they could under the ACA, and would cushion their out-of-pocket costs via the more aggressive Health Savings Accounts (HSAs) that the AHCA creates. The AHCA repeals all of ACA taxes, and eliminates the penalties for individual and employer responsibility provisions. Other ACA taxes the bill would remove include the:

- tanning tax
- branded prescription drug tax
- health insurance tax
- Medicare tax imposed on unearned income for tax payers earning more than \$200,000 (\$250,000 for couples filing jointly)
- Cadillac Tax
- small employer tax
- prohibitions on paying for over-the-counter drugs with tax subsidized funds
- penalties for using tax subsidized funds to pay for non-medical purposes
- requirement that employers reduce their deduction for expenses allowable for retiree drug costs without reducing the deduction by the amount of the retiree drug subsidy
- the level of medical expenses that must be incurred to claim a tax deduction
- Medicare percent tax surcharge on tax payers with incomes exceeding \$200,000

All of these taxes would be eliminated by the end of 2017. The Joint Committee on Taxation projects that repeal of ACA taxes would result in costs totaling nearly \$600 billion over the next 10 years. Researchers at Brookings Institute have reported that repeal of ACA taxes would make it impossible to pay for an ACA replacement, and would worsen the fiscal problems facing Medicare. In January 2017, the Centers for Medicare and Medicaid issued a statement noting that ACA repeal would move forward Medicare Trust Fund depletion to 2025.

‘Echoing these findings, the Kaiser Family Foundation similarly reports that repealing ACA taxes would leave seniors, and individuals with low-incomes particularly disadvantaged in their ability to access health care. Despite these vast changes, the AHCA leaves some of the ACA’s taxes intact. Current taxes on high-cost, employer-sponsored health plans and the penalty for special business arrangements that exist only to avoid paying taxes remain. Two changes stand out amidst the AHCA provisions to alter ACA taxes. Premium tax credits can still be used to pay for health plans available off the exchanges or catastrophic plans, but unlike the ACA, the bill sets specific guidelines prohibiting the use of federal funds to pay for coverage that includes abortions...’

The AHCA also changes the current applicable percentages used to set the standard for income a taxpayer must spend to qualify for premium tax credits. Percentages would be defined based on age. Age based subsidies would have a negative effect on millions of working class and low-income families. Under the ACA, individuals and families were eligible for subsidies to help pay for premiums, deductibles and other out-of-pocket costs. ACA subsidies were based on household income. The shift away from adjustable, income-based subsidies to flat rate age-based tax credits would expose individuals across age groups to premium increases and higher health care costs.

More than repealing or changing to the ACA tax requirements, the AHCA also creates new tax credits. Beginning in 2020, taxpayers not offered employer-sponsored health insurance, or not eligible for government sponsored health insurance through Medicaid or Medicare, would be able to access the new tax credit. The new credit would be refundable and advanceable on a monthly basis through an insurance company, and could be used to pay for individual market premiums. The tax credit is age adjusted, and can be determined by adding up the total number of people eligible in a household to determine the credit amount. Children and adults younger than 30 can get a credit of up to \$2000; 30 to 39 year olds can get a credit of up to \$2500; 40-49 year olds can receive a credit of up to \$3000; 50 – 59 year olds can get a credit of up to \$3500; and 60 years old up to Medicare recipient age would receive up to \$4000. The maximum amount available is \$14000, and only the five oldest people in a family could be counted towards the calculation. Income eligibility for the new tax credits begin to phase out at \$75,000 for individuals and \$150,000 for couples filing jointly. Following the AHCA tax credit model, a family of four with two adults and two children could earn a tax credit of up to \$10,000: \$3000 for each parent and \$2000 for each child. If that same family chose a plan costing \$12,000 per year, or \$1000 per month, that family would have to pay \$2000 out of pocket, or \$167 per month. The tax credit would reduce the premium dollar for dollar paid up front each month. The family in the above example would still receive the tax credit even if they have zero tax liability.

The bill's provisions for new tax credits also come with many stipulations. Taxpayers who do not claim enough of a credit during the year would be eligible for a tax credit when filing their income taxes for that year. On the other hand, taxpayers claiming too much of a tax credit during the year, would have to pay it back when filing a return for that year. Other stipulations include requirements that only U.S. citizens and legal residents, and individuals not receiving Medicare or Medicaid could be eligible for the tax credits. Prisoners or other individuals awaiting disposition of charges would be ineligible for the tax credit.

The AHCA uses Health Savings Accounts (HSAs) to fundamentally change how health care would be financed, particularly for individuals not offered health insurance coverage through an employer. HSAs are not new. They predate, and were included in the Affordable Care Act. Each of the previous Republican ACA replacement plans included HSAs to subsidize health care, and help consumers pay out-of-pocket costs. Funds in health savings accounts are intended for use in the event of a catastrophic or unexpected medical emergency until health insurance kicks in. Unspent money can be rolled forward and ultimately serve as savings accounts.

Under the ACA, individuals and families could contribute a maximum of roughly \$3550 for individuals and \$6700 for families, but the amount of those contributions nearly double in the proposed bill. The promise of the health savings accounts might seem like a good deal; however, in reality many Americans lack the extra savings to contribute to HSAs. Further, the HSA scheme offers no immediate benefits for people with chronic conditions such as diabetes or hypertension, or a cancer patient who may drain his HSA account to pay for costly care only to later discover he needs another round of costly treatments. For a low-income family with little or no tax liability at all, HSAs have no value. In the event these families face a catastrophic or unexpected medical event, the American Health Care Act does not offer enough coverage. Ultimately HSAs and the new, higher allowable contribution limits weigh in favor of those with the means to make contributions.

In summary, the American Health Care Act is a plan that does not deliver on the Republican promise to increase access, choice, and control for individuals, families, and states. The plan in its current form severely cut ACA taxes, and eliminates ACA subsidies that allowed millions of people to pay for health care premiums, deductibles, and other out-of-pocket costs. As of Wednesday, March 7 the bill had not been scored by the Congressional Budget Office. In January 2017, the CBO warned that ACA repeal could be devastating and lead to enormous coverage losses and higher costs for millions of people. House Republicans have ignored CBOs warnings, and instead have written a health care path that could have devastating implications for millions of people, our health care financing system, and our economy.”

National Disability Rights Network

“The legislation revealed by House Republicans last night is a giant step backwards in the treatment and care of individuals with disabilities.

It repeals the expanded Medicaid match that encourages the community integration of people with disabilities and counters biases that lead to institutionalization. It permits discrimination against people with disabilities in the insurance market for their pre-existing conditions. It caps Medicaid funding which means a sharp reduction in services and availability of this important health care lifeline for children and adults with disabilities. In short, this plan is terrible.

The National Disability Rights Network urges the House not to send people with disabilities back to a time when it was nearly impossible for us to obtain health insurance, live in the home of our choice or participate in community life. We will never go back to those days. Never.”

National Partnership Women and Families

“House Republicans’ Affordable Care Act (ACA) repeal bill would wreak havoc on our health care system by making health coverage more expensive and inadequate for millions of women and families. The shroud of secrecy surrounding the Republicans’ process and their attempt to sneak through a bill that would have such a devastating impact, without allowing anyone to review it, is shameful.

Now that the bill has been revealed, it is clear why Republicans didn’t want people to see it. Their proposal radically overhauls and cuts Medicaid while simultaneously gutting the ACA by repealing financial assistance for low-income families and making it harder for people to afford coverage. It also defunds Planned Parenthood from the Medicaid program, denying 2.5 million people access to essential health care.

The proposal jeopardizes the Essential Health Benefits (EHB) standard for our nation’s most vulnerable. The EHB standard is a groundbreaking advance for women’s access to quality insurance coverage.

Moreover, the Republican bill interferes with women’s ability to make health care decisions by making abortion coverage inaccessible. It would harshen and expand already harmful abortion coverage restrictions, denying women the ability to access the care they need.

The Republican repeal bill is an affront to women and families. It reflects its authors’ determination to deny women access to quality, affordable health care, including the comprehensive reproductive health care and abortion services that are essential to their health, equality and economic security.

This bill takes us back to the days when there were few benefit standards or consumer protections in place – to a time when insurers were the ones who decided what and who they would cover, what doctors we could see, and where we could get care.

We demand an open and transparent process that enables the public to see what’s really in these plans and how it will affect their health and wellbeing. Right now, this Congress seems hell bent on taking health coverage away from tens of millions of people, increasing health care costs for working people, and destroying Medicaid. Our country’s women and families deserve better.”

National Physicians Alliance

“The National Physicians Alliance opposes the draft Republican House bill revealed last night. We believe the drastic cuts it proposes to Medicaid, coupled with the substantial reductions in subsidies that helped millions afford healthcare would be extremely detrimental to our patients.

Moreover, the bill would, in effect, shift huge costs onto working families, force many to pay more for worse coverage and push millions of American off of health coverage entirely. All the while, the proposed legislation hands millionaires, billionaires and health insurance CEOs a massive new tax break.

The National Physicians Alliance supports efforts to improve healthcare in America. However, we believe the misguided priorities in this bill would move us in the wrong direction.”

AFL-CIO

“Millions of people will lose their health care coverage thanks to a plan introduced by Congressional Republicans. This haphazard “repeal and replace” effort would result in painful taxes on working families, cuts to Medicaid, and tax giveaways for the super-rich. Of all the bad ideas in this flawed plan, forcing workers to pay a so-called “Cadillac tax,” on employer provided health care has to be among the worst. That’s a terrible plan for healthcare in America.

The reality is, this isn’t a healthcare plan at all. It’s a massive transfer of wealth from working people to Wall Street. For more than a century, the labor movement has fought to make health care a right for every American. The Republican plan contradicts this very idea by making care less affordable and accessible. It’s bad for healthcare, it’s bad for working families, it’s bad for our economy and we will fully oppose it.”

American Federation of State, County, and Municipal Employees

“The replacement plan put forward by congressional leadership is no replacement at all for the tens of millions of Americans who rely on the Affordable Care Act to keep their families healthy without fear of bankruptcy. It is simply a tax cut for corporations and the wealthy, funded by gutting Medicaid and shifting health care costs onto states and working families.

This so-called replacement plan strips women of access to vital preventive care services by defunding Planned Parenthood. It endangers Medicare solvency and allows insurance rates for older Americans to skyrocket. Millions of working people, children and people with disabilities will be put at risk. In fact, some of the only interests who stand to gain from this plan are the health insurance and pharmaceutical corporations that will receive massive tax breaks, paid for by increasing out-of-pocket costs for patients.

Though this bill has been kept secret, and congressional leadership has failed to provide lawmakers and the public with a CBO score for their legislation, we already know that it will leave millions without coverage. But the questions remain – how many will lose their coverage, and at what cost to jobs, local economies and state budgets? No vote should occur on this legislation until those questions are sufficiently answered.”

National Council of La Raza (NCLR)

“This bill is a threat to America’s well-being and represents a step back to the days when health insurance was financially out of reach for too many working Americans. Our nation’s future depends on healthy and hard-working families. The changes to Medicaid will devastate a program that is a lifeline for 74 million vulnerable Americans, including children, people with disabilities, and 18 million Latinos. This effort to radically change the financing structure of Medicaid will jeopardize their lives.”

Asian & Pacific Islander American Health Forum

“Many things are clear from the bill, yet many unknowns remain. What we know is that millions of Americans, including Asian Americans, Native Hawaiians and Pacific Islanders (AAs and NHPs) relying on coverage under the ACA will be worse off. Under the guise of flexibility, this plan would end Medicaid as we know it by phasing in per-capita caps. Under the guise of access, the bill would reduce the financial support that is allowing millions of low- and moderate-income Americans to afford their monthly premiums. House Republicans would offer fewer tax credits to individuals and families by restricting eligibility to citizens, nationals and “qualified aliens” under the Personal Responsibility and Work Opportunity Reconciliation Act definition. In contrast, the ACA provides assistance to all lawfully present persons. Limiting tax credits only to persons who are citizens or “qualified aliens” would render many immigrant groups with lawful status ineligible, including Compact of Free Association (COFA) migrants. More than eight in 10 previously uninsured AAs and NHPs qualify for financial assistance through the ACA.

At the same time, the Centers for Medicare & Medicaid Services has proposed changes that would make it harder for consumers to sign up for and access affordable quality health coverage that they are eligible for under the ACA. The proposed rule, with a comment period ending today, would undermine the strength of the health insurance Marketplaces while reducing access for consumers.

In total, members of Congress who oppose the ACA are putting aside regular order to dismantle the law without fully explaining their plans. House Republicans are pushing this bill through committees without a score from the Congressional Budget Office and not taking into account the potential impact on the lives of 20 million Americans, including 2 million AAs and NHPs who stand to lose coverage if the law is repealed.”

National Committee to Preserve Social Security & Medicare

“On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I write to ask you to reject proposals being considered as part of the Affordable Care Act (ACA) repeal that would harm seniors by driving up their out-of-pocket costs for prescription drugs and preventive services, and hastening Medicare’s insolvency.

Since passage of the ACA, nearly 12 million people with Medicare have saved over \$26.8 billion on prescription drugs, an average of \$2,272 per beneficiary. The ACA reduces prescription drug prices for seniors and closes the coverage gap, known as the “donut hole.” Prior to passage of the ACA, Medicare beneficiaries paid 100 percent of the cost of their drugs when in the coverage gap; under the ACA, beginning in 2011, beneficiaries paid a reduced cost for brand name and generic

drugs. In 2017, Medicare beneficiaries in the donut hole receive a 60 percent discount on brand-name drugs and a 49 percent discount on generic drugs. The law closes the coverage gap in 2020 when beneficiaries will pay 25 percent of the cost of their drugs, what beneficiaries pay now before entering the donut hole.

Under provisions of the ACA, Medicare beneficiaries are eligible to receive many preventive services with no out-of-pocket costs – no coinsurance or Part B deductible. These services include flu shots and tobacco cessation counseling, as well as screenings for cancer, diabetes, cardiovascular disease and other chronic diseases. Seniors can also get an annual wellness visit so they can talk with their doctor about any health concerns. Over 40 million seniors received at least one preventive service with no out-of-pocket costs in 2016, and over 10 million beneficiaries made an annual wellness visit.

In addition, the ACA reduced the rate of increase in Medicare payments to providers and, over a six-year period, reduced overpayments to Medicare Advantage plans to bring them closer to the costs of care for a beneficiary in traditional Medicare. These reductions in Medicare spending, estimated by the Congressional Budget Office (CBO) to be \$802 billion over ten years, are lowering costs for Medicare beneficiaries.

These reductions in spending not only make the Medicare program more financially sustainable, they reduce costs for seniors. The Part A deductible and copayments for inpatient hospital and skilled nursing facility care are based on hospital payments; lower payments mean lower out-of-pocket costs. The Medicare Part B premium, which covers 25 percent of program costs, and the Part B deductible, which increases at the same rate as the Part B premium, are lower than they were projected to be before passage of the ACA due to lower increases in program spending.

The ACA also includes important delivery system and payment reforms designed to bring down Medicare's costs in ways that don't harm care. For example, the ACA established the Center for Medicare and Medicaid Innovation (CMMI) to develop and test new ways of delivering and paying for care that are intended to improve quality while reducing the rate of growth in Medicare spending. These include Accountable Care Organizations, bundled payments and medical homes – all of which are intended to provide incentives to physicians and others to provide high-quality coordinated care for beneficiaries, especially those with multiple chronic conditions and those dually eligible for Medicare and Medicaid. The ACA also aims to improve care and save costs through programs to reduce hospital acquired infections and unnecessary hospital readmissions by coordinating care and services for patients when they leave the hospital.

The ACA has improved Medicare Advantage plans for enrollees. From 2010-2017, the average MA premium is projected to have decreased by 13 percent and enrollment to have increased by 60 percent – to 18.5 million Medicare beneficiaries (32 percent). Since 2014, the ACA provides additional protections for MA plan members by limiting the amount these plans spend on administrative costs, insurance company profits, and items other than health care, to 15 percent of their Medicare payments. Also, due to the ACA, MA plans can no longer charge enrollees more

than traditional Medicare for chemotherapy administration, skilled nursing home care and other specialized services.

The ACA is a highly complex piece of legislation that includes many benefit increases for seniors on Medicare, contains many program improvements that help to drive the cost of health care down and extends the solvency of the Part A trust fund. For these reasons, we strongly believe that any replacement legislation should do no less than the ACA for our senior population.”

Catholic Health Association of the United States

“We are strongly opposed to the House GOP’s Affordable Care Act (ACA) “Repeal and Replace” legislation that asks the low-income and most vulnerable in our country to bear the brunt of the cuts to our health care system. In addition to moving away from an effective coverage expansion that has provided health care to more than 20 million working people, this proposal would also take many backward steps in the continual effort to improve our health care system, including:

- Capping federal financing for the Medicaid program, which will lead to major reductions in benefits and coverage for vulnerable families
- Eliminating cost-sharing subsidies for low-income people
- Eliminating the income affordability adjustment for tax credits
- Penalizing individuals with pre-existing conditions with a 30% monthly premium surcharge for a year, should they have a lapse in coverage
- Creating barriers to initial and continuing Medicaid enrollment

This will substantially increase the number of uninsured people and uncompensated care costs for safety net providers. This nation is too great a country to pass legislation that substantially increases the number of uninsured by taking away coverage individuals and families just obtained, increases uncompensated care and disrupts the insurance market for the entire nation.

The Catholic Health Association’s Vision for U.S. Health Care calls for health care to be available and accessible to everyone, paying special attention to poor and vulnerable individuals. Radically restructuring the Medicaid program—with per capita caps or block grants—fundamentally undermines coverage for over 70 million poor and vulnerable children, pregnant women, elderly and disabled individuals in our nation. Federal Medicaid funding caps simply shift the cost burden onto local and state governments, providers and individual beneficiaries, ultimately leading to the loss of Medicaid coverage for millions of individuals.

The ACA is not a perfect law, and we have always said it should be improved where necessary. This new plan does not improve the law—instead, it undermines it and leaves behind millions of people who have obtained meaningful, affordable insurance that was not possible before the ACA.

We strongly encourage the full House to reject this ‘replacement’ bill and work to craft legislation that addresses the real issues without creating unneeded chaos in the system and coverage loss for those who need health care.

While there are many opportunities to improve both the Affordable Care Act and the Medicaid program by creating greater flexibility for state innovation, we believe this proposal will simply erode the safety net and jeopardize the health and economic safety of millions of Americans. We stand ready to work with all members of Congress to improve the availability, affordability, coverage and quality of our health care system in ways that do not harm those who need our help and support.”

American Federation of Teachers (AFT)

“Ripping healthcare away from Americans to give huge tax breaks to the wealthy is about as cruel as it gets. This isn’t a healthcare plan—it’s a massive giveaway to insurance companies and those at the top, while it hits America’s families with a triple whammy of less coverage, higher costs and more taxes. This bill will potentially leave millions without coverage.

“That Republicans are now trying to ram something through after keeping it under lock and key makes it clear that they want to hide the details and cost from the American people. If something sounds too good to be true, it is. They know that if their true intent were exposed, Americans would soundly reject their efforts.”

National Education Association

“It’s time for the Republican leadership to come clean with the American people. Repealing the ACA will harm our students and their families by forcing cuts to critical programs, reducing financial support for lower-income Americans, and taxing the middle class. Bottom line, working Americans will pay more for less coverage while insurance executives and the wealthy get handouts.

The ACA expanded coverage to more than 20 million previously uninsured Americans, dramatically reducing the number of uninsured children in this country. The Republican leadership plan will reverse those gains, leading millions to potentially lose coverage while making drastic cuts in Medicaid funding, benefits, and eligible beneficiaries, and forcing some states to consider diverting money from education to health care.

Medicaid’s support for school-based health services will also suffer under the Republican leadership plan. Mental health care, vision and hearing screenings, diabetes and asthma management are just some of what school children stand to lose.

We will continue to defend the ACA and Medicaid, our country’s health care safety nets, and quality, affordable coverage for children and working families. It’s time for Congress to do the same and look out for students and ordinary Americans.”

American Federation for Suicide Prevention

“Suicide is currently the 10th leading cause of death in the United States. Every year 1 in 5 Americans struggle with a mental illness and veterans account for 1 in 5 suicide deaths. 1.1 million Americans attempt suicide every year.

The American Foundation for Suicide Prevention (AFSP) has set a bold goal to reduce the U.S. suicide rate 20% by 2025. Research has shown that treating the underlying mental health conditions that can lead to suicide is critical to preventing this tragic loss of life, which claims the lives of more than 43,000 Americans every year. Maintaining and increasing access to mental health and substance use treatment will help us achieve this 20% reduction in the suicide rate and save tens of thousands of lives.

As you consider making changes to the Affordable Care Act (ACA), AFSP urges you to keep important provisions that can help prevent suicide including:

- Continued inclusion of mental health and substance use parity as an essential health benefit
- Elimination of annual and lifetime caps
- Preserving coverage of pre-existing conditions
- Expanding access to care and preventive health coverage
- Guaranteed coverage of people under their parent’s health plans up to the age of 26
- Preserving funding of programs like Medicaid and Medicare to ensure access to mental health services for low income and elderly populations

We must ensure the gains we have made in mental health and substance use disorder coverage remain in place so every American has a path to a more healthy and productive life. Let us stand together to make this happen.

The American Foundation for Suicide Prevention is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that’s smart about mental health through education and community programs, develops suicide prevention through research and advocacy, and provides support for those affected by suicide. AFSP has 85 chapters in all 50 states with programs and events nationwide. In addition AFSP has tens of thousands of grassroots volunteers who are very concerned about maintaining parity and equal access to mental health and addiction services.”

Cystic Fibrosis Foundation

“The bills released by the two House committees this week fail to adequately protect people living with cystic fibrosis and place the lives of millions of Americans living with serious and chronic diseases at risk.

The CF community has come so far in the fight against this deadly disease, and it's crucial that this progress is not jeopardized by inadequate, unaffordable health care coverage. At a time when advances in CF care are more promising than ever, these measures could restrict our community's access to existing therapies as well as new treatments as they become available.

In particular, we are concerned that:

The legislation would effectively eliminate Medicaid expansion and alter its financing structure in a way that would put coverage of new and innovative treatments at risk. Medicaid provides a

critical source of health care coverage for half of children and a third of adults with CF. We must preserve this safety net by retaining expanded eligibility and ensuring adequate funding for Medicaid.

The bills do not support an individual market that works well for people with intensive health care needs, including people with CF. By providing states with funds that could be used for a wide range of activities -- including high-risk pools, reinsurance, provider payments and programs to promote access to preventive services -- these bills offer no assurance that, regardless of where they live, people with CF will be able to purchase an adequate, affordable plan in the individual insurance market.

The legislation inadequately supports young people with high health care needs by basing financial assistance primarily on age rather than income. This could leave younger individuals with CF without enough support to purchase a plan that covers the breadth of their specialty care. This is particularly important for our community, as 75 percent of people with CF are younger than age 30.

We commend lawmakers for not exposing patients to higher premiums based on their health care status when they have a gap in coverage, as was put forward in other proposals. On behalf of the CF community, we urge members of Congress to protect and address the needs of people with cystic fibrosis, a life-threatening disease. We look forward to working with members of Congress as they continue to refine this legislation and will evaluate any bills through the lens of our policy principles.

HIV Medicine Association

“The HIV Medicine Association is deeply concerned about the impact of the House ACA replacement bill on the health and lives of the 1.2 million Americans living with HIV. The private insurance market elements, such as the requirement for continuous coverage and the insufficient tax credits for lower income individuals, will likely shut the door on coverage in the individual insurance market for most people with HIV. Forty percent of individuals with HIV in care rely on the Medicaid program for their healthcare coverage. The House proposal to fund Medicaid based on a per capita cap will shift costs to the states and threaten access to healthcare services and treatment for the hundreds of thousands of individuals with HIV who are covered by the program. If advanced, the ACA replacement bill stands to threaten our progress in diagnosing and treating patients with HIV and increase healthcare disparities both between states and based on socioeconomic status. These proposals will not only harm individuals with HIV but will compromise our nation’s public health by leaving fewer with access to the antiretroviral treatment that keeps patients healthy and reduces their risk of transmitting HIV to near zero. We strongly urge the committees to reconsider the bill and the accelerated and non-transparent process with which these proposals have been advanced.”

Leadership Conference on Civil and Human Rights

“This proposal is truly disheartening. It doesn’t ensure that all Americans will continue to have health coverage, as its supporters claim. Rather, it drastically cuts financial assistance for low-income people living at or below the poverty line, undermines and places severe limitations on the Medicaid expansion, and proposes to defund Planned Parenthood centers from the Medicaid program.

Repealing and replacing the ACA and restructuring Medicaid with this plan would be detrimental to many communities that The Leadership Conference represents, in particular people of color and underserved populations. The ACA has resulted in millions of Americans gaining access to affordable and quality health care. Our most vulnerable populations are at risk of losing the coverage on which their lives depend.

We need a plan that serves the health needs of all Americans. This plan would do just the opposite and should be rejected”

MomsRising

“The House Republican plan to obliterate the Affordable Care Act and replace it with a plan that would make health insurance less affordable, less accessible, and less comprehensive is a dangerous step in the wrong direction. This bill would create a health care crisis by throwing millions of people off of their insurance. If it is enacted, fewer people would be covered and those who do have insurance would have weaker protections and face significantly higher costs. It is now clear why House Republicans tried to hide this bill for so long. Congress must reject it immediately.

The American Health Care Act makes a mockery of every campaign promise Donald Trump made about health care. It sets the stage for deep, punitive, permanent cuts to Medicaid in just a few years, which would cause grave harm resulting in rationing care for some of the most vulnerable people in our country: Black, Latinx, Asian, Native American, LGBTQ+, and low-income families; as well as pregnant women, people with disabilities, and the elderly. The Republican plan would allow insurance companies to raise premiums and out-of-pocket costs, especially for seniors. The only winners would be the wealthy, and the losers, as too often is the case, would be women, communities of color, and all those who struggle to pay for health coverage and care.

The GOP plan would put coverage out of reach for millions of families. It undermines one of the Affordable Care Act’s (ACA’s) greatest achievements—granting protection to those with pre-existing conditions—by forcing those with any significant gap in their insurance coverage to pay hefty penalties. Experts agree, this could lead to a toxic health care environment in which only those who are sick and can afford coverage get the health care they need.

It would be devastating for people like MomsRising member Helena of Plantation, FL, who is a self-employed, single mother of three. Helena could not afford health insurance but, once the ACA was implemented, she applied and was approved, with her kids, for Medicaid coverage. But because Florida didn’t participate in the Medicaid expansion, she was ‘kicked off’ in 2016. Luckily,

she says, ‘I was able to get coverage under the ACA, and qualified for the tax credit, so I’m still insured. I worry that my insurance will be taken away, and that my kids will no longer be covered.

Further harming the health of women and families, the American Health Care Act would defund Planned Parenthood, cutting off health care—including birth control, cancer screenings and other essential health services—for millions of women who have no other health care provider.

Simply put, this legislation would mean America’s moms and families pay more for less comprehensive coverage, putting our families’ and country’s economic security at risk.

MomsRising members have put pressure on Congress since January to reject a repeal of the ACA. Last month, our members delivered books with hundreds of stories from people who rely on the ACA, Medicaid, Medicare and CHIP to congressional offices in Washington D.C. and across the country to educate lawmakers about the impact of those programs. Thousands more have sent letters and made phone calls urging representatives to protect our health care coverage. We will work tirelessly to ensure that the American Health Care Act does not become law. Every lawmaker who supports it will have to answer to constituents.”

Children’s Defense Fund

“The American Health Care Act threatens progress at a time when we must continue to move forward, not backwards for children. We urge you not to move the act out of committee without major revisions for children.” – Marian Wright Edelman

The Children’s Defense Fund is urging Leadership in the House Ways and Means and Energy and Commerce committees to not move the "American Health Care Act" forward out of committee. The bill to repeal the Affordable Care Act and decimate Medicaid was released March 6 and committee action is scheduled to begin today. The "American Health Care Act" takes from the poor to give hundreds of millions of dollars in tax breaks to the wealthy who need it least. The bill destroys Medicaid’s 50 year guarantee of affordable, comprehensive health coverage to poor and low income children and children with disabilities.”

Families USA

“The GOP health care proposal would be laughable if its consequences weren’t so devastating.

This bill would strip coverage from millions of people and drive up consumer costs. It shreds the Medicaid social safety net that serves more than 72 million people, including many children, senior citizens and people with disabilities. And it once again leaves millions of people in America with chronic illness and disease at the mercy of insurance companies.

And they’re doing this without knowing the bill’s full impact on the federal budget.”

Consumers Union

“Consumers should be able to understand the final bill before it is marked up and they deserve to see a score from the nonpartisan Congressional Budget Office to show the budgetary and coverage implications. The likelihood that this bill covers far fewer consumers (and those less fully) than

those who received coverage under the ACA further makes a rushed, secretive process a wholly inadequate way to proceed.”

Sister Simone Campbell, NETWORK Advocates for Catholic Social Justice

“Our test for any ACA replacement bill is simple: Does the bill protect access to quality, affordable, equitable healthcare for vulnerable communities? After reviewing the House GOP replacement bill, the answer is a resounding no. Instead of providing greater health security, the bill increases costs for older and sicker patients and drastically cuts the Medicaid program, all while providing huge tax cuts to wealthy corporations and individuals. This is not the faithful way forward and must be rejected.”

Young Invincibles

“House Republicans introduced a bill to repeal and replace the ACA, which would have devastating effects on millions of young adults, a group which has seen the greatest health care gains under the ACA: in the past six years, Millennial uninsurance rates have dropped from 29 percent to 16 percent.”

Planned Parenthood

“One in five women in America has relied on Planned Parenthood, and their health care shouldn't get caught up in congressional Republicans' extreme agenda. This proposal would deny millions of women access to cancer screenings, birth control, and STD testing and treatment.”

5 HEALTH ECONOMISTS' VIEWS

U.S economists expressing opposition to Senate healthcare bill

“A group of economists that includes six Nobel Prize winners is expressing opposition to Senate Republicans' legislation to replace ObamaCare, arguing that it "threatens reduced coverage and higher costs for those who continue to have it.”

“In a letter to Senate Majority Leader Mitch McConnell (R-Ky.) and Senate Minority Leader Charles Schumer (D-N.Y.), the economists wrote that "the Senate bill would narrow coverage, and by driving relatively healthy people from the market, raise premiums for those who remain.”

“The Senate healthcare bill unveiled last week does away with ObamaCare's individual and employer mandates, caps federal Medicaid spending and makes cuts to ObamaCare's tax credits. Senate GOP leadership is aiming to hold a vote on the measure this week.

“The economists said they think it is likely that the Senate bill would reduce coverage for almost as many people as the House-passed bill. The Congressional Budget Office predicts that the House bill would result in 23 million fewer people having insurance over a decade.

"At a time when economic change is making life more difficult for all but the relatively well-to-do, denying people to access health insurance is a giant step in the wrong direction," the economists wrote in the letter, first reported by Vox.

"The economists also argued that the Senate bill would reduce help for people that are currently buying health insurance through federal and state exchanges. And they criticized the Senate bill because it would largely use savings from cutting healthcare subsidies and coverage to cut taxes for high earners.

"The economists spoke positively about ObamaCare, also known as the Affordable Care Act, because it "has provided high quality, affordable health coverage for millions of previously uninsured Americans and helped to slow the growth of health care spending."

"While they said ObamaCare isn't perfect, they also argued that the Senate bill doesn't address their concerns.

"We call on Congress to work on legislation to improve the health delivery system, in general, and The Affordable Care Act, in particular," the economists wrote. "The goal should be to hold down health costs and increase access to affordable, quality health coverage for all."

"A total of more than three dozen economists signed the letter, including Nobel Laureates Peter Diamond of the Massachusetts Institute of Technology, Oliver Hart and Eric Maskin of Harvard University, Daniel Kahneman of Princeton University, Daniel McFadden of the University of Southern California and Al Roth of Stanford University."

"As Republicans struggle to find an acceptable replacement for Obamacare, a task that does not yet appear to be complete given the growing opposition to their recent proposal, they would do well to remember the words of the person who invented healthcare economics, Kenneth Arrow.

"Professor Arrow, a Nobel Prize-winning economist who recently passed away at the age of 95, argued that the market for healthcare is not like other markets for several reason

"Healthcare often involves large, unexpected expenses. To be able to pay these large expenses if and when they occur, people must have adequate savings or the ability to borrow when needed to cover the costs. But even that may not be enough, an individual may not have saved enough or be able to borrow enough to cover necessary healthcare costs. In the face of such uncertainty – not even knowing who will need healthcare and when – pooling money into an insurance fund and then sharing the risk of a major expenditure across individuals is a natural way to handle this uncertainty.

"But health insurance markets have the well-known problems that are difficult to overcome. First, there is what economists call moral hazard – people tend to take more risks when they are insured or seek healthcare for trivial ailments. The insurance company is paying, so why not? Deductibles, which make it costly to take risks or get help for minor problems, are one way to overcome the moral hazard problem.

“The bigger problem is called “adverse selection.” When people are pooled together in an insurance fund some will have very high expected medical costs (due, for example, to pre-existing conditions), others will have low expected costs, and the premium they are charged will reflect average healthcare use. For the healthy, that’s a bad deal – the premiums are more than their expected health spending. So many of them won’t purchase insurance (and the emergency room is available for serious problems, and if the bill is big enough someone else will end up paying). That leaves more people with high expected health costs in the insurance pool, leading to higher premiums and more dropouts, a process that continues until only the highest cost patients are left and the premiums are unaffordable.

“One way to stop this spiral to market collapse is a mandate that keeps healthy people in the insurance pool. The mandate in Obamacare wasn’t strong enough, and too many relatively healthy (and often young) people went without insurance. The mandate in the Republican proposal is even weaker and actually creates an incentive to go without insurance. The penalty for going without insurance does not occur until you sign up for insurance after a lapse, so the rational thing to do is to wait as long as possible before getting insurance. It’s hard to see how this will work.

“The presence of insurance companies in the health services market creates another problem. It means people are going to have their choices – what will be paid for, the type of care, etc. – determined by insurance companies and the policies they offer. Unlike most other goods, you can’t choose whatever health care treatment you want. The insurance company must approve it, and insurance companies will deny payment whenever possible. They have whole staffs devoted to finding reasons to deny payment, so some type of regulatory oversight is needed to ensure consumers get the care they were promised.

“But the most problematic aspect of delivering healthcare in the private marketplace is that consumers do not have the information they need to make informed healthcare choices. What type of implantable heart monitor is best? If they are on sale down the road, can I trust the quality? Do I even need this procedure – are there other treatments that are equally or more effective? Doctors often disagree, if they don’t know the answers, how can I make informed choices?

“We often don’t care about information problems; for example, the market for wine certainly involves a great deal of uncertainty on behalf of consumers. In many cases, people likely pay far too much for wine due to their lack of knowledge. But unlike health care, the consequences of making a bad wine choice won’t end up harming your health permanently, or maybe even causing death. When market failures have potentially severe consequences, such as in healthcare or the financial sector, regulation is needed to insulate against very costly outcomes for individuals or the economy as a whole.

“How can the information problem be solved? One way is through professional standards, certification, and self-policing within the medical profession. We expect more from doctors than we expect from, say, car salespeople. We expect doctors to guide us in making the best possible

healthcare choices, but I have no such expectation when I buy a car. Doctors could sell all sorts of unnecessary tests, follow-ups, etc. to unwitting consumers – think of all the unnecessary add-ons you are pressured to purchase after agreeing to buy a car – but we expect more from medical professionals.

“In this regard, Professor Arrow made an interesting comment in an interview in 2009 when asked if anything had changed since he wrote his path-breaking paper on health economics decades ago:

“If you look closely at my argument there is a sociological structure. There is a kind of sociological thesis. The market won't work -- it doesn't work well in the health context. But something else supplements the market, and the thing I put stress on in the paper are the elements that put a non-economic influence on the market: professional commitments to provide a service, to engage in services that aren't self-serving. Standards of caring decided by non-economic actors. And one problem we have now is an erosion of professional standards. In a way, there is more emphasis on markets and self-aggrandizement in the context of healthcare, and that has led to some of the problems we have today.”

“Another way to overcome the information problem is to let an informed agent make decisions on your behalf. This is the role that institutions such as HMO's are supposed to play. But HMOs make less money when consumers receive more care, and consumers do not trust HMO-type institutions to make important decisions about their health. Thus, regulatory oversight is needed to make sure that insurance companies are delivering policies that provide adequate coverage, and that consumers can get the care they pay for.

“That does not end the long, long list of problems in healthcare markets. For example, if everyone around me is healthier, I am less likely to get sick, so there are what economists call “externalities” in these markets. When externalities are present, the private sector will not produce the socially desirable quantity of a good. Government mandates that, for example, require people to be vaccinated against some diseases can overcome this problem.

“When you put all of these problems together, especially the information problem, professor Arrow's assertion seems clearly true. The market for healthcare does not operate like most markets. Government involvement is needed to ensure consumers get the care they need, and to ensure that care providers are not taking advantage of consumer's lack of knowledge.

“Once the need for government involvement to overcome market failures is accepted, and to me, it seems impossible to deny, the question is how well a particular healthcare proposal addresses these problems. Obamacare is not perfect, and some tweaks were needed. But it did a pretty good job of tackling these varied and difficult problems in healthcare markets.

“However, the Republican plan does not even seem to recognize the full extent of the problems in healthcare markets, and when it does, the remedies are far from adequate. Anyone who is

serious about a delivering broad-based, affordable healthcare insurance should give it two bigly thumbs down.”

Heritage Foundation

“The key problem with the draft House health care bill is that it fails to correct the features of Obamacare that drove up health insurance costs. Instead, it mainly tweaks Obamacare’s financing and subsidy structure.

“Basically, the bill focuses on protecting those who gained subsidized coverage through the law’s exchange subsidies and Medicaid expansion, while failing to correct Obamacare’s misguided insurance regulations that drove up premiums for Americans buying coverage without government subsidies.

“That is both a policy problem and a political problem.

“About 22 million individuals currently receive subsidized health coverage through the exchanges (8 million) and the Medicaid expansion (14 million). For them, Obamacare’s higher insurance costs are offset by the law’s subsidies. However, that is not the case for another group of about 25 million Americans with unsubsidized individual-market coverage (10 million people) or small-employer plans (at least another 15 million people).

“Those 25 million are the ones who most need relief from Obamacare, and have the strongest motivation to politically support repeal and replace. Their lived experience of Obamacare has basically been “all pain, no gain,” as they have been subjected to significant premium increases and coverage dislocations with no offsetting subsidies.

“Unfortunately, the draft House bill provides no meaningful relief for that group that is most adversely affected by Obamacare and most supportive of repeal.

“Instead, the draft bill leaves Obamacare’s costly insurance regulations in place, and attempts to offset those costs with even more subsidies—a variant of the same basic approach in Obamacare.

“New Subsidy Program

“In that regard, the draft bill’s new “Patient and State Stability Fund” is particularly problematic. That program would provide grants to states of up to a total of \$100 billion over the nine years 2018-2026.

“There are a several significant problems with this new program.

“First, it substitutes new funding for old Obamacare funding without adequately addressing the misguided Obamacare insurance market rules and subsidy design that made the exchanges a magnet for high cost patients.

“Those mistakes in Obamacare created an insupportable burden on the individual insurance market by concentrating expensive patients in only that small portion of the total market.

“Second, like Obamacare, it doesn’t actually reduce premiums, but rather masks with subsidies the effects of Obamacare provisions that drove up premiums in the first place.

“Third, it creates a new entitlement for states. Furthermore, without a resulting reduction in unsubsidized premium levels, future Congresses will likely face pressure from states and constituents to extend and expand the program.

“The Medicaid Problem

“The draft bill also fails to wind down the Medicaid expansion and may encourage states to add enrollees.

“Under the Medicaid expansion, the federal government reimbursed states 100 percent of the cost of expanding Medicaid to able-bodied adults, with federal support eventually declining to 90 percent.

“Yet, states continue to receive significantly less federal assistance (50 percent to 75 percent, depending on the state) for covering the more vulnerable populations (such as poor children and the disabled) that the program was intended for. That policy was both inequitable and unaffordable.

“The draft bill does not correct that inequity, but rather reduces the enhanced match rate from 95 percent to 80 percent. The better approach would be to allow states to immediately cap expansion population enrollment, while also setting federal reimbursement for any new expansion enrollees at normal state match rates.

“Such changes would likely limit the addition of new individuals to the program, and also substantially reduce the size of the federal revenue loss that expansion states will incur when the program terminates. That is because a significant share of current enrollees can be expected to leave the program for other coverage during the transition period.

“Unequitable Tax Treatment

“Yet another policy mistake is the failure to take the first step toward providing more equitable tax treatment of health insurance.

“The House version drops a proposed cap on the unlimited tax exclusion of employment-based health insurance contained in an earlier version, while retaining the so-called “Cadillac Tax”—the 40 percent excise tax on so-called “high cost plans”—and delaying its implementation until 2025.

“Congress should kill that punitive excise tax and replace it with a cap.

“While the Cadillac tax would force employers to alter the health benefit plans that they provide their workers, no such effect would result from the cap on the exclusion. It would simply limit the amount of employer health benefits that constitute pre-tax income to workers.

“Such a change would make the tax treatment of employer-sponsored health benefits consistent with the tax treatment of other benefits offered by employers, such as retirement savings plans, group life insurance, and dependent care, to name three of the more common ones.

“Workers would still be able to use after-tax income to purchase additional coverage, just as they can with other employer benefits, and the employer would still be able to offer a plan whose value exceeds the level of the cap on pre-tax funding.

“What a cap on the tax exclusion would do is to encourage both employers and workers to rethink how much of total employee compensation should be devoted to health benefits.

While employers would still have total flexibility to design benefit plans that suit their own circumstances, a cap on the amount of pre-tax funding would encourage both employers and workers to reevaluate the trade off between higher health care spending and higher cash wages.

“There are numerous other issues with the bill. For example, while allowing insurance companies to charge a mark-up of 30 percent for delayed enrollment can help address continuity of coverage issues, mandating that penalty is not the way to proceed.

“This bill misses the mark primarily because it fails to correct the features of Obamacare that drove up health care costs. Congress should continue to focus on first repealing the failed policy of Obamacare and then act to offer patient-centered, market-based replacement reforms.”

This alternative view by the Heritage Foundation must be considered in revising and improving the current health care bill in Congress.

6 CONGRESSIONAL BUDGET ANALYSIS OF AHCA

“CBO and the staff of the Joint Committee on Taxation (JCT) have completed an estimate of the direct spending and revenue effects of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives. CBO and JCT estimate that enacting that version of H.R. 1628

would reduce the cumulative federal deficit over the 2017-2026 period by \$119 billion. That amount is \$32 billion less than the estimated net savings for the version of H.R. 1628 that was posted on the website of the House Committee on Rules on March 22, 2017, incorporating manager’s amendments 4, 5, 24, and 25.

“In comparison with the estimates for the previous version of the act, under the House-passed act, the number of people with health insurance would, by CBO and JCT’s estimates, be slightly higher and average premiums for insurance purchased individually—that is, nongroup insurance—would be lower, in part because the insurance, on average, would pay for a smaller proportion of health care costs. In addition, the agencies expect that some people would use the tax credits authorized by the act to purchase policies that would not cover major medical risks and that are not counted as insurance in this cost estimate.

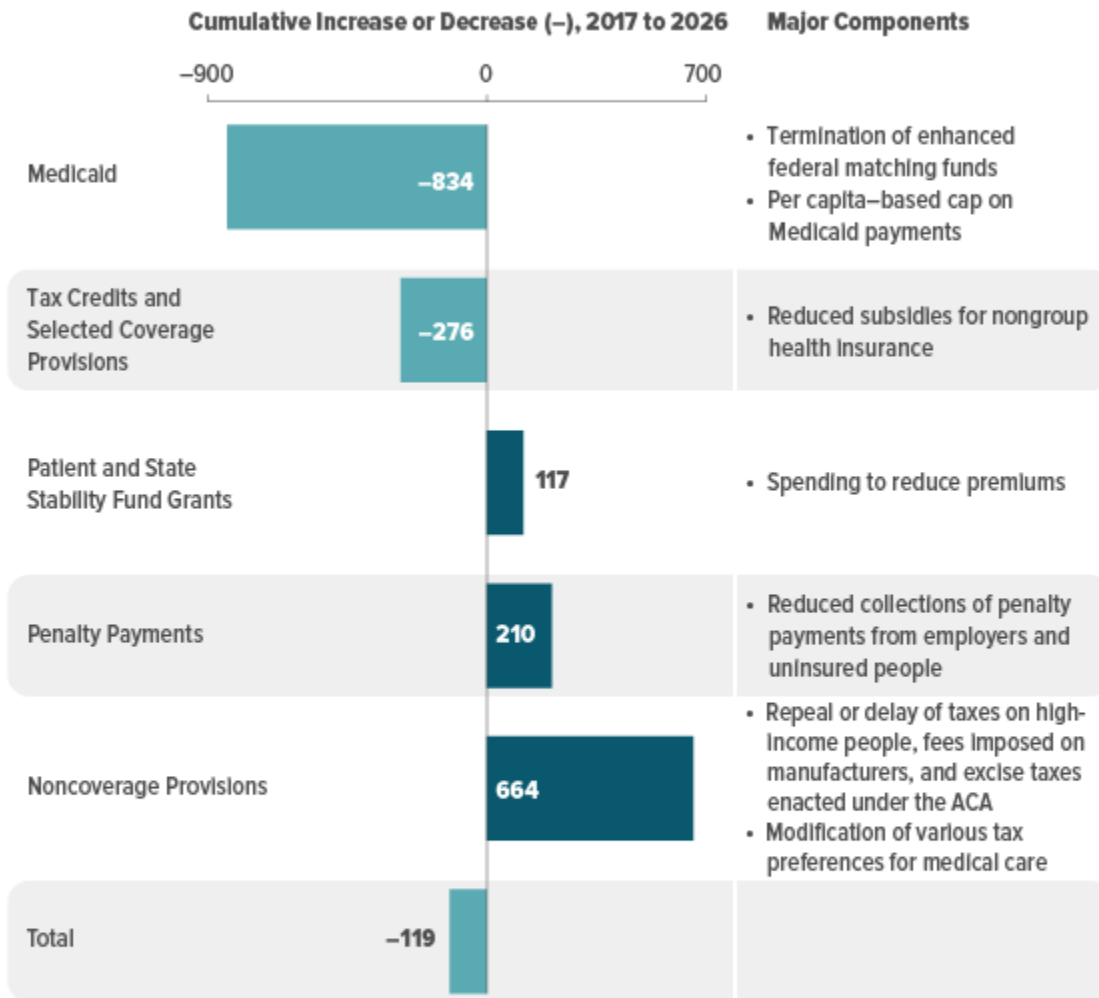
“Effects on the Federal Budget

“CBO and JCT estimate that, over the 2017-2026 period, enacting H.R. 1628 would reduce direct spending by \$1,111 billion and reduce revenues by \$992 billion, for a net reduction of \$119 billion in the deficit over that period. The provisions dealing with health insurance coverage would reduce the deficit, on net, by \$783 billion; the noncoverage provisions would increase the deficit by \$664 billion, mostly by reducing revenues.

“The largest savings would come from reductions in outlays for Medicaid and from the replacement of the Affordable Care Act’s (ACA’s) subsidies for nongroup health insurance with new tax credits for nongroup health insurance (see figure below). Those savings would be partially offset by other changes in coverage provisions—spending for a new Patient and State Stability Fund, designed to reduce premiums, and a reduction in revenues from repealing penalties on employers who do not offer insurance and on people who do not purchase insurance. The largest increases in the deficit would come from repealing or modifying tax provisions in the ACA that are not directly related to health insurance coverage—such as repealing a surtax on net investment income, repealing annual fees imposed on health insurers, and reducing the income threshold for determining the tax deduction for medical expenses.

Net Effects of H.R. 1628 on the Budget Deficit

Billions of Dollars



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

These estimates are for H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017.

ACA = Affordable Care Act.

“Pay-as-you-go procedures apply because enacting H.R. 1628 would affect direct spending and revenues. CBO and JCT estimate that enacting H.R. 1628 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027. CBO has not completed an estimate of the potential impact of the legislation on discretionary spending, which would be subject to future appropriation action.

“Effects on Health Insurance Coverage

“CBO and JCT broadly define private health insurance coverage as consisting of a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. The agencies ground their coverage estimates on that widely accepted definition, which encompasses most private health insurance plans currently offered in the group and nongroup markets. The definition excludes policies with limited insurance benefits (known as mini-med plans); “dread disease” policies that cover only specific diseases; supplemental plans that pay for medical expenses that another policy does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or hospitalization; and single-service plans, such as dental-only or vision-only policies. In this estimate, people who have only such policies are described as uninsured because they do not have financial protection from major medical risks.

“CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under H.R. 1628 than under current law. The increase in the number of uninsured people relative to the number projected under current law would reach 19 million in 2020 and 23 million in 2026. In 2026, an estimated 51 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law. Under the legislation, a few million of those people would use tax credits to purchase policies that would not cover major medical risks.

“Stability of the Health Insurance Market

“Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people living in areas with participating insurers and on the likelihood of premiums’ not rising in an unsustainable spiral. The market for insurance purchased individually with premiums not based on one’s health status—that is, nongroup coverage without medical underwriting—would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable.

“Under Current Law.

“Although premiums have been rising under current law, most subsidized enrollees purchasing health insurance coverage in the nongroup market are largely insulated from increases in premiums because their out-of-pocket payments for premiums are based on a percentage of their income; the government pays the difference between that percentage and the premiums for a reference plan. The subsidies to purchase coverage, combined with the effects of the individual mandate, which requires most individuals to obtain insurance or pay a penalty, are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas.

“Nevertheless, some areas of the country have limited participation by insurers in the nongroup market under current law. Several factors could lead insurers to withdraw from the market—including lack of profitability and substantial uncertainty about enforcement of the individual

mandate and about future payments of the cost-sharing subsidies to reduce out-of-pocket payments for people who enroll in nongroup coverage through the marketplaces established by the ACA.

“Under the Legislation.

“CBO and JCT anticipate that, under H.R. 1628, nongroup insurance markets would continue to be stable in many parts of the country. Although substantial uncertainty about how the new law would be implemented could lead insurers to withdraw from or not enter the nongroup market, several factors would bring about market stability in most states before 2020. In the agencies’ view, those key factors include subsidies to purchase insurance, which would maintain sufficient demand for insurance by people with low health care expenditures, and grants to states from the Patient and State Stability Fund, which would lower premiums by reducing the costs to insurers of people with high health care expenditures.

“The agencies expect that the nongroup market in many areas of the country would continue to be stable in 2020 and later years as well, including in some states that obtain waivers from market regulations. Even though the new tax credits, which would take effect in 2020, would be structured differently from the current subsidies and would generally be less generous for those receiving subsidies under current law, other changes (including the money available through the Patient and State Stability Fund) would, in the agencies’ view, lower average premiums enough to attract a sufficient number of relatively healthy people to stabilize the market.

“However, the agencies estimate that about one-sixth of the population resides in areas in which the nongroup market would start to become unstable beginning in 2020. That instability would result from market responses to decisions by some states to waive two provisions of federal law, as would be permitted under H.R. 1628. One type of waiver would allow states to modify the requirements governing essential health benefits (EHBs), which set minimum standards for the benefits that insurance in the nongroup and small-group markets must cover. A second type of waiver would allow insurers to set premiums on the basis of an individual’s health status if the person had not demonstrated continuous coverage; that is, the waiver would eliminate the requirement for what is termed community rating for premiums charged to such people. CBO and JCT anticipate that most healthy people applying for insurance in the nongroup market in those states would be able to choose between premiums based on their own expected health care costs (medically underwritten premiums) and premiums based on the average health care costs for people who share the same age and smoking status and who reside in the same geographic area (community-rated premiums). By choosing the former, people who are healthier than average would be able to purchase nongroup insurance with relatively low premiums.

“CBO and JCT expect that, as a consequence, the waivers in those states would have another effect: Community-rated premiums would rise over time, and people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive nongroup health insurance at premiums comparable to those under current law, if they could purchase it at all—despite the additional funding that would be

available under H.R. 1628 to help reduce premiums. As a result, the nongroup markets in those states would become unstable for people with higher-than-average expected health care costs. That instability would cause some people who would have been insured in the nongroup market under current law to be uninsured. Others would obtain coverage through a family member's employer or through their own employer.

“Effects on Premiums and Out-of-Pocket Payments

“CBO and JCT projected premiums for single policyholders under H.R. 1628 (before any tax credits were applied) and compared those with the premiums projected under current law for policies purchased in the nongroup market. H.R. 1628, as passed by the House, would tend to increase such premiums before 2020, relative to those under current law—by an average of about 20 percent in 2018 and 5 percent in 2019, as the funding provided by the act to reduce premiums had a larger effect on pricing.

“Starting in 2020, however, average premiums would depend in part on any waivers granted to states and on how those waivers were implemented and in part on what share of the funding available from the Patient and State Stability Fund was applied to premium reduction. To facilitate the analysis, CBO and JCT examined three general approaches states could take to implement H.R. 1628. Because a projection of a specific state's actions would be highly uncertain, the agencies' estimates reflect an assessment of the probabilities of different outcomes, without any explicit predictions about which states would make which decisions. CBO and JCT estimate the following:

- About half the population resides in states that would not request waivers regarding the EHBs or community rating, CBO and JCT project. In those states, average premiums in the nongroup market would be about 4 percent lower in 2026 than under current law, mostly because a younger and healthier population would be purchasing the insurance. The changes in premiums would vary for people of different ages. A change in the rules governing how much more insurers can charge older people than younger people, effective in 2019, would directly alter the premiums faced by different age groups, substantially reducing premiums for young adults and raising premiums for older people.
- About one-third of the population resides in states that would make moderate changes to market regulations. In those states, CBO and JCT expect that, overall, average premiums in the nongroup market would be roughly 20 percent lower in 2026 than under current law, primarily because, on average, insurance policies would provide fewer benefits. Although the changes to regulations affecting community rating would be limited, the extent of the changes in the EHBs would vary widely; the estimated reductions in average premiums range from 10 percent to 30 percent in different areas of the country. The reductions for younger people would be substantially larger and those for older people substantially smaller.
- Finally, about one-sixth of the population resides in states that would obtain waivers involving both the EHBs and community rating and that would allow premiums to be set

on the basis of an individual's health status in a substantial portion of the nongroup market, CBO and JCT anticipate. As in other states, average premiums would be lower than under current law because a younger and healthier population would be purchasing the insurance and because large changes to the EHB requirements would cause plans to cover a smaller percentage of expected health care costs. In addition, premiums would vary significantly according to health status and the types of benefits provided, and less healthy people would face extremely high premiums, despite the additional funding that would be available under H.R. 1628 to help reduce premiums. Over time, it would become more difficult for less healthy people (including people with preexisting medical conditions) in those states to purchase insurance because their premiums would continue to increase rapidly. As a result of the narrower scope of covered benefits and the difficulty less healthy people would face purchasing insurance, average premiums for people who did purchase insurance would generally be lower than in other states—but the variation around that average would be very large. CBO and JCT do not have an estimate of how much lower those premiums would be.

“Although premiums would decline, on average, in states that chose to narrow the scope of EHBs, some people enrolled in nongroup insurance would experience substantial increases in what they would spend on health care. People living in states modifying the EHBs who used services or benefits no longer included in the EHBs would experience substantial increases in out-of-pocket spending on health care or would choose to forgo the services. Services or benefits likely to be excluded from the EHBs in some states include maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits. In particular, out-of-pocket spending on maternity care and mental health and substance abuse services could increase by thousands of dollars in a given year for the nongroup enrollees who would use those services. Moreover, the ACA's ban on annual and lifetime limits on covered benefits would no longer apply to health benefits not defined as essential in a state. As a result, for some benefits that might be removed from a state's definition of EHBs but that might not be excluded from insurance coverage altogether, some enrollees could see large increases in out-of-pocket spending because annual or lifetime limits would be allowed. That could happen, for example, to some people who use expensive prescription drugs. Out-of-pocket payments for people who have relatively high health care spending would increase most in the states that obtained waivers from the requirements for both the EHBs and community rating.

“Uncertainty Surrounding the Estimates

“The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates discussed in this document are uncertain. In particular, states would have a wide range of options—notably, the optional waivers discussed above that would allow them to modify the minimum set of benefits that must be provided by insurance sold in the nongroup and small-group markets and that would permit medical underwriting for people who did not demonstrate continuous coverage. The array of market regulations that states could implement

makes estimating the outcomes especially uncertain. But, throughout, CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

“Macroeconomic Effects

“Because of the magnitude of its budgetary effects, this legislation is “major legislation,” as defined in the rules of the House of Representatives. Hence, it triggers the requirement that the cost estimate, to the greatest extent practicable, include the budgetary impact of its macroeconomic effects. However, because of the limited time available to prepare this cost estimate, quantifying and incorporating those macroeconomic effects have not been practicable.

“Intergovernmental and Private-Sector Mandates

“JCT and CBO have determined that H.R. 1628, as passed by the House, would impose no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). JCT and CBO have determined that the legislation would impose private-sector mandates as defined in UMRA. On the basis of information from JCT, CBO estimates the aggregate cost of the mandates would exceed the annual threshold established in UMRA for private-sector mandates (\$156 million in 2017, adjusted annually for inflation).”

THE NATIONAL BLACK CHURCH INITIATIVE'S INNOVATIVE HEALTH POLICY PLAN FOR OUR NATION

*In Response to the House and Senate Health
Reform Legislation*

7 THE NATIONAL BLACK CHURCH INITIATIVE'S FIVE BILLION DOLLAR HEALTH DISPARITIES AND CULTURAL COMPETENCY FOCUS

NBCI asserts that billion dollars be appropriated to addressing Health Disparities. If this country is serious about resolving health disparities and cultural competencies, it must be willing to put its money where its mouth is. It must focus on diseases that impact minority health population and real innovative dollars. This is why we will propose in this legislation that 1 billion dollars be appropriated over the next 5 years which will equal a 5-billion-dollar investment to address the issues of obesity, cardiovascular disease, cancer, lupus, autism, HIV/AIDS, violence, diabetes, and mental health in focused way. The billion dollars a year will spur innovation in these areas as pointed out by former Senator William H Frist who served our country well. NBCI's innovative health plan is the most progressive health document ever developed for a minority population and it employs all the relevant scientific based approaches to finally deal with health disparities and cultural competency.

According to William H. Frist in his report *Overcoming Disparities in Health Care*:

“In spite of evidence that some of the largest gaps in care and access are defined by SES, geography, lack of insurance, and lack of access to high-quality medical care, many argue that disparities are instead exclusively racial and ethnic. Some accuse providers of having ingrained preferences in medical decision making—preferences tainted by implicit racism. They also argue that health disparities are, fundamentally, civil rights matters.

“Equality has been a principle essential to the medical profession for thousands of years. We cannot and will not tolerate discrimination. However, lawsuits will not eliminate health disparities. Instead, we must improve the overall quality of care and also aggressively promote public health interventions aimed specifically at closing the gaps in quality of care. In this paradigm, the best

way to eliminate health disparities is through improvements in the care we deliver to each patient, emphasizing patient dignity and empowerment.

“Promote patient dignity and personal responsibility.”

“Patients must be central to our efforts to improve health care. For instance, a person with a chronic illness such as diabetes must essentially “own” that illness if he or she is to have any hope of effectively managing it. Providers can help with high-quality treatment and the best recommendations, but patients must act on those recommendations. They must stop smoking, eat right, exercise, take their medication, and monitor their blood sugar, based on their own volition and usually outside of the clinical setting. Public policies must encourage patients to embrace personal responsibility.

“Policies that promote dignity and personal responsibility will help decrease individuals’ risky behavior. The major causes of death among African Americans, for instance, are heart disease, cancer, stroke, accidents, and diabetes. Most of these are chronic diseases rather than acute illnesses, and all of these causes of death are at least arguably preventable. Further, the top three can be reduced by decreasing tobacco use alone. We must promote policies that help people address individual behavior, such as smoking.

“Improve communication.”

“Effective communication between health care providers and their patients also is essential for high-quality care. According to the National Adult Literacy Survey, almost ninety million U.S. adults have difficulty reading written text. Further, according to the research, patients with limited health literacy and chronic illness have less knowledge of disease management than those with higher literacy levels.

“Focus on cultural context.”

“One’s community and cultural background affect perceptions of health. Therefore, providers must understand the communities they serve. One of my colleagues describes a community health center patient who was Latina. This woman had poorly controlled diabetes, but she adamantly and consistently declined insulin. When my colleague asked her what insulin “meant to her” and why she was so frightened of it, she confided that she had many family members with diabetes. Those she knew who used insulin eventually went on hemodialysis and died shortly after that. This patient equated insulin with hemodialysis and death. Only when the patient’s providers understood insulin from her perspective could they and she improve her care.

“The Closing the Health Care Gap Act of 2004 (S. 2091) builds on the Minority Health and Health Disparities Research Act of 2000. It addresses disparities by focusing on five key areas:

- (1) improving the quality of health care;
- (2) expanding access to high-quality care;
- (3) strengthening national efforts and coordination;

(4) helping increase the diversity of health professionals and promoting more aggressive health professional education intended to reduce barriers to care; and

(5) improving research to identify sources of racial, ethnic, and geographic disparities and assess promising intervention strategies.

“Improving quality.

“Disparities in U.S. health care are largely subsets of our overall quality problems. These result in less-than-optimum care for all and disproportionately worse care for many. Therefore, as embodied in the Closing the Health Care Gap Act, any policy solution for health disparities must start with improving the general quality of care.

“Information technology.

“First, health information technology (HIT) is critical. Robust care information and access to it will help providers and patients creatively redesign clinical practice in ways that will improve quality and close these gaps. All providers, including safety-net providers, must have access to HIT. HIT will help physicians and nurses who are working closely with their patients to provide higher-quality care at lower cost.

“Performance measurement.

“Second, we must be able to assess the clinical care we provide to improve the quality of that care. We do not measure performance uniformly; in fact, we do not even have rudimentary standardized “yardsticks.” Therefore, a fundamental step will be to develop appropriate measurement tools. Specifically, federal health programs should develop and implement a uniform set of performance measures so that patients, consumers, and providers can make informed, evidence-based decisions about health care.

“Provider incentives.

“We also must give providers incentives to promote innovative clinical redesign, which will improve the overall quality of care and close the gaps. Government now pays for episodes of care, not quality and outcomes. Federal officials have started to rethink these payment strategies so that we pay for results rather than doctor visits and procedures. Congress has begun to encourage pay-for-performance efforts through legislation, most notably the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173). We also should consider paying for care that demonstrably closes quality gaps.

“Patient self-management.

“Improving the quality of care also means that providers must recognize that patients largely manage their chronic illnesses themselves. To improve the quality of care, patients need providers to help them get better at self-management.

“Better data.

“Finally, we need better demographic data about the race, ethnicity, SES, and primary language of people receiving care. The current data establish the care disparities, but the federal health programs and the private health market need much better information about these population groups to refine and target interventions. For instance, almost half of insurance enrollees are in health plans that do not collect these data.

“Access to high-quality care.

“As part of an attack on health disparities, we need to address rising health care costs and lack of insurance. Rising costs increase the number of uninsured people and reduce access to high-quality care. The best way to drive down overall costs while increasing value is to foster competitively driven innovation—as we do in the rest of our economy. Lower overall health costs, in turn, can help the entire system by making care and coverage more affordable.

“The idea is to link payment, effectively and efficiently, to outcomes that patients value, such as healing better and faster or closing care gaps. We should cultivate a health care system that encourages providers and patients, with properly aligned incentives, to work together to improve care. In such a marketplace, patients and providers would decide how to structure a productive clinical interaction—and productivity determined by doctors and patients is not likely to include pushing ever more chronically ill patients through ten-minute appointments in rushed, inefficient clinical settings.

“Some have voiced concerns that health care is somehow different: that the therapeutic relationship between doctor and patient should not be subject to competitive forces. Further, many argue that quality chasms and health disparities cannot be fixed by fostering competition. Certainly, competition does not provide all of the answers. We will need a strong safety net and vigorous attention to vulnerable populations. But all of our immediate health care system problems—rising costs, questionable quality, patient safety, rising numbers of uninsured people, and, yes, health disparities—are interrelated and can be improved by empowering patients and providers. We simply cannot afford to forgo the lower costs and increased quality and value that the right kind of competition will drive.

“To foster this kind of competition and empower patients, we need to adopt (1) market reforms to make the cost of health care more sensitive to consumer demand; (2) a more stable and consumer-friendly insurance market; (3) a variety of more affordable, consumer-directed health care products such as health savings accounts (HSAs); and (4) broader risk spreading and more effective risk adjustment throughout the individual and small-employer markets.

“Of course, these changes will not in and of themselves put insurance coverage in the hands of many Americans. Therefore, a variety of tools targeted at different groupings of the uninsured—from refundable tax credits to expanded public programs—are necessary. The Closing the Health Care Gap Act, for instance, provides refundable tax credits for low-income Americans, a solution that would help improve access to care for many who otherwise cannot afford health coverage.

“We also need a sturdy safety net. Therefore, we must continue to strengthen this system, particularly our growing network of community health centers (CHCs). We should double the capacity of CHCs over the next ten years and target sufficient resources to maintain that network. As provided in the Closing the Health Care Gap Act, we should also promote specific interventions at the community level, using patient navigators, preventive services, and disease management strategies to bring high-quality, evidence-based care to large groups of patients. CHCs are perfectly situated to develop these interventions.

“National leadership.

“As envisioned in the Closing the Health Care Gap Act, a reauthorized, reinvigorated, properly funded Office of Minority Health (OMH) at the Department of Health and Human Services (HHS) that targets health disparities, broadly defined, will be important. However, a single office is not enough. We must engage and leverage the entire federal health apparatus, including HHS, the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ), as well as the Departments of Veterans Affairs and Defense, to systematically address disparities whenever and wherever they may occur. Using the federal health apparatus in this way would bring health disparities to the top of the agenda of all the federal health agencies, so that all of these agencies, not just the OMH, would be charged to consider health disparities as they develop, implement, and manage programs.

“The health professions.

“We also need health care providers who are trained to work with health disparity populations. Providers need to know the patients they are caring for; they need to understand, if not be a part of, these communities. We need evidence-based, model training in cultural understanding and competence. The Closing the Health Care Gap Act, for instance, promotes the development of model curricula in cultural fluency and competence. Our training programs should invest in high-quality, board-certified providers who will work in these communities, and we should provide the right incentives so that these highly trained providers will want to stay in these roles.

“Certainly, increasing the number of minorities in the health professions will be a positive step. However, in this national effort, we need to be more focused on outcomes—which care systems and settings close gaps faster and provide the highest-quality care. From that framework, patient-provider race concordance may be extremely important, but the bottom line is the outcome, not the means of getting there.

“Translating science into cures.

“It now takes approximately seventeen years for new evidence to be widely adopted by U.S. physicians. That is too long. We also need to ensure that our research evaluates potentially significant racial and ethnic clinical differences.³⁴ In addition, we should refocus our mountains of research at the NIH, the CDC, and AHRQ from the lab bench to the bedside, the clinic, and patients’ homes, where this knowledge will save lives. Finally, we should fund and promote

translational research for quality improvement techniques as well as the HIT to help embed science into clinical decision making at the point of care.

“Disparities in U.S. health care offend the founding American principle that we are all created equal. We fought a desperate Civil War that challenged and then reaffirmed that creed of equality. Together we endured and forged 140 years of progress in racial equality, progress that has at times been agonizingly slow. Admittedly, there have been difficult hours when we have not been true to our creed. But in the last measure, ours has been a nation that has moved progressively toward, not away from, the fruits of these noble ideals for all. I am confident that our generation can meet the challenge posed by the “unfinished work” of health disparities. I am also confident that one day all Americans, regardless of skin color or social status, will have equal opportunity to prevent and overcome disease and live longer, happier, and healthier lives.”

We support this well researched and multi-faceted approach to eliminating health disparities by former senator William H. Frist. Health disparities must be confronted by a significant investment by not only our communities, churches, and private institutions, but also our governments, federal and local.

8 THE NATIONAL BLACK CHURCH INITIATIVE’S NATIONAL HEALTHCARE PLAN

Neither the Affordable Care Act, the American Health Care Act, nor the Better Reconciliation and Care Act bills talk about cutting funding to pharma and the profits of health insurers and hospitals. Neither bills reduce premiums for individuals who do not receive subsidies.

Health Disparities continue to plague our nation as African American, Latino, and other minority groups fall behind whites in cancer survival rates, mortality, and many other areas. More disconcertingly are the rates of HIV/AIDS, diabetes, heart disease, obesity, and other chronic illnesses among African American women and children. African Americans are particularly vulnerable in cities such as Baltimore, MD, Atlanta, GA, Memphis TN, Orlando, FL, Jackson, MS, New Orleans, LA, (in which African Americans make up only 32 percent of the state population but 73 percent of the state’s new cases of HIV/AIDS), Miami, FL, and Baton Rouge, LA.

The following are NBCI’s recommendations

1. Incorporate these essential components in every major bill going forward: Mandated child health care; Health care decisions driven by hard science, data collection and statistical evaluation of procedures, theories and innovative practices; Prohibition of discrimination; Emphasis on education, testing and early diagnosis, prevention and data collection; Emphasis on physical exercise and nutrition program block grants; Commitment to cultural competency in health care workforce; Emphasis on voluntary data collection and research data; Encouragement of African Americans and other diverse

populations to voluntary clinical trial participation; Universal access to affordable care; Comprehensive review on cost saving, streamlining, upgrading technology, rooting out corruption and providing comprehensive education of system procedures in Medicaid and Medicare; Removal of the IRS from the health care plan, and the individuals mandate/tax and penalties

2. Eliminate individual mandate and the employer mandate for employers under 100 employees and monetary penalties for insurance under Obamacare
3. Keep the mandate for employers with over 100 employees but again, eliminate the penalty
4. Provide a physical every 2 years to anyone receiving Medicare, Medicaid, and any subsidy to identify abnormalities and to incorporate diet and exercise in their lifestyles if they are physically able to do so. Two expensive issues that drive the cost of healthcare are HIV and obesity. Emphasis should be place on these two health issues.
5. *Implement universal adequate cancer, diabetes, and heart disease screenings at an appropriate age so that there can be some prediction of the spike in health care cost going forward so that we can know how to create health cost saving measures to deal with them at the time or plan for them.*
6. Cover women's reproductive health and sex education and other essential components for young girls at a very early age of competency. Focus on but not limited to issues around women's health like lupus, breast cancer, HIV, and other debilitating diseases and conditions with the focus of prevention.
7. Implement Vice President Biden's Manhattan Project on Cancer Research.
8. The National Institute of Health should not be cut at 18% but increase at 18% annually.
9. Establish health savings accounts for anyone making over \$100,000
10. Increase the annual amount of money that individuals and families can contribute to their Health Savings Accounts, known as HSAs. The new contribution limits for individuals would be \$6,550, and \$13,100 for families. (The current limit is \$3,400 for individuals, and \$6,750 for families). The bill would also lower the tax penalty for people who use money from their HSAs to pay for non-medical expenses. The penalty would be 10 percent, down from the current level of 20 percent.
11. Restore 800 billion in Medicaid and Medicare expansion over ten years. (NBCI will not be opposed to letting the state run this program if they are going to do it more efficiently, effectively, and with cost savings. We are betting that the states can create savings strategies but not at the expense of access of quality of care which should be evaluated by third party independent evaluators. The Medicaid should not be a part of the state's budget; it should be a separate fund for recipients)
12. Maintain Medicaid expansion coverage levels under Obamacare
13. Ensure that Medicaid, CHIP and other safety net programs are adequately funded, and expand CHIP coverage for children with autism and development of disability issues.

14. Cap total annual co-payments of every major plan to \$500 for a family of 4 and \$1000 for individuals starting after 2019; in the meanwhile, maintain the cap on out of pocket expenses
15. Increase subsidies from federal government for those making over the poverty rate so that they can afford adequate health care insurance.
16. Guarantee that the poor, the old, the young, and the vulnerable to receive healthcare for free through Medicaid and Medicare and working individuals and families to pay no more than 15% of their monthly income on healthcare. We are asking the federal government and industry in a federal-private formula to pay no more than 15%. We do not want this to be only a federal burden. Especially for companies with non-profit status.
17. Cut prescription drug prices by 10-25% for those working whose incomes are over the federal poverty rate if they do not receive this coverage through their employer. (We want the federal government to be able to negotiate without cutting into pharmaceutical industry's ability to fund research and development for innovative therapies and drugs to the lowest possible price. This should also allow pharma to support clinical trials for African Americans and Women.) (See recommendations for the FDA)
18. Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans.
19. Preexisting conditions must be center piece of any major bill going forward; as a mandate without any ability to waiver from that bed rock principle.
20. Include Mental health and dental coverage in any major bill going forward
21. Given to state block grants for Preventative medicine in terms of screenings, diet, and physical exercise
22. Maintain key insurance market reforms
23. Eliminate Obama-style insurance markets and allow individuals to purchase plans across states
24. Implement ReX as a preventative measure as health information and health education. (See ReX description)
25. Keep the tax credits to middle income Americans making up to 400% of the federal poverty level to offset the cost of premiums.
26. Bar insurers from setting a limit on how much they have to pay to cover someone.
27. Bar insurers from charging older persons 3x more based on age; however, this should be mean tested to ensure that rich individuals do not receive government subsidies *as a means of double dipping*.
28. Reduce regulatory burdens that detract from patient care and increase costs.
29. Provide greater cost transparency throughout the health care system.
30. Incorporate common sense medical liability reforms. Cap liability at 5-10 million dollars depending on the egregious medical mistake. (Johns Hopkins Study on Hospital Mistakes)
31. Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends

32. Guaranteed coverage for young people under their parents health plan up to age 30 unless they have a job making 400% of the federal poverty rate.
33. Take suggestions from every health economists from both sides of the aisle with the goal of reducing healthcare premium cost as stated in recommendation #13.
34. Consider gun violence and substance abuse (opiates) as a chronic health disorder and deal with it accordingly with all its ramifications with the objective of reduce gun violence by 10-15% every year.
35. Promote cultural competency and diversity training for all healthcare workers as a requirement for employment.

9 FINANCING THE HEALTHCARE PLAN

Taxes pay for health reform. The following are ways the ACA is being funded.

- Personal income taxes
- A tax on Medicare of 0.9 percent
- Unearned income tax on people who earn more than \$200,000 per year
- Spending cuts in other government departments
- A tax levied against insurance companies
- Taxes levied against businesses of more than 50 full-time workers that don't comply with the law

NBCI has the following recommendations for financing the new healthcare plan:

- Increase by 15% any individual who goes without health coverage for 100 days
- Keep tax on the rich, keep the 0.9% Medicaid payroll tax and 3.8% investment tax on individuals making 200,000 and married couples making 300,000
- Add a tax of 4% on individuals making over 1 million dollars for 2 consecutive years
- Eliminate tax on high cost employer plan

10 BIBLIOGRAPHY

- Butler, P. A. 2000. ERISA and state health care access initiatives: Opportunities and obstacles. New York: The Commonwealth Fund.
- Chaikind, H. R. 2003. ERISA Regulation of Health Plans: Fact Sheet. Washington, DC: Congressional Research Service.
- Coleman EA, Tyll L, LaCroix AZ, Allen C, Leveille SG, Wallace JI, Buchner DM, Grothaus LC, Wagner EH. Recruiting African-American older adults for a community-based health promotion intervention: which strategies are effective? *Am J Prev Med.* 1997 Nov-Dec;13(6 Suppl):51–56.
- Colon-Otero, G., R. C. Smallridge, L. J. Solberg, T. D. Keith, T. A. Woodward, F. B. Willis, and A. N. Dunn. 2007. Disparities in participation in cancer clinical trials in the United States: A symptom of a healthcare system in crisis. *Cancer* 112(3):447–454.
- Co-payments to rise as access to drugs tightens for patients on Medicare Part D. 2008. *The Cancer Letter* 23(11):1, 4.
- Cultural Competence And Health Care Disparities: Key Perspectives And Trends *Health Aff (Millwood)* March 2005 24:2499-505
- Davis, R., Hitch, A., Nichols, M., Rizvi, A., Salaam, M., & Mayerdavis, E. (2009). A collaborative approach to the recruitment and retention of minority patients with diabetes in rural community health centers. doi:10.1016/j.cct.2008.09.007
- Dilts, D. M., and A. B. Sandler. 2006. Invisible barriers to clinical trials: The impact of structural, infrastructural, and procedural barriers to opening oncology clinical trials. *Journal of Clinical Oncology* 24(28):4545–4552.
- EDICT. 2008. The EDICT Project: Policy Recommendations to Eliminate Disparities in Clinical Trials. Houston, TX: EDICT Project.
- Ford M, Siminoff L, Tilley B, et al. Unequal Burden of Disease, Unequal Participation in Clinical Trials: Solutions from African American and Latino Community Members. *Health & Social Work* [serial online]. February 2013;38(1):29-38. Available from: CINAHL Plus with Full Text, Ipswich, MA.
- George S, Duran N, Norris K. A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal Of Public Health* [serial online]. February 2014;104(2):e16-e31. Available from: PsycINFO, Ipswich, MA.
- HHS (U.S. Department of Health and Human Services). 2009. Health Information Technology for the Future of Health and Care: Meaningful Use. <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1325&parentname=CommunityPage&parentid=1&mode=2> (accessed October 27, 2009).
- IOM (Institute of Medicine). 1999. The Unequal Burden of Cancer: An Assessment of Nih Research Programs for Ethnic Minorities and the Medically Underserved. Washington, DC: National Academy Press.
- IOM. 2009a. Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research. Washington, DC: The National Academies Press.
- Jha, A. K., T. G. Ferris, K. Donelan, C. DesRoches, A. Shields, S. Rosenbaum, and D. Blumenthal. 2006. How common are electronic health records in the United States? A summary of the evidence. *Health Affairs* 25(6):w496–w507.

- KFF (Kaiser Family Foundation). 2009. Medicare Fact Sheet: Medicare Advantage. Menlo Park, CA: Kaiser Family Foundation.
- KFF (Kaiser Family Foundation). Medical Debt Among People With Health Insurance. Menlo Park, CA: Kaiser Family Foundation. <http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/>
- KFF (Kaiser Family Foundation). Summary of the Affordable Care Act. Menlo Park, CA: Kaiser Family Foundation. <http://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>
- Moving Beyond Access: Achieving Equity In State Health Care Reform Health Aff (Millwood) March 2008 27:2447-455
- Taylor, H. 2004. Most physicians do not participate in clinical trials because of lack of opportunity, time, personnel support and resources. Harris Interactive: Health Care News 4(9):1–8.
- The National Black Church Initiative (1996) The National Black Church Health Emergency Declaration: A National Health Prevention Program. Washington: NBCI Press.
- The National Black Church Initiative (2016) The National Black Church Initiative Clinical Trial Education Awareness and Participation Program (CTEAPP). Washington: NBCI Press.
- The National Black Church Initiative (2017) The National Black Church Initiative Recommendations to the Food and Drug Administration. Washington: NBCI Press.
- Vicini F, Shah C, Fakhouri M, et al. Strategies for Reducing Cancer Incidence and Mortality in African American and Arab American and Chaldean Communities in the Detroit Metropolitan Area. *American Journal Of Clinical Oncology-Cancer Clinical Trials* [serial online]. 2012;35(4):316-321. Available from: Science Citation Index, Ipswich, MA.