RSC
Republican Study Committee

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Health Care Solutions From Members of the RSC

The Republican Study Committee has become known as a fountain of robust, forward-thinking ideas and bold action. Continuously on the forefront of crafting positive, problem-solving solutions, RSC Members have introduced no fewer than 70 health care bills so far in the 111th Congress. This document summarizes each of those bills.

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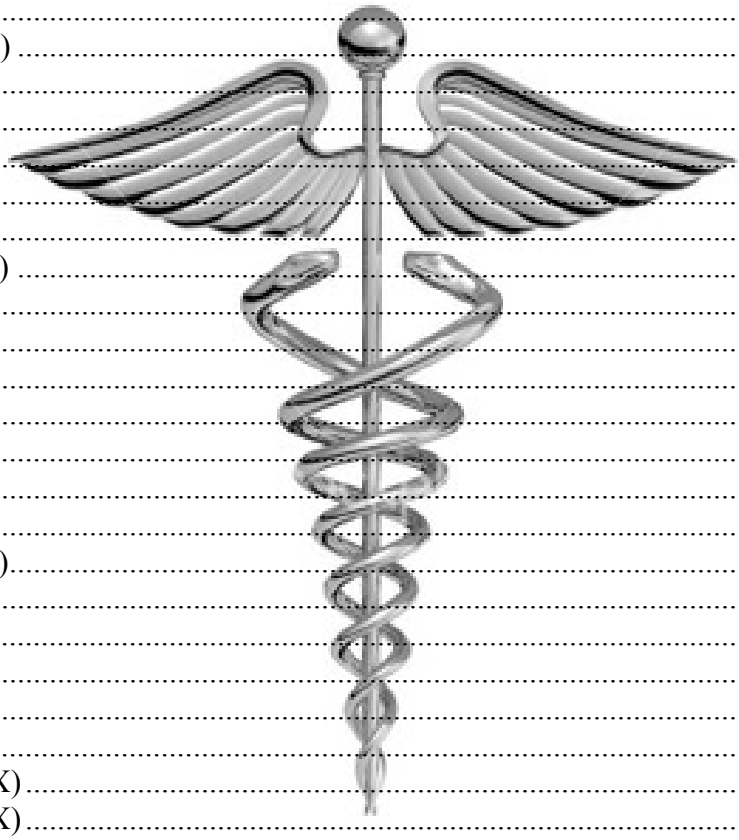

This document is for informational purposes only and may not be exhaustive.
The RSC does not necessarily endorse every bill listed here.

H.R. 77 – The Health Care Incentive Act
(Issa, R-CA)

Introduced: January 6, 2009

Summary: The Health Care Incentive Act allows for an employer, who is required by state law to pay an employee at a rate higher than the federally mandated minimum wage, to offer their employees health care benefits and get a credit toward the minimum wage for doing so.

This legislation instructs the Department of Labor to promulgate a rule to allow employers who participate in interstate commerce and whose state has a minimum wage higher than the federal minimum wage to include the value of health care benefits provided to an employee in determining the wage such employer is required to pay.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 109 – America's Affordable Health Care Act of 2009
(Fortenberry, R-NE)

Introduced: January 6, 2009

Summary: America's Affordable Health Care Act seeks to promote more affordable insurance options for individuals who do not receive health coverage through their employer, and also for those with complex or chronic health conditions. It permits insurance companies to offer policies with fewer mandated benefits, called "health benefit plans." It would allow individuals and families who do not receive health insurance coverage through their employer or from the government to have the option of purchasing one of these lower cost health benefit plans. These plans would be required to cover, at minimum, inpatient hospital services and physicians' surgical and medical services.

More specifically, it authorizes a health insurance issuer to apply to the Secretary of Health and Human Services to certify health insurance policies offered in the individual market as Health Benefit Plans. It will allow these certified plans to be offered to individuals in all states without regard to state and local mandated benefit laws. This legislation recognizes that for every mandated benefit, a certain segment of the population is priced out of the market and cannot afford health care coverage. Mandates may benefit the employer market, but can price individuals out of the individual market.

This legislation enhances coverage opportunities for those with complex or chronic conditions, by providing more funding to states for high-risk pools. High-risk pools offer insurance coverage options to individuals with pre-existing medical conditions who are otherwise unable to obtain insurance in the individual market. Specifically, it amends the Public Health Service Act to increase the authorization of appropriations for FY2010-

FY2014 for grants to states for the creation and operation of qualified high risk health insurance pools. It also authorizes funds to encourage state to adopt best practice protocols regarding the operation of high risk pools.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 198 - Health Care Tax Deduction Act of 2009 (Stearns, R-FL)

Introduced: January 6, 2009

Summary: The Health Care Tax Deduction Act will allow individuals to take a tax deduction from gross income for health insurance premiums and unreimbursed prescription drug expenses paid for by the taxpayer. This deduction covers health insurance premiums for the taxpayer, the taxpayers spouse, and dependents.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 270 – TRICARE Continuity of Coverage for National Guard and Reserve Families Act of 2009 (Latta, R-OH)

Introduced: January 7, 2009

Summary: This legislation allows retired members of the National Guard and Federal Reserve Components with 20 or more years of faithful and honorable service to purchase healthcare that was available to them during their time in active service or after they reach 60 years of age. Currently, members who have retired but are not yet 60 years of age are not eligible for TRICARE health insurance, and are referred to as being in the "gray area." Right now there are approximately 220,000 retirees that fall within the "gray area," with an additional 12,100 service members retiring and entering this status each year. CBO has not scored the legislation, however since this would allow "Gray Area" reservists to purchase TRICARE Standard health coverage at 100% of the premium, the sponsor office notes that the costs would be fully offset.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 321 – SCHIP Plus Act of 2009
(Fortenberry, R-NE)

Introduced: January 8, 2009

Summary: The State Children's Health Insurance Program (SCHIP) Plus Act would offer eligible families the choice of retaining coverage for their children in SCHIP or, alternatively, using SCHIP funds to help pay for insurance coverage for their children purchased from the private individual market. This latter option also permits families to use the funds toward the overall cost of a family insurance plan, so that children and parents are covered under one plan, rather than having children receive coverage under SCHIP while parents receive coverage under another insurance plan. This option is only for "targeted low-income children" or those SCHIP-eligible children of families at 200% of the federal poverty level or lower. Enrollment will be voluntary and offered as a coverage option along with traditional SCHIP coverage. Those electing such coverage shall be provided one opportunity per year to switch coverage from SCHIP to a private individual-style or family-style plan.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 464 – More Children, More Choices Act of 2009
(Price, R-GA)

Introduced: January 13, 2009

Summary: The More Children, More Choices Act is divided into three main components. It reauthorizes the SCHIP program, provides a tax credit for families with children that are between 200% to 300% of the federal poverty level (FPL), and adopts a "federalism" healthcare initiative.

SCHIP will be reauthorized at $7 billion per year, increasing to $8 billion in 2014. This legislation will also provide $100 million per year for the outreach and enrollment of eligible, uninsured children. The limit for the SCHIP program will be set at 200% of the FPL, and states will be required to cover 90% of the eligible children before expanding programs further. This legislation will grandfather in all existing children and individuals, until their current waivers expire.

A tax credit of $1,400 will be provided for all children (insured or uninsured) in families that are between 200% and 300% of the FPL. This credit would be advanceable and refundable.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 502 – Health Care Freedom of Choice Act
(Bachmann, R-MN)

Introduced: January 14, 2009

Summary: Under current law, medical care purchased through an employers insurance plan is tax-free, but the same premiums and expenses are not fully deductible if paid by an individual. In effect, the tax code forces working and retired Americans to seek health care through their jobs, preventing them from choosing their own plans, doctors, and treatments, and limiting their employment options due to medical considerations. Further compounding the problem, many businesses that provide health insurance offer employees the "choice" of only one plan. This legislation allows taxpayers to deduct the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, the taxpayer's spouse, or a dependent.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 504 – Medicare Hearing Enhancement and Auditory Rehabilitation (HEAR) Act of 2009
(Bilirakis, R-FL)

Introduced: January 14, 2009

Summary: The Medicare Hearing Enhancement and Auditory Rehabilitation (HEAR) Act amends Medicare to cover hearing aids and auditory rehabilitation services under the Medicare program.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 544 – Flexible Health Savings Act of 2009
(Royce, R-CA)

Introduced: January 14, 2009

Summary: The Flexible Health Savings Act allows up to $500 of unused health benefits in a plan or other arrangement to be carried forward to the next plan year or be contributed to a health savings account or a qualified retirement plan. This can be done without affecting the status of such plan or arrangement as a tax-exempt employee benefit cafeteria plan.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 643 – Care for Life Act of 2009
(Fortenberry, R-NE)

Introduced: January 22, 2009

Summary: The Care for Life Act seeks to encourage and assist women throughout their pregnancies and after childbirth by providing services to help alleviate financial, social, emotional, and other difficulties that may otherwise compel a decision for abortion.

This legislation requires the development of a Pregnancy Care Information Service database which will include information on providers of pregnancy support services. It also establishes a toll-free number to provide referrals to pregnancy support services. A public outreach campaign will also be implemented to provide information on pregnancy support services to vulnerable women.

Grants may be awarded for the exclusive purpose of providing pregnancy support services. There will be an increase in the credit for the adoption of a special needs child from $10,000 to $15,000, and this credit will be refundable.

Another key piece of this legislation is that is prohibits private health insurers from imposing any preexisting condition exclusion against an expectant mother who has had at least 12 months of creditable coverage before seeking coverage. It also prohibits private health insurers from imposing a waiting period or otherwise discriminating in coverage or premiums related to pregnancy against a woman if she has had at least 12 months of creditable coverage. This provision will be made retroactive to January 1, 2009.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 688 – Kids First Act
(Granger, R-TX)

Introduced: January 26, 2009

Summary: H.R. 688 was introduced as an alternative bill for SCHIP reauthorization. The Kids First Act would reauthorize SCHIP at $7.78 billion for 2009, $8.044 billion for 2010, $8.568 billion for 2011, $9.032 billion for 2012, and $9.505 billion for 2013. Like the Democrat bill (H.R. 2), this legislation expands SCHIP by $19.3 billion over the same four and a half year period. This legislation required new enrollees to be children or pregnant women at less than 200% of the federal poverty level, this reflects the original intent of the SCHIP program in 1997. Waivers will be allowed to continue until they expire, but this legislation immediately reduces the matching rate to the Medicaid matching rate.

The Kids First Act prohibits illegal immigrants from obtaining SCHIP coverage and prohibits any new waivers to add adults. This legislation also prevents states from utilizing "income disregards" to weaken eligibility requirements and encourages states to offer premium assistance, in order to move children to private coverage.

Grant funding for outreach and enrollment is included to increase the number of eligible but un-enrolled children who are covered by SCHIP. This legislation also increases the amount states are allowed to provide in premium assistance for the purchase of private insurance in order to prevent "crowd out" which happens when children or with private insurance switch to a public program.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 879 – The Affordable Health Care Expansion Act
(Granger, R-TX)

Introduced: February 4, 2009

Summary: H.R. 879 provides a tax credit to be used for the purchase of health insurance, regardless of whether or not the insurance is provided by an employer. The tax credits are pre-payable, so individuals and families who cannot pay for health care upfront are eligible immediately. Under H.R. 879, the tax credit granted to individuals is also refundable; families receive the full value of the tax credit regardless of their tax liability. Individuals will receive a $1,000 credit, married couples will receive a $2,000 credit, there will be an additional $500 credit for each dependent with a maximum of a $3,000 credit per family. Those with higher premium costs will receive tax credits toward 50% of any additional premiums.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 917 – To Increase the Health Benefits of Dependents of Members of the Armed Forces Who Die Because of a Combat-Related Injury. (Guthrie, R-KY)

Introduced: February 9, 2009

Summary: This legislation amends the TRICARE program (a Department of Defense [DOD] managed care program) to require that, when a member of the Armed Forces dies on or after September 11, 2001, because of a combat-related injury incurred while on active duty for a period of more than 30 days, the members dependents receiving benefits under a contract for medical and dental care shall continue to be eligible for benefits under TRICARE Prime.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1075 – Restoring Essential Care for Our Veterans for Effective Recovery (RECOVER) Act (Scalise, R-LA)

Introduced: February 13, 2009

Summary: The RECOVER Act (Restoring Essential Care for Our Veterans for Effective Recovery) directs the Secretary of Veterans Affairs, in the event of a major disaster, in an area near a Department of Veterans Affairs (VA) medical facility, to contract with one or more non-VA facilities in that area to provide such services to veterans who reside within 150 miles of the VA facility that is unable to provide the services.

This requirement is inapplicable to a VA facility that is closed, or that the Secretary intends to close, as part of the Capital Asset Realignment for Enhanced Services (CARES) process.

This Act is applicable to any VA facility unable to provide covered services on or after August 29, 2005, by reason of a major disaster.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1086 – Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2009 (Gingrey, R-GA)

Introduced: February 13, 2009

Summary: Lawsuits are causing doctors to face skyrocketing insurance rates. The threat of litigation causes many physicians to practice "defensive medicine," recommending tests and procedures in order to limit future liability rather than focusing on the needs of their patients. The HEALTH Act, modeled after California's 30-year-old and highly successful health care litigation reforms, addresses the current crisis and will make health care delivery more accessible and cost-effective in the United States.

Under the HEALTH Act's guidelines, a plaintiff may recover punitive damages totaling either $250,000 or double the amount of economic damages awarded—whichever is greater. The HEALTH Act also lowers health care costs by preventing unfair double recoveries (i.e., a plaintiff being awarded future lost wages both by his insurance company and by a court judgment). This Act limits the number of years a plaintiff has to file a health care liability action to ensure that claims are brought while witnesses are available and memories fresh, and before evidence is destroyed. It also guarantees that health care lawsuits will be filed no later than 3 years after the date of injury, providing defendants with ample access to the evidence they need to defend themselves. In some circumstances, however, it is important to guarantee patients additional time to file a claim. Accordingly, the Act extends the statute of limitations for minors injured before age 6.

Instead of making a party responsible for another's negligence, this legislation ensures that a party will only be liable for that party's own share. Under the current system, defendants who are only 1% at fault may be held liable for 100% of the damages. This provision eliminates the incentive for plaintiffs' attorneys to search for "deep pockets" and pursue lawsuits against those minimally liable or not liable at all. It also requires that the jury be informed of any payments already made.

The Health Act does not limit the economic damages a patient can receive for physical injuries resulting from a provider's care, unless otherwise restricted by state law. Only unquantifiable non-economic damages, such as pain and suffering, are limited to no more than $250,000. The HEALTH Act does not put a hard cap punitive damages. Rather, it allows punitive damages to be the greater of two times the amount of economic damages awarded or $250,000. The bill also allows ensures that past and current expenses will continue to be paid at the time of judgment or settlement, while future damages can be funded over time. This ensures that a plaintiff will receive all her damages in a timely fashion without risking the bankruptcy of the defendant. Penniless defendants are in no party's best interest.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1118 - Health Care Choices for Seniors Act
(Blackburn, R-TN)

Introduced: February 23, 2009

Summary: Once an individual turns 65, he or she must sign up for Medicare Part A in order to receive Social Security payments. Once signed into Medicare, individuals can no longer contribute tax-free into their Health Savings Account. This bill allows individuals to opt-out of joining Medicare until age 70, while allowing them to still receive Social Security benefits. Also, if an individual chooses to opt out of Medicare, he or she will receive a voucher that is actuarially equivalent to the average (mean) Medicare payments to all individuals of that same age in the Medicare Part A program.

By allowing individuals to wait to join Medicare, this allows the individual to continue their pre-tax contributions to the HSA. By delaying Medicare penalties to the age of 70, this takes away one significant incentive for individuals to automatically join at 65. It allows 5 more years for individuals to choose when they want to join Medicare, stay with their private insurance company for a few years, or the opportunity to join Medicare for a few years, and switch back.

The legislation caps the age that people can switch back and forth at 70. Most health issues occur in later years of life, so by forcing an individual to make the decision at 70, it requires that person to start paying premiums at that time or face penalties if they sign up later. Enrollment dates for Medicare will remain the same. Currently, Medicare enrollment at age 65 has a seven-month grace period. It begins three months before the 65th birthday, includes the month of turning 65 and ends three months after that birthday. If the senior does not enroll during this initial enrollment period, each year he/she is given another chance to sign up during a general enrollment period from January 1 through March 31. Coverage would begin the following July. An individual cannot just sign up for Medicare and have benefits start automatically. There would be a time period in between signing up and coverage so it would not be easy to go back and forth.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1189 – Colorectal Cancer Prevention, Early Detection, and Treatment Act of 2009
(Granger, R-TX)

Introduced: February 25, 2009

Summary: Under H.R. 1189, grant funding will be provided to the Centers for Disease Control and Prevention for colorectal cancer screening and treatment programs. Any entity receiving a grant is required to match the funds provided in an amount equal to not less than $1 for each $3 of Federal funds provided in the grant in a fiscal year. The screenings and treatments target individuals between 50 and 64, but also provides services for those under 50 who are at a high risk of getting colorectal cancer. The bill gives priority to low-income, uninsured, and/or underinsured individuals who would not be able to afford screenings and treatment.

The screenings and treatment will assist individuals in full, providing follow-ups, diagnostic and therapeutic services, and treatment for detected cancers. In addition, the federal grants provided will be used to train and educate health professionals in the detection of colorectal cancer. The funds provided will contribute to research for the evaluation of the colorectal screenings and treatment program.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1253 – Health Insurance Restrictions and Limitations Clarification Act of 2009
(Burgess, R-TX)

Introduced: March 3, 2009

Summary: This legislation would amend the Employee Retirement and Income Security Act of 1974, the Public Health Service Act, and the Internal Revenue Code to require group health plans to reveal any limitations and restrictions on benefits. These limitations and restrictions would have to be disclosed to the sponsor of the health plan prior to the sale of the plan. The issuer must also make descriptions of these limitations and restrictions available to participants and beneficiaries in an easily understandable manner.

Status: This legislation passed the house on March 31, 2009 by a vote of 422 – 3 and was referred to the Senate Committee on Health, Education, Labor, and Pensions on April 1, 2009.

H.R. 1441 – Ryan Dant Health Care Opportunity Act of 2009 (Marchant, R-TX)

Introduced: March 11, 2009

Summary: The Ryan Dant Health Care Opportunity Act will amend Medicaid, as amended by the Children's Health Insurance Program Reauthorization Act of 2009, to give states the option to disregard certain income in providing continued Medicaid coverage for certain individuals with extremely high annual lifelong orphan drug costs.

The legislation is designed to allow a Medicaid state option that would permit individuals to be released from the qualifying earnings restrictions. This legislation would apply only to individuals who have prescription drug costs of $200,000 a year or more and are already on Medicaid. These individuals will be on Medicaid for the duration of the illnesses and some can work without most of the earnings restrictions.

Status: This legislation was attached as an amendment to H.R. 3200 in the House Committee on Energy and Commerce.

H.R. 1458 – Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2009 (Camp, R-MI)

Introduced: March 12, 2009

Summary: The Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act will help kidney transplant recipients maintain Medicare Part B coverage of immunosuppressive drugs. These drugs are necessary to help reduce the likelihood of organ rejection.

Most kidney transplant recipients qualify for Medicare immunosuppressive drugs coverage, regardless of age, as individuals with end stage renal disease (ESRD) are entitled to Medicare coverage for kidney dialysis or transplantation if they or their spouse have paid into Social Security for a minimum of 40 quarters. However, unless they are also eligible for Medicare due to age or disability (receiving SSDI), their Medicare coverage ends 36 months post-transplant and they are forced to find other ways to pay for these expensive medications. Conversely, Medicare coverage for dialysis is indefinite.

Congress has acted previously to ensure access to these life saving medications for aged and disabled Medicare beneficiaries, but ESRD beneficiaries are still subject to the 36-month cap. This bill corrects this inequity, and would provide lifetime coverage of immunosuppressive drugs for kidney recipients who were ESRD beneficiaries at the time of transplant. The bill would eliminate the 36-month time limitation for the purposes of the transplant anti-rejection medications only -- all other Medicare coverage would cease three years after the transplant, as under current law.

Medicare spends approximately $17,000 annually on a beneficiary who has a functioning kidney transplant (after the first year of transplant), compared to $71,000 annually on a beneficiary who is on dialysis (Source: U.S. Renal Data System Annual Report, 2008).

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1468 – Medical Justice Act of 2009 (Burgess, R-TX)

Introduced: March 12, 2009

Summary: The Medical Justice Act sets forth provisions regulating civil actions for an injury or death as the result of health care based on successful reforms adopted by the State of Texas. Caps will be placed on non-economic damages against healthcare practitioners and institutions. Caps will also be set on for wrongful death awards. This legislation also requires expert reports to be provided, and allows the payment of future damages to be made on a periodic or accrual basis.

The amount a person will be entitled to for non-economic damages will be set at $250,000 from a single institution or class of practitioner and $500,000 from a class of institutions for a total possible non-economic cap of $750,000 in some cases. The cap on a wrongful death award from a single healthcare practitioner will be set at $1,400,000 total. This amount includes compensatory, punitive, statutory, and other types of damages, and will be adjusted for inflation. The jury must be unanimous in both the liability of the practitioner and the amount of the award. A claim must be brought within 2 years of when the negligence or the health care on which the claim is based occurs. For individuals under age 12, a claim must be brought before the individual reaches age 14.

Not later than 120 days after filing, the party filing must present to the other parties a qualified expert report. This report is a written report by a qualified health care expert that includes a curriculum vitae of the expert, and a summary of the opinion as to the standard of care applicable, how that standard was not met, and the relationship between the two. This report may not be used during trial.

A defendant may initiate a settlement by serving one or more qualified offers to the person seeking damages. If the qualified settlement offer is not accepted and the offeree receives a judgment at trial that is significantly less favorable than that offer, the offeree is responsible for the litigation costs of the defendant. Also, a health care practitioner that provides emergency health care on a Good Samaritan basis is not liable for damages except for willful or wanton negligence or more culpable misconduct.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1658 – Veterans Healthcare Commitment Act of 2009 (Tiahrt, R-KS)

Introduced: March 19, 2009

Summary: Prohibits anything in current law provisions authorizing the recovery by the United States of the cost of certain medical care and services provided by the Department of Veterans Affairs (VA) to veterans for non-service-connected disabilities from allowing the United States to recover or collect any charges from any third party for care or services furnished to a veteran for a service-connected disability.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1707 – Helping HANDS for Autism Act of 2009 (Granger, R-TX)

Introduced: March 25, 2009

Summary: This legislation creates a grant program to provide "autism navigator" services to help families navigate the web of services and care they need. Navigators will help guide families to current health, education, housing and social services that are often available to individuals in the autism spectrum. The program will help connect families to important treatment options soon after diagnosis, help families identify education options, and help coordinate individuals' care and community support.

H.R. 1707 also provides for the development, demonstration and dissemination of a standard curriculum for the training of first responders (police, fire departments, emergency medical technicians and other volunteers) in assisting individuals with autism and other cognitive behavioral disabilities. It provides grants to states and local government to support training of first responders.

This legislation also creates a HUD task force comprised of appropriate national and state autism advocacy groups, community-based organizations and parents who are charged with developing a housing demonstration grant program for adults with autism. The goal of the grant program is to provide individualized housing and services to adults with autism spectrum disorders.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 1891 – Sunset of Life Protection Act of 2009 (Alexander, R-LA)

Introduced: April 2, 2009

Summary: The Sunset of Life Protection Act allows a deduction from gross income for 50% of long-term care premiums. This deduction is without regard to the 7.5 % adjusted gross income limitation applicable to other medical or dental expenses. This legislation also allows individual taxpayers to claim this tax deduction regardless of whether they itemize other deductions or not. This deduction applies to expenses for medical care of the taxpayer, the taxpayer's spouse, or a dependent.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2051 – To Amend Title 10, United States Code, to Authorize Extended Benefits for Certain Autistic Dependents of Certain Retirees. (Miller, R-FL)

Introduced: April 22, 2009

Summary: This legislation revises TRICARE to authorize the Secretary of Defense to provide extended health care services and treatment for dependent autism-diagnosed children of military retirees who are not entitled to hospital insurance benefits under Part A of Medicare, and who are not enrolled under part B (Supplementary Medical Insurance) of such title. The health care services shall be entered into by the Secretary by way of contract with private providers.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2249 – Health Care Price Transparency Promotion Act of 2009 (Burgess, R-TX)

Introduced: May 5, 2009

Summary: The main purpose of H.R. 2249 is to increase healthcare transparency requirements for hospitals and health plans, as to fully inform citizens of various issues involving their health care. The bill would require each hospital disclose information regarding charges for certain inpatient and outpatient hospital services in a timely manner to all patients seeking such information. The bill also requires that hospitals and clinics must provide any patient with health insurance an estimate of all out-of-pocket health care costs within a certain period of time at the request of the patient.

Under this legislation the Secretary is not authorized or required to establish uniform standards for State laws. It allows the states to craft their laws requiring the information as they see fit. The data required would have to meet the "floor" standard and the manner in which they display the info could be coordinated with the Secretary but would not be mandated. In addition, states with previously established laws that meet the requirements of H.R. 2249 will not need to change their laws, however states with established laws that do not meet the standards of the bill will need to change only the pieces of legislation that do not meet H.R 2249's requirements. In order to fully understand which types of cost information patients find useful, the Agency for Health Care Research and Quality will conduct research on the variances of information provided by hospitals. In addition, the AHRQ will determine how information varies according to an individual's health insurance coverage and how information can be provided in a timely manner. AHRQ will begin their research 18 months after the bill is enacted. H.R. 2249 is to be effective October 1st, 2010. Also, in cases where additional State legislation beyond appropriations is required to enact this legislation, an extension will be given until the first calendar quarter after the close of the first regular session of the State legislature.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2373 – Home Oxygen Patient Protection Act of 2009
(Price, R-GA)

Introduced: May 12, 2009

Summary: The Centers for Medicare and Medicaid Services (CMS) released a rule in October 2008 that caps Medicare reimbursements for home oxygen suppliers at 36 months. Without adequate recognition of the services that home oxygen providers furnish, the quality of care that patients have come to expect will deteriorate, leading to an increase in the number of emergency room visits. This legislation amends part B (Supplementary Medical Insurance) of title XVIII (Medicare) of the Social Security Act to restore payments for home oxygen therapy through the beneficiary's period of medical need.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2520 - Patients' Choice Act
(Ryan, R-WI)

Introduced: May 20, 2009

Summary: The Patients' Choice Act would transform health care in America by strengthening the relationship between the patient and the doctor by using the forces of choice and competition rather than rationing and restrictions. It seeks to ensure universal, affordable health care for all Americans.

The Patients' Choice Act invests in prevention by establishing an Interagency Coordination Committee that will develop a national strategic plan for prevention. It also requires the development of a science-bases nutrition counseling brochure to be distributed to food stamp recipients and prohibits the purchase of foods that do not meet science-bases standards for proper nutrition.

This legislation outlines the requirements for certification of state-based health care exchanges to facilitate the purchase of innovative private health insurance. States are not required to create exchanges but have the option to do so. Any health insurance plan licensed in the state may participate in the exchange, but plans are not required to participate. Plans may still sell health insurance outside the exchange.

Under this bill, States may develop automatic enrollment procedures to ensure that any individual seeking health coverage has the opportunity to enroll in a plan of their choice. No one will be required to enroll in health insurance coverage. Plans offered through this exchange may not discriminate based on pre-existing conditions, so individuals are guaranteed access to a health insurance plan through the exchange.

Qualifying individuals will be eligible to receive an advanceable, refundable credit of at least $2,290 and $5,710 respectively in 2010, with subsequent annual cost-of-living adjustments. Should the credit exceed the cost of a health insurance product, the excess amount will be deposited into a medical savings account, or a health savings account.

The current individual income tax exclusion for employment-based heath benefits will be converted into a tax cut for taxpayers. The exclusion of health benefits from FICA payroll taxes remains. Contributions made by employers toward employee health care are still deductible as a business expense deduction.

Long-term services in Medicaid will be expanded to include an array of services, including assistive technology, community treatment teams, recovery support, and transitional care without the need for federal waivers. The legislative reorganization includes authorization of $100 million annually in new grants to states for program integrity. It also includes authorization of $100 million in outreach grants and transition rules to ensure seamless transition and effective continuation of care.

The legislation also aids low income families. Each eligible family that enrolls in the supplemental health care assistance program shall be issued a debit card with a dollar-amount value that may be used to pay for qualifying health care expenses. Families whose annual income does not exceed 100% of the poverty level will be provided $5,000. Families whose annual income is between 100% and 120% will receive $4,000. An additional $1,000 is made available for each family in which there is a pregnancy during a 12-month period. An additional $500 is made available for each member of the family under the age of 1 year old.

Fixing Medicare is also a key part of this legislation. Inefficiencies will be eliminated to increase choice in Medicare Advantage. Wealthy Medicare beneficiaries will be required to contribute a little more for their care under Medicare Part D, and all seniors will be rewarded for preventative healthy behaviors.

Reform to tort litigation for medical malpractice claims is also a key part in reigning in out of control health care costs. Funding will be available for States to establish review panels or health care tribunals. Qualifying review panels will be comprised of medical experts and attorneys appointed by the state who review health care claims and make a determination as to the liability of the parties involved. Parties may reject the determination and file a claim relating to the injury in a state court. Any party filing in state court forfeits awards from panel determination. Qualifying health care tribunals are composed of judges with explicit expertise in health care litigation who review cases at the request of individuals who have a health care claim. After review of the case, the tribunal would make a determination as to the liability of the parties involved. Parties may reject the determination and file a claim relating to the injury in a state court. The third option allows states to utilize a combination of the review panel and health care tribunal.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2607 - The Small Business Health Fairness Act (Johnson, R-TX)

Introduced: May 21, 2009

Summary: The rising cost of health insurance premiums is the biggest factor contributing to the decline of insured Americans, and the number one problem facing small businesses in this country. Estimates indicate 60 percent or more of the working uninsured work for or depend on small employers who lack the ability to provide health benefits for their workers. Working families should not have to face the struggles of everyday life without health insurance. This legislation would expand access to health coverage for uninsured families by creating Small Business Health Plans. These plans would allow small businesses to band together through associations and purchase quality health care for workers and their families at a lower cost. This pooling would increase small businesses' bargaining power with health care providers, give them freedom from costly state-mandated benefit packages, and lower their existing health care costs by as much as 30 percent.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2692 – CAH Designation Waiver Authority Act of 2009 (Thornberry, R-TX)

Introduced: June 3, 2009

Summary: Every year, more and more of our rural community hospitals close due to higher costs and the inability to make ends meet. The loss of a hospital to a small rural community is often a serious blow to the whole community. The Critical Access Hospital designation is one way to equalize the playing field for these small community hospitals and to give them a chance at survival. H.R. 2692 would once again allow States the authority to waive the 35 mile requirement for Critical Access designation as long as a hospital meets all the other requirements for designation.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2784 – Partnership to Improve Seniors Access to Medicare Act (Thornberry, R-TX)

Introduced: June 10, 2009

Summary: The Partnership to Improve Seniors Access to Medicare Act would create a program that would provide $20,000 a year in student loan repayment to medical professionals who agree to fill up to 30% of their practice for the year with Medicare patients. The goal of this bill is to provide an additional incentive for doctors, nurses, and other medical professionals to accept Medicare patients into their practice. As many of you know, it is becoming increasingly difficult to find a doctor who accepts Medicare in many areas of the country. Often, seniors are forced to drive great distances to find a doctor who accepts Medicare.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2785 – Health Care Paperwork Reduction and Fraud Prevention Act (Thornberry, R-TX)

Introduced: June 10, 2009

Summary: The Health Care Paperwork Reduction and Fraud Prevention Act establishes a Commission on Billing Codes and Forms Simplification that is tasked with working with Medicare and the medical community to standardize and simplify billing practices while protecting patient privacy. The Commission would also study electronic forms and billing practices with the same goals in mind. This measure takes a practical approach by establishing pilot programs to work out the details with doctors, insurance companies, and government agencies before system-wide changes are implemented.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2786 – Patient Fairness and Indigent Care Promotion Act of 2009 (Thornberry, R-TX)

Introduced: June 10, 2009

Summary: The Patient Fairness and Indigent Care Promotion Act would help doctors treat low-income patients by allowing them to deduct the costs of treatment as a bad debt write-off from their federal taxes. This measure will help provide incentives to doctors to treat more non-paying patients. The bill will also save the health care industry money because it is almost always more expensive to treat individuals in emergency rooms than in doctors' offices. As you know, the median cost of an emergency room visit is nearly five times the cost of a typical office visit, so the more people out of the emergency room, the more money saved throughout the entire health care system.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2787 – Medical Liability Procedural Reform Act of 2009 (Thornberry, R-TX)

Introduced: June 10, 2009

Summary: The Medical Liability Procedural Reform Act will authorize the Attorney General to give grants to states that establish health care tribunals that provide alternatives to current tort litigation. The data collected in these projects will be used to improve patient care and decrease medical errors. With $60 to $108 billion being spent on defensive medicine every year, clearly change is needed. These tribunals will not only provide a more fair and predictable liability process for doctors, they will encourage the sharing of best practices among medical professionals in all states, leading to a safer, and more uniform medical system for all Americans.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2925 – Communities Building Access Act (Hoekstra, R-MI)

Introduced: June 17, 2009

Summary: The Communities Building Access Act would provide $45 million in federal grants over a seven-year period for two models of proven, locally designed and administered health care programs for the uninsured, and would establish a data and assistance center to evaluate and aid in the proliferation of these programs. The legislation was specifically designed to compliment, not duplicate, current federal initiatives for the uninsured, including health savings accounts, community health centers, and Medicaid and S-CHIP programs.

These community grants would be leveraged with employer, employee and other community contributions to purchase a locally-developed insurance-like product for individuals working in small businesses not already offering health benefits. These community matching grants are intended to increase access to specialty care for low-income individuals who regularly access voluntary provider networks or other primary care clinics for the uninsured. Examples of allowable grant expenditures include fees for recruiting specialist providers, training for treating specialty conditions, electronic medical records for uninsured individuals (known to improve providers willingness to volunteer), and administration of specialty care community clinics.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 2975 – Medical Practice Protection Act of 2009 (Campbell, R-CA)

Introduced: June 19, 2009

Summary: The Medical Practice Protection Act is a liability reform bill modeled after California's extremely successful Medical Injury Compensation Reform Act (MICRA), which has kept liability insurance rates stable in the state. Under this legislation's guidelines, there is an unlimited cap placed on economic damages, and a $250,000 hard cap on non-economic damages. This legislation also has a ban on subrogation by collateral sources, and will ensure injured parties are fully compensated. The periodic payment of future damages is allowed if requested.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless there is proof of fraud, intentional concealment, or the

presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

There will be court supervision over the share of damages that are actually paid to the claimant. In particular, in any health care lawsuit in which the attorney for a party claims a financial stake in the outcome of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to the attorney, and to redirect such damages to the claimant. Under no circumstances shall the total of all contingent fees for representing all claimants in a health care lawsuit exceed 40% of the first $50,000 awarded, 33.3% of the next $50,000 awarded, 25% of the next $500,000 awarded, or 15% of any amount by which the recovery is in excess of $600,000.

Punitive damages may be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that the person acted with malicious intent to injure the claimant, or that the person deliberately failed to avoid unnecessary injury that the person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is rendered against the person, no punitive damages may be awarded with respect to the claim in that lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court.

The Medical Practice Protection Act differs from other Medical Professional Liability Reform bills by only not capping punitive damages, but instead establishing a "clear and convincing" standard for awarding damages.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3141 – Strengthening the Health Care Safety Net Act of 2009 (Sullivan, R-OK)

Introduced: July 9, 2009

Summary: The Strengthening the Health Care Safety Net Act seeks to restore funding to Medicaid's Low Disproportionate Share Hospital (DSH) States for FY 2009. Since FY 2009, low DSH states are receiving limited consumer price index inflation adjustments to reimburse for uncompensated care costs for the indigent and uninsured. This legislation is intended to continue the increases to low DSH states and to create a grant program for local health care organizations willing to create a coordinated program to serve their low income and uninsured constituents.

A redistribution fund will be created for unused federal Medicaid DSH funds to strengthen the nation's health care safety net. Half of the funds will be redistributed to increase the availability of DSH funds to states currently receiving low or less than average DSH

allotments, and the other half will be used to provide grant funds to integrated "health access networks" of community health centers, public hospitals, federally qualified health care centers, and other safety net providers.

This legislation will also keep funds allocated to the safety net with their providers, provide grant money to test implementation of high quality integrated networks of safety net providers, and update the grandfather clause of OB/GYN mandated services for low DSH states. It will also require that CMS create a DSH reporting document for allocations and expenditures and that all states' expenditures be recorded on the document, even if DSH money is being spent through a waiver.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3217 - Health Care Choice Act (Shadegg, R-AZ)

Introduced: July 14, 2009

Summary: The Health Care Choice Act empowers consumers by giving them the ability to purchase an affordable health insurance policy with a range of options. It will allow consumers to purchase health insurance licensed in other states – expanding choice and increasing affordability. Interstate shopping is vital to bringing prices down through free enterprise. The National Center for Policy Analysis notes that a healthy 25-year-old male could purchase a basic health insurance policy in Kentucky for $960 a year. That same policy in New Jersey, however, would cost $5,880 a year. The Health Care Choice Act would enable the market to mitigate such enormous price differentials.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3218 - Improving Health Care for All Americans Act (Shadegg, R-AZ)

Introduced: July 14, 2009

Summary: The bill allows Americans who do not have employer-sponsored care or those not satisfied with their employer-sponsored plan to buy their own plan on the same tax-advantaged basis their employer enjoys. Americans who pay income taxes get a dollar-for-dollar reduction in their tax bill up to $2500 for individuals and $5000 per family. Americans who don't pay income taxes get the same amount from the government to buy a policy of their choice. This credit is allowed only to citizens, nationals, and those who are lawfully present in the U.S.

This legislation creates expanded options for the purchase of low-cost health care from new pooling mechanisms. Insurance pools that Americans can select to join will be dramatically expanded by allowing churches, alumni associations, trade associations, and other civic groups to set up new insurance pools and offer affordable health care packages to their members. Instead of having only one group policy to choose from, under this bill, every American will be able to choose from a number of "group plans."

The Improving Health Care for All Americans Act takes a radically different approach in contrast to what has been discussed by President Obama, as well as Democrats in both chambers. It gives people choices and places American families back in control of their plans and their health care. This legislation will reduce the cost and improve the quality of health care while expanding access and portability.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R 3261 – Access to Medical Treatment Act (Burton, R-IN)

Introduced: July 20, 2009

Summary: For thousands, FDA-approved drugs simply do not work, or offer only limited relief; yet the Food and Drug Administration (FDA) often denies access to promising natural therapies because they do not meet the Agency's strict guidelines for approval. The Access to Medical Treatment Act (AMTA) addresses this by giving Americans the freedom to choose any licensed health care practitioner and any method of medical treatment the individual desires as long as the treatment is not dangerous and the patient is fully informed of its side effects. This legislation will not dismantle the FDA, undermine its authority, or change conventional medical practices.

Of course, patient safety is paramount. AMTA ensures access to safe and effective therapies through a carefully controlled and monitored system whereby only three

categories of drugs and devices would be allowed: (1) those that are undergoing FDA approval that have limited patient access; (2) treatments approved for use in select foreign countries but not FDA approved; and (3) non-patentable natural substances with proven pharmacological treatment value. Furthermore, AMTA requires physicians and authorized health care practitioners – under strict medical supervision – to recommend and provide both non-FDA and FDA-approved therapies only when there is no reason to conclude that a treatment would cause harm to a patient. Prescribing substances covered by the Controlled Substances Act and public advertising about the efficacy of a treatment by a manufacturer, distributor, or other seller of the treatment is strictly prohibited. The safety requirements go even further by requiring continual provider examination that a treatment is within a provider's scope of medical practice, detailed informed consent, and medical outcomes reported to the National Institutes of Health and the Centers for Disease Control.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3356 – Medicare Beneficiary Freedom to Choose Act (Johnson, R-TX)

Introduced: July 28, 2009

Summary: Currently, seniors can opt out, or delay enrollment, in Medicare Parts B and D, but not Part A. That's due in large part to agency regulations that require a senior who receives their monthly Social Security benefit and is 65 to be automatically enrolled in Medicare Part A. This bill allows individuals to voluntarily opt out of Medicare Part A when they become eligible for the benefit. There are seniors who can afford to pay for and would prefer private health coverage who should be able to opt out of the Medicare program. There are other seniors who like the type of coverage they have, either through their retiree benefits or through their employer, that would like to opt out of Medicare Part A so they can keep their current coverage.

Estimates show that if 1% of seniors chose to opt out of Medicare, it could save up to $1.5 billion per year. Due to the increasing number of retirees, in 2017 that number increases to $3.4 billion per year. This bill would give individuals the ability to opt out of the Medicare Part A program once they become eligible.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3372 – Health Care Over Use Reform Today Act (HEALTHCOURT Act) of 2009 (Price, R-GA)

Introduced: July 29, 2009

Summary: The Health Care Over Use Reform Today Act is a medical liability reform bill that develops performance-based quality measures established by the Physician Consortium for Performance Improvement (PCIP) and physician specialty organizations. It will establish a best-practices affirmative defense set by a qualified physician consensus-building organizations and physician specialty organizations. It will also allow for grants for State Health Courts for the resolution of disputes concerning injuries allegedly caused by health care providers.

The Secretary of Health and Human Services shall issue best-practice guidelines that have been endorsed by the qualified physician-based consensus entity and physician specialty organizations. If a physician has followed best practice guidelines then no non-economic damages will be awarded in trial. There will also be no punitive damages awarded against health care practitioners based on a claim that such treatment caused harm where that treatment was subject to review by the PCIP, that treatment was approved by the PCIP, or that treatment is generally recognized among qualified experts as safe, effective, and appropriate. There will be no presumption of negligence if a participating physician does not adhere to the guidelines, and states may build-upon these provisions in addition to this Act.

This Act will give grants to states to create administrative health care tribunals. Each case must first be reviewed by a panel of experts made up of no less than 3 and no more than 7 members (half must be physicians), selected by a state agency with clearly defined expertise. This panel will make a recommendation about liability and compensation. The parties my settle or may proceed to the tribunal. At the tribunal state, parties may be represented by counsel. The tribunal must be presided over by a special judge with health care expertise. The judge will have the authority to make binding rulings on standards or care, causation, compensation, and related issues. The legal standard for the tribunal will be gross negligence. If either party is displeased with the tribunal's decision, that party may appeal the decision to a state court, to preserve a trial by jury. Any determinations made by the panel and the tribunal will be admissible in court. Once one party appeals to a state court, any previous determinations are void. If the party that appeals to state court is unhappy with the court's decision, the party may not receive the compensation that the tribunal determined to be appropriate.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3400 – Empowering Patients First Act
(Price, R-GA)

Introduced: July 30, 2009

Summary: The Empowering Patients First Act aims to increase patients' control over their health care decisions by offering more choices and the highest quality available. This legislation is centered on granting access to patient-controlled health insurance coverage for all Americans, while improving the health care delivery structure and reining in out-of control costs. There are limitations on federal funds being used for abortions, and this legislation only applies to legal permanent residents or citizens of the United States.

The purchase of health care will be made financially feasible using a hybrid tax structure. The income tax deduction on health care premiums will be extended to those who purchase coverage in the non-group/individual market. This deduction will be above the line, and will be capped to allow for a deduction up to the average value of the national health exclusion for employer sponsored insurance indexed for inflation. A low income tax credit will be provided for premiums on a sliding scale, phased out as income increases. The credit will be based on the average health care insurance costs across the U.S., offered at $2,000 for an individual, $4,000 for a couple, and $5,000 for a family. This credit will be advanceable and refundable for individuals and families up to 200% of the federal poverty level. It will be a phased out credit from 200% to 300% of the federal poverty level.

The Empowering Patients First Act will also allow individuals the choice to opt out of federal benefits, the Federal Employees Health Benefit Program (FEHBP), and employer subsidized group health plans. For example, an individual will be allowed to opt out of Medicare with the ability to retain their Social Security benefits.

This legislation protects employer-sponsored insurance by allowing for an employer to auto-enroll employees with an opt-out. Small businesses will receive tax incentives for this adoption. Employers will be required to disclose on their W2 Form the annual amount the employer spends on the employee's premium.

Improvements will also be made in the individual market by incorporating pooling mechanisms for small businesses (from H.R. 2607 by Congressman Johnson) and for individual membership accounts (from H.R. 3218 by Congressman Shadegg). Also incorporated will is H.R. 3217 by Congressman Shadegg, which will allow individuals to shop for insurance across state lines. An individual in a state may only shop across state lines if their state premium exceeds 10% above the national average. Those with pre-existing conditions or high health care needs will also be ensured coverage by an increased federal block grant for functioning, qualified high risk pools. States will not receive credits unless they establish a pool meeting certain criteria.

A key way to rein in on out-of-control costs is through medical liability reform. Caps on non-economic damages will be established by incorporating Congressman Gingrey's HEALTH Act of 2009 (H.R. 1086). Affirmative defense measures will be put into place

through provider-established best-practice measures. There will be no presumption of negligence if a participating physician does not adhere to the guidelines.

Medicare reform is necessary, and this legislation will reform Medicare physician payments. It will rebase SGR and establish two separate conversion factors, one for primary care and one for all other services.

There will also be incentives for physicians. Primary care physicians will receive help with loan repayment, up to $50,000 after 5 years of practice. There will be a Health Professional Student Loan (HPSL) program created for medical schools which allow the deferment of payments until after full residency and any fellowship training programs are completed. Also, Emergency Room physicians will be allowed to receive a deduction for uncompensated care.

Also incorporated in this legislation are portions of H.R. 3176 from Congressman Barton in the 110th Congress. States will be required to cover 90% of SCHIP eligible individuals below 200% of the federal poverty level first before they can expand current eligibility levels. There will be vouchers to purchase Medicaid & SCHIP, and any unspent money will be refunded based on the state/federal share unless the enrollee has an Health Savings Account (HSA). The State will be required to include pathways for premium assistance for employer sponsored insurance as part of the State plan.

This legislation will also allow for employers to offer discounts for healthy habits. There will also be HSA clarification for the treatment of capitated primary care payments as amounts paid for medical care. This provision is also found in H.R. 2520 by Congressman Ryan.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3422 – Medicare Support for Rural Hospitals Act (King, R-IA)

Introduced: July 30, 2009

Summary: The Medicare Support for Rural Hospitals would increase Medicare payments to so-called "tweener" hospitals in FY10. "Tweener" hospitals are too big to be considered for the extra Medicare payments that Critical Access Hospitals can get, but they're too small to have the volume of patients necessary to make the regular Medicare Prospective Payment System work for them as large hospitals do. This legislation pays for these payments by repealing the section of the SCHIP expansion bill that allows states to "verify citizenship" for Medicaid purposes through the use of Social Security numbers rather than through the use of verifiable citizenship documents like birth certificates.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3438 – Access to Insurance for All Americans Act (Issa, R-CA)

Introduced: July 31, 2009

Summary: The Access to Insurance for All Americans Act allows for non-federal employees to enroll in the same health care plan that is currently enjoyed by Members of Congress and federal employees through the Federal Employee Health Benefit Program. Individuals may enroll in a health benefits plan, unless the individual is enrolled or is eligible to enroll for coverage under a public health insurance program, like Medicare or Medicaid. Uniformed service members and those enrolled or eligible to enroll in a plan under Chapter 89 are not eligible.

This legislation would allow for a tax deduction equal to the amount paid for premiums during the taxable year for coverage for the taxpayer, spouse, and dependents. This legislation also allows the insurance plans to be portable, so employees can take their coverage with them when they change jobs.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3454 – Medicare Hospice Reform and Savings Act of 2009 (Sullivan, R-OK)

Introduced: July 31, 2009

Summary: The Medicare Hospice Reform and Savings Act directs the Centers for Medicare and Medicaid Services (CMS) to reform the hospice payment system, and provide relief to those hospices that have received demands from CMS for back payments for the 2006, 2007, and 2008 audit years. The legislation also repeals the Budget Neutrality Adjustment Factor (BNAF).

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3478 – Patient-Controlled Healthcare Protection Act of 2009 (Gohmert, R-TX)

Introduced: July 31, 2009

Summary: The Plan would provide incentives for employers, employees and the self-employed to purchase private insurance with a high deductible, while paying into a Health Savings Account (HSA). There is no limit on the amount that may be placed in the HSA**,** and any amount not used rolls over. It can also be gifted to other individuals' HSA, inherited by the HSA of heirs, and accessed by a debit card coded for healthcare purchases only.

Anyone eligible for Medicare, Medicaid, SCHIP or any combination has the option each year of having the federal government purchase private insurance with a high deductible, while also funding cash into a Health Savings Account that covers the deductible. This plan would put the country on a correction course to actually save money on healthcare each year, all while giving patients the control and coverage we have long desired.

This plan provides patients both choices and security, allowing the selection of the doctor you choose without interference from an insurance company or government bureaucrat. The legislation further provides for complete transparency in the cost of healthcare by requiring healthcare providers to produce a list of charges for procedures, treatments, or expenses to any potential patient, as well as the prices that are charged to other entities. Also, anyone seeking to travel or immigrate to the United States must provide proof that they will have full healthcare coverage while here. Such coverage may be through a sponsoring employer or a resident in whose household the immigrant intends to reside. Otherwise, a visa will not be granted. If healthcare coverage ceases while the migrant is here, then the visa expires. If someone who is illegally in the U.S. requires free healthcare, that alien will get it as the law requires, then be deported. Anyone who has been deported following the receipt of free healthcare, and is found again illegally in the U.S., will be guilty of committing a felony. The bill sponsor notes, **"**We simply cannot allow

immigrants coming here illegally to bankrupt this nation so immigrants have no United States to come to legally. This will also protect the free market principles on which our nation was founded. This plan gives patients complete control and complete coverage that is affordable and accessible. Medicine will once again be about the patient's needs and the doctor's diagnosis, with true competition like we haven't had in a very long time, if ever."

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3584 – Health Care Consumer Protection Act of 2009 (Forbes, R-VA)

Introduced: September, 16, 2009

Overall: Right now, insurers sometimes cancel an individual's coverage simply because they miss one payment, often leaving an individual with thousands of dollars in uncovered medical bills. This often occurs while they were hospitalized and unable to pay their bills as usual, due to illness or injury. The Health Care Consumer Protection Act would preserve the ability for consumers to reinstate their cancelled benefits once they pay any back premiums. To guard against fraud, companies can impose a fee to prevent repeated non-payment and reinstatement.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3610 – Health Savings and Affordability Act of 2009 (Austria, R-OH)

Introduced: September 22, 2009

Overall: The Health Savings and Affordability Act makes improvements and expansions to Health Savings Accounts (HSAs), as well as makes health care insurance tax deductible for everyone. Currently, individuals who receive health insurance through an employer-sponsored program pay for these benefits with pre-tax dollars. Those who pay for their own health insurance out-of-pocket, pay for their plans with after-tax dollars. To correct this disparity and improve fairness, this bill provides for a tax deduction for qualified health insurance costs for individuals who purchase their own health insurance.

Current law allows HSA-eligible spouses 55 and older to make additional catch-up contributions to their HSAs. However, these catch-up contributions must be deposited into separate accounts even if both spouses are eligible to make catch-up contributions. This bill allows both spouses, if both are 55 or older, to make catch-up contributions to one HSA account even if a spouse is not a beneficiary of the account.

Some family plans have both individual and family-as-a-whole deductibles. Under current law, family coverage plans with both individual and family-as-a-whole deductibles do not qualify as High Deductible Health Plans (HDHP) if both of the deductibles do not meet the minimum annual deductible for family coverage. This legislation would qualify family plans with both individual and family-as-a-whole deductibles as HDHPs if either the individual or family deductible meets the minimum deductible for qualified HDHPs.

This legislation would eliminate some of the requirements previously placed on rolling over unused funds from employer sponsored Flexible Spending Arrangements (FSAs) and Health Reimbursement Arrangements (HRAs). Additionally, this legislation would prohibit the "use it or lose it" stipulation of FSAs if there is a balance left on the account at the end of the year. It also allows for a one-time unlimited roll-over from an FSA or HRA into an HSA, and eliminates the additional 10 percent tax for failure to maintain an HDHP.

This legislation would allow for certain exercise equipment and physical fitness programs to be treated as a qualified medical expenses, which would in turn allow for a medical expense tax deduction up to $1,200 when taxpayers itemize.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R 3693 – Ensuring the Future Physician Workforce Act of 2009 (Burgess, R-TX)

Introduced: October 1, 2009

Summary: This legislation would keep the Sustainable Growth Rate (SGR) at 2009 levels (1.1%) for 2010. Beginning in 2011 the SGR would be eliminated and the Medicare Economic Index (MEI) will be used to produce updates.

Because Medicare treats some of the country's sickest patients, it is important that Medicare constantly seek to improve the care it provides. The incentives to report such data are set at 2.0 percent for 2009. Starting in 2010, the bonus payment would increase for quality reporting from 2.0 percent to 3 percent and the program would remain in effect through 2011. In 2012, the bonus would decrease to 1 percent and eligible measures would focus on the 10 highest cost disease conditions.

Under this legislation, each physician would receive a report on their billing practices to Medicare, compared to those of other area physicians. This is done so they know how they compare to the average and can personally examine areas that may be inappropriately utilized. This report will be confidential. Each beneficiary would also receive an annual report on the amount of payments made to or on the behalf of the individual (Parts A and B). This is done so they know how they compare to the average and can personally examine their usage.

This legislation will also collect data on Medicare savings gained by diverting hospital stays (Part A) with out-patient care (Part B). Medicare funding will also be examined to see where savings can be found within the system.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3700 - 10 Prescriptions for a Healthy America Act (Gingrey, R-GA)

Introduced: October 1, 2009

Summary: The 10 Prescriptions for a Health America Act are a collection of themes taken from the August town halls that would safeguard the health care of the over 80% of the people who are satisfied with their current coverage. It does so by prohibiting Congress from enacting health care reform legislation in the 111th Congress that creates a government-run health care plan, cuts Medicare benefits, adds to the deficit, raises taxes, rations health care, imposes either an individual or employer mandate, or that provides coverage to illegal immigrants. Additionally, this legislation would require Congress to enact before the end of the year the following: meaningful medical liability reform, market coverage for individuals with pre-existing conditions, and other measures to reduce the overall cost of health care.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R 3741 – Assuring Coverage for Americans with Pre-existing Conditions Act of 2009 (Hoekstra, R-MI)

Introduced: October 7, 2009

Summary: The purpose of H.R. 3741 is to provide Federal matching funding for State insurance expenditures for high-risk pools. The Secretary of Health and Human Services will provide each State an amount equal to 50% of the funds expended by the State in order to establish a high-risk pool, reinsurance pool, or other risk-adjustment mechanism used for subsidizing the purchase of private health insurance. Each State will receive a maximum of fifty cents times the average number of residents in the State in a fiscal year. The Secretary of Health and Human Services may establish terms and conditions such as application forms or other requirements to carry out the provisions of H.R. 3741. The bill does not require a State to operate a reinsurance pool or other risk adjustment mechanism and does not prevent States from operating a similar pool or mechanism through a private entity.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3776 - Helping Make Health Insurance Affordable for Individuals and Small Businesses Act of 2009 (Graves, R-MO)

Introduced: October 8, 2009

Summary: The Helping Make Health Insurance Affordable for Individuals and Small Businesses Act allows individuals to fully deduct the cost of health insurance premiums from their income taxes. Current law only allows individuals to deduct non-compensated health care costs, including premiums, when those costs exceed 7.5% of their adjusted gross income (AGI). This usually requires tax payers to spend many thousands of dollars before being granted even a limited ability to deduct these costs.

However, those individuals with access to an employer-sponsored group plan can pay their premiums on a pretax basis, which shields these payments from both income and payroll taxes. While not providing full pretax treatment, The Helping Make Health Insurance Affordable for Individuals and Small Businesses Act is a step in the right direction toward ending the tax code's discrimination against the uninsured.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3806 - Enhanced Rural Health Care Extension Act of 2009 (Moran, R-KS)

Introduced: October 14, 2009

Summary: Small towns are built around the "The Basics" – hospitals, pharmacies, long term care facilities, churches, schools, grocery stores, and jobs. Access to these basics determines whether communities survive and flourish. The Rural Community Hospital Demonstration Program, which is set to expire in November 2009, helps rural hospitals by providing them with enhanced Medicare reimbursements for inpatient services and other assistance. H.R. 3806, the Enhanced Rural Health Care Extension Act of 2009 would (i) extend the program by 5 additional years; and (ii) expand the program to include and consider hospitals from the 15 states with the lowest population density in the U.S. Only the country's ten least sparsely populated states were originally authorized for participation. Rural hospitals across the country appear to meet all the necessary criteria to be considered for participation in the program but are denied that opportunity because their state is not included. H.R. 3806 would allow many of those hospitals that opportunity.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3821 - Improved Employee Access to Health Insurance Act of 2009 (Deal, R-GA)

Introduced: October 15, 2009

Summary: Currently, many individuals have the option to enroll in employer-sponsored health insurance plans, but simply do not enroll. The Improved Employee Access to Health Insurance Act would prohibit states from enacting laws which keep employers from 'auto-enrolling' employees in currently offered health benefit plans, provided the employee has the option to opt out with no penalty. Research suggests that auto-enrollment mechanisms, by overcoming inertia and complexity, could increase coverage levels dramatically. In contrast to a federal mandate that all Americans must purchase insurance or face fines, the approach taken in this bill would protect individuals' ability to make their own health care decisions.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3822 – To Permit Employers to Provide Contributions and Assistance to Certain Employees who Purchase Individual Health Insurance. (Deal, R-GA)

Introduced: October 15, 2009

Summary: Due to a flaw in current law, employers in the U.S. cannot help their workers buy insurance on the individual market through tax-free defined contributions. The economic realities of operating a small business in a competitive market often mean that small businesses are not capable of fully funding the cost of health insurance coverage for all of their employees, and this prohibition in current law only serves to prevent small businesses from being able to provide at least partial assistance to their employees. This leaves workers in these businesses with the unappealing options of going without health insurance, buying it with after-tax dollars on the individual market, or (if they are low-income) enrolling in a government-subsidized program like Medicaid. This legislation would correct this flaw in current law by clarifying that employers who do not offer insurance today may provide tax-free defined contributions to workers' individually purchased insurance policies. Further, it would reform existing rules governing insurance markets that make it difficult for employers to help their workers buy health insurance on the individual market.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3823 - Medicaid and SCHIP Beneficiary Choice Improvement Act (Deal, R-GA)

Introduced: October 15, 2009

Summary: Today, most Medicaid and SCHIP beneficiaries do not have the option of selecting premium assistance for a higher-quality private health insurance plan instead of the standard, one-size-fits-all state-run benefit. The Medicaid and SCHIP Beneficiary Choice Improvement Act would provide all Americans on Medicaid and SCHIP the ability to use premium assistance to purchase private insurance instead of participating in the government-run option. Specifically, it would provide all Medicaid and SCHIP beneficiaries with the right to choose the health care coverage that best fits their needs by requiring all state Medicaid and SCHIP programs to give beneficiaries the option of receiving premium assistance for employer-sponsored health insurance coverage or any other participating health insurance plan that has met the coverage requirements that already exist in current law. States would establish a uniform monthly payment rate for these alternative coverage option plans that must be at least 90% of the per capita monthly cost of the state's standard Medicaid or SCHIP benefit.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3824 – Expanded Health Insurance Options Act (Deal, R-GA)

Introduced: October 15, 2009

Summary: Today, individuals must buy insurance within their individual states, which limits the size of the insurance pool and therefore can increase the cost of health insurance premiums while limiting the number of choices available to healthcare consumers. This bill would authorize states to form regional compacts that will govern the sale of health insurance, which will increase the size of insurance pool and reduce premiums by spreading risk among a larger number of participants.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R 3830 – Health and Wellness for Americans Act of 2009 (Fortenberry, R-NE)

Introduced: October 15, 2009

Summary: This Act establishes a national Chronic Disease Prevention and Wellness Individual Achievement Matrix that defines a standard national benchmark for prevention and wellness upon which incentives may be based. It consists of the following six measurable, demonstrable clinical factors that, when achieved, significantly reduce risk of the leading chronic diseases suffered by Americans.

1. Achieve the recommended body mass index for an individual's height and weight, or alternatively, an individual's recommended waist circumference;
2. Achieve the recommended lipid profile levels that make up a full lipid panel, or alternatively, the recommended ratio of high density lipoprotein (HDL) to low density lipoprotein (LDL);
3. Achieve the recommended blood pressure level;
4. Achieve the completion of all cancer screenings recommended for age and gender, based on guidelines of the U.S. Preventive Services Task Force;
5. Achieve a non-smoking status; and
6. Achieve the recommended fasting blood sugar level, or alternatively if diabetic, the recommended hemoglobin A1c level.

The purpose of establishing this standard national benchmark is to help individuals lower their risks of chronic disease, to reduce the overall incidence of chronic disease on a national scale, and to lay the foundation for future policies that incentivize individual achievements based on this matrix.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3831 – Hospice Support Act of 2009 (Fortenberry, R-NE)

Introduced: October, 15, 2009

Summary: The purpose of this the Hospice Support Act is to prevent reductions in the reimbursement of hospice services. Hospice is a concept of health care that allows individuals who have a short life expectancy of approximately six months or less, and who want to approach their final days in the comfort of their home without extensive medical intervention or hospitalization, to receive pain control medications and basic nursing care in their homes. Under the American Recovery and Reinvestment Act of 2009, hospice care may undergo reductions in its Medicare reimbursement. This Act eliminates the phase out of the Medicare hospice budget neutrality adjustment factor so that no such reductions in reimbursement result.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3839 – To amend title 10, United States Code, to authorize the reimbursement of mental health counselors under TRICARE, and for other purposes. (Rooney, R-FL)

Introduced: October 15, 2009

Summary: H.R. 1308 is a bill that would require face-to-face screening for troops returning from deployment. In an appeal to Congress, the Department of Defense stated that the current post-deployment health screenings were sufficient and that a face-to-face program would stretch an already thin staff of mental health professionals. A study conducted at the Naval postgraduate school in conjunction with Stanford University suggested that nearly 35% of U.S. returning troops from Iraq will suffer from Post Traumatic Stress Disorder (PTSD). Additionally, Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff, spoke at a defense forum on nonphysical injuries of war and said that local communities had a responsibility to help those returning veterans.

Currently, TRICARE requires that any mental health services provided by professional licensed counselors to require a physician referral and supervision. This referral and supervision standard does not apply for licensed social workers or certified marriage and family therapists. Today there are over 110,000 professional licensed counselors in the United States, licensed to practice independently as full-fledged mental health professionals. These professional licensed counselors have equivalent education, training and scopes of practice to TRICARE providers who have independent practice rights. In 2006 the Veterans Benefits, Health Care, and Information Technology Act amended Section 7401 to explicitly recognize licensed mental health counselors as service providers for our nation's veterans. Today TRICARE law fails to provide access to those currently serving on active duty to the same population of mental health professionals. There is no

valid clinical or policy basis for continuing this outdated, inconsistent policy of requiring referral and supervision for use of professional counselors' services. There is no valid clinical or policy basis for continuing this outdated, inconsistent policy of requiring referral and supervision for use of professional counselors' services. This legislation authorizes reimbursement of mental health counselors under TRICARE.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3889 – Offering Patients True and Individualized Options Now Act (Broun, R-GA)

Introduced: October 21, 2009

Summary: The Offering Patients True and Individualized Options Now (OPTION) Act is a comprehensive health care plan that will protect the health care elements that thrive and transform health care financing failures. Once implemented, the OPTION Act will make the purchase of health care more affordable to more people.

The OPTION Act will extend the tax deduction on health care premiums to all individuals, making health care expenses totally deductible for individuals, and not just businesses. All expenses currently allowed to be purchased with Health Savings Accounts (HSAs) will be tax deductible also. Individuals who have employer health care plans but still incur costs on medical expenses, deductibles, premiums, pharmaceuticals (prescribed, over the counter, etc.), or any medical related expenses would qualify for this deduction. Medicare recipients will also be allowed to deduct their Medicare supplemental insurance premiums.

This legislation increases access to health care by expanding the contribution levels and eligibility of HSAs. Medicare recipients will be allowed to continue to contribute money into their HSAs even after they reach Medicare eligibility, as this is forbidden under current law. Additionally, if an individual with an HSA passes away with money in their HSA, that money will be allowed to be inherited by the beneficiaries of the account holder's estate. HSA contributions will continue to rollover from year to year and will be compounded. Interest earned from HSA's will be tax-deductible. Companies will be allowed and encouraged to purchase catastrophic insurance for their employees as a companion for matching employee contributions, or a certain percentage of employee contributions, into an HSA. Under this legislation, HSA savings would automatically be eligible to rollover into Medicare Savings Accounts.

Individuals with HSA's will be allowed to donate their contributions to charity, which would also be a qualifying tax deduction. Physicians would also be allowed a tax credit, of up to $8,000, for providing charity medical care. Eligible charity care will consist of both volunteering in clinics as well as pro bono work performed in a private practice.

Medicare reform is an essential key in health care reform, and Medicare will be restructured from a government administered health care program to a market-based voucher system. Medicare will issue vouchers to each participant in the program at the beginning of the year, at a specific amount equal to 110% of the current per beneficiary allotment of Medicare per county. This voucher may be used to buy private insurance, or contributed with additional funds into a Medicare Savings Account (MSA). The MSA would have the same tax benefits and be under the same regulations as HSAs.

Portability of health insurance plans will be increased allowing for individuals to be able to keep their health insurance indefinitely if they choose once they leave their jobs. There is also nothing in this legislation that will preclude a medical provider or an insurance company from publicly disclosing their prices, which will allow for greater transparency in the health care market. Individuals will also be allowed to shop across state lines for health insurance.

This legislation allows for medical professionals with certified, basic medical knowledge (such as a PA, RN, EMT, etc.) to triage patients coming into an Emergency Department (ED) and decide if their ailment is truly "emergent", by the current EMC standard. The EMC standard is: If a treatment is deemed to not be emergent then a technician, with redundant approval, would be able to direct the patient to a more suitable treatment place, such as a clinic, an urgent care facility or simply to their regular physician. Ideally, this component would be part of a large scale education and resource allocation program, to help serve underserved populations by utilizing the hospitals, clinics and doctors in various areas.

Any qualified entity will be allowed to create an insurance pool and negotiate health insurance plans on behalf of any participating member. This provision takes existing Association Health Plan Language (as of yet not law) and expands it to allow for the inclusion of not just associations, but any entity (Rotary Clubs, Neighborhood Associations, etc.) who meet basic qualifications such as having a Constitution, conducting regular meetings and having a tax identification number on file with a state's Secretary of State's office, to negotiate on behalf of their participating membership health care plans and rates.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 3971 – Health Savings Account Expansion Act of 2009
(Flake, R-AZ)

Introduced: October 29, 2009

Summary: Currently, in order for an individual to open a Health Savings Account (HSA), the individual must enroll in a qualified High Deductible Health Plan (HDHP). The Health Savings Account Expansion Act would remove this mandate and allow individuals to use pre-tax dollars to pay for health care regardless of their enrollment in an insurance plan. This legislation would also permit HSA's to pay for health insurance premiums.

Existing law maximizes yearly contributions to an HSA at $3,000 for an individual and $5,950 for a family. This legislation increases the allowable yearly contribution to $8,000 for an individual and $16,000 for a family. These funds could be used to pay for health insurance premiums, paying for health care costs out of pocket, or to build a reserve for future medical expenses that if not used can be used for retirement.

In the first year that Medicare enrollees become eligible to enroll in Medicare they would be allowed to contribute funds into an HSA. The maximum amount allowed would be in proportion to the number of months in the calendar year they were not eligible to enroll in Medicare.

This section would also repeal the current tax deduction if health care costs exceed 7.5 percent of adjusted gross income and thus would have a tendency to reduce demand for medical care while simplifying the tax code. In addition, it would eliminate the current health care premium tax benefit for employer sponsored health insurance.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 4007 – To authorize the Secretary of Health and Human Services to make grants to 5 States to establish medical malpractice tribunal pilot programs, and for other purposes.
(Lee, R-NY)

Introduced: November 3, 2009

Summary: This legislation allows the Secretary of Health and Human Services to make grants to five states in order to establish pilot programs for medical malpractice cases. The pilot programs will last for three years. Grants are only available to states in which the average cost of medical malpractice insurance exceeds the national average, and that state has not placed a limit on noneconomic damages or that state has not established or begun to establish a medical tribunal program.

Under these programs, cases will first be heard by a medical tribunal composed of a State trial court judge, a physician, and a lawyer. If the tribunal determines that the evidence would be sufficient to support the plaintiff, then the plaintiff may pursue the case through the usual judicial process. If the tribunal determines that the evidence would be insufficient to support the plaintiff, the plaintiff may still pursue the case through the usual process only after filing with the clerk of court, in which case a bond will be pending. The amount will be determined by the State trial judge serving on the tribunal.

At the end of the third year the Secretary shall collect data from each state. The specific points of interest include any change in the average cost of medical malpractice insurance, the number of physicians actively practicing medicine, the number of medical malpractice liability insurance carriers, and the amounts paid by medical malpractice liability insurance carriers as a result of those cases. The Secretary will also collect the percentage of medical malpractice cases considered meritorious by the medical tribunal that were settled prior to trial, compared to the percentage of all medical malpractice cases filed in the 3 year period preceding the grant program. The number of medical malpractice cases considered meritorious by the medical tribunal that were tried to a judgment, and the number of judgments that were for the plaintiff will also be collected. The number of medical malpractice cases considered nonmeritorious by the medical tribunal that were tried to a judgment, and the number of judgments that were for the plaintiff will be collected. This information will then be submitted to Congress.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 4018 – Additional Health Insurance Options for Unemployed Americas Act of 2009
(Deal, R-GA)

Introduced: November 4, 2009

Summary: The inflexibility of COBRA or state continuation of coverage policies often result in consumers being locked into high-cost plans or risk losing federal consumer protections which limit portability. This bill would rescind the federal requirement that individuals exhaust COBRA or state continuation of coverage before federal consumer protections are available. This would permit individuals leaving group coverage to exercise their federal rights immediately, provided there is no more than a 63-day break in coverage. This change will give individuals who leave group coverage – often because they have lost their job – additional options to obtain insurance and protect them from facing pre-existing condition exclusions.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 4019 – To amend the Public Health Service Act to limit preexisting condition exclusions in the individual health insurance market to those permitted in the group health insurance market. (Deal, R-GA)

Introduced: November 4, 2009

Summary: In many cases, individuals with pre-existing conditions face exclusion of coverage for particular health conditions for which coverage is most needed. This bill would prohibit a health insurance issuer providing individual coverage from imposing a pre-existing condition exclusion beyond the extent to which the issuer is allowed to apply such an exclusion in the group market.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 4020 – Guaranteed Access to Health Insurance Act of 2009 (Burgess, R-TX)

Introduced: November 4, 2009

Summary: Currently, individuals with high medical costs find it difficult, if not impossible, to purchase healthcare coverage, which results in millions of Americans being "uninsurable." This bill would strongly encourage states to establish either a high-risk pool or a reinsurance program to cover the "uninsurable." This bill would provide $5 million in 'seed grant' funding to each state which currently does not have a high-risk pool and would authorize $20 billion to remain available until expended. The Congressional Budget Office has estimated the cost of fully funding high-risk pools at $20 billion over the next ten years; however, outside groups estimate the cost to be much higher. By authorizing $20 billion, to be available until expended, this will ensure adequate funding for the high-risk pool program until Congress needs to reauthorize at some time in the future.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

H.R. 4038 – Common Sense Health Care Reform and Affordability Act (Camp, R-MI)

Introduced: November 6, 2009

Summary: The Common Sense Health Care Reform and Affordability Act requires States establish either a functioning high risk pool or a resinsurance program and provides $25 billion in federal funding for these programs. States will have to eliminate high risk pool waiting lines and premiums for enrollees in high risk pools would be limited to 150% of the average premium charged in a State (currently capped at 200%).

This legislation extends existing HIPAA guaranteed availability protections, which will improve insurance portability and protections for Americans with pre-existing conditions. Under current law, individuals purchasing health insurance in the individual market are protected from pre-existing condition exclusions if there is not a substantial break in coverage, their previous coverage was through an employer, and they fully exhaust COBRA coverage. This provision would allow individuals to receive those same protections regardless of the source of their prior coverage and without requiring them to exhaust COBRA coverage.

The bill prohibits health plans from arbitrary annual or lifetime spending caps, thereby protecting individuals with a catastrophic diagnosis or chronic disease by ensuring health plans meet their obligations to those with the most expensive medical needs. This bill further prohibits health insurers from unlawfully canceling health insurance. If an insurance company attempts to cancel health coverage on the basis of fraud the policy holder can appeal that decision with an independent external appeals panel and the coverage would remain in force while that appeal is being considered. This provision insures that no American's access to needed medical care will be harmed by the wrongful cancelation of their health insurance plan.

States will be incentivized to establish reforms that reduce the cost of health insurance and expand coverage by being offered $50 billion in incentives. States will have to meet targets for reductions in health plan premiums and the number of uninsured in order to receive federal funds. States could not meet these targets by directly subsidizing health insurance or expand eligibility for government programs, like Medicaid.

Small businesses will be allowed to pool together through Association Health Plans (AHPs) to leverage lower cost health insurance on behalf of their employees. By creating larger insurance pools for small businesses, these provisions will make health insurance more affordable and more accessible.

Employers will be allowed to adopt auto-enrollment for health insurance, provided that employees are allowed to decline the coverage, by removing any potential legal barriers. Similar provisions have been adopted for 401(k) plans and have resulted in increased enrollment. Currently, almost 10 million employees have access to employer sponsored insurance and do not enroll.

Differences in state regulation of health insurance have resulted in significant variance in health insurance costs from state to state. Americans residing in a state with expensive health insurance plans are locked into those plans and do not currently have an opportunity to choose a lower cost option. This provision will allow Americans to purchase licensed health insurance in any state. Insurance sold in a secondary state will be still be subject to the consumer protections and fraud and abuse laws of the policy holder's state of residence.

Under current law, low and moderate-income individuals are eligible for a limited, nonrefundable tax credit for a portion of their contributions to IRAs and 401(k)s. Section 231 expands this "saver's credit" to cover contributions to Health Savings Accounts (HSAs), making HSAs more attractive to families earning under $50,000 annually. This legislation also allows taxpayers to use HSA funds to pay monthly premiums on their high deductible health plans (HDHPs), but only if, after the distribution, taxpayers retain a balance in their HSAs equal to or greater than twice the amount of the minimum annual deductible. Currently, taxpayers may use HSA funds only for qualified medical expenses incurred after the establishment of the HSA, which might be some time after the establishment of the HDHP. Section 234 allows taxpayers to use HSA funds for qualified medical expenses incurred after the establishment of the HDHP but before the establishment of the HSA, as long as the expenses are not incurred more than 60 days after the establishment of the HDHP.

In order to combat the rising costs caused by defensive medicine, the Common Sense Health Care Reform and Affordability Act incorporates the same language as the HEALTH Act that passed each year under Republican control of the House. These provisions include: a statute of limitations on bringing a case; cap on noneconomic damages to $250,000 with assignation of proportional responsibility; allows the court to restrict lucrative attorney contingency fees; clarifies and limits punitive damages; and protects states with existing functional medical liability laws. These provisions set no caps on economic damages, which are often the largest component of liability awards, thus patients will continue to have their rights to economic damages protected.

This legislation explicitly prohibits any federal funding from being used to pay for abortions. The legislation also includes a conscience protection clause that ensures individual and institutional health care providers are protected from being forced to participate in procedures such as abortion to which they have a moral or religious objection.

Medicare reform is also an essential part in health care reform and this legislation does this by requiring Medicare to improve enforcement of the Medicare Secondary Payer Act and also requires states to improve compliance with Medicaid Secondary Payer requirements.

Status: This legislation was offered as an Amendment in the Nature of a Substitute to H.R. 3962 and failed by a vote of 176 to 258.

H.R. 4138 – Medicare SGR Improvement and Reform Act of 2009 (Gingrey, R-GA)

Introduced: November 19, 2009

Summary: The Medicare SGR Improvement and Reform Act would provide physicians with a 2% Medicare payment rate increase in each of the next 4 years. This rate increase would erase the scheduled 21% cut in 2010 and the roughly 5% cuts in 2011, 2012, and 2013. This legislation states unequivocally that the policy of the Federal government is to permanently replace Sustainable Growth Rate (SGR).

This legislation would avert the scheduled Medicare physician cuts in a fiscally responsible way by including reforms that would fully offset the cost of the bill. These reforms would implement comprehensive, meaningful medical liability reform, ending junk lawsuits and costly defensive medicine by protecting doctors from overzealous trial lawyers who are looking to get rich quick. This is accomplished by incorporating Congressman Gingrey's HEALTH Act of 2009 (H.R. 1086) into this bill. This is expected to save $54 billion. This legislation also uses existing resources that are available to the Health and Human Services Secretary that are contained in the Medicare Improvement fund. The Medicare Improvement fund is designed to improve physician payments and contains an expected savings of $22.3 billion.

An approval process will be created at the FDA for biosimilar products with appropriate patent and market protections that continue to encourage innovation. This will provide Americans with access to affordable biologics while reducing the cost of health insurance. This portion is nearly identical to H.R. 1548 that was introduced by Rep. Eshoo and Rep. Barton, and has an expected savings of $5.7 billion.

The Medicare SGR Improvement and Reform Act also enacts health insurance administrative simplification policies, eliminating inefficiencies that unnecessarily drive up health care costs, by creating greater standardization in health care forms and transactions. This provision is expected to save $19 billion.

Status: This legislation was offered as the Motion to Recommit to H.R. 3961 and failed by a vote of 177 to 252.

H.R. 4505 – To enable State homes to furnish nursing home care to parents any of whose children died while serving in the Armed Forces. (Thornberry, R-TX)

Introduced: January 26, 2010

Summary: Currently an individual is allowed admission into a State Veterans Home if the individual is an eligible veteran, the spouse of an eligible veteran, or a Gold Star parent. According to the Code of Federal Regulations (CFR), administered by the VA, Gold Star parents are eligible for admission to State VA Nursing Homes if they have lost all of their children who were serving our country on active duty military service. This legislation would permit admission into a State VA Nursing Home to any parent that lost at least one son or daughter, who died while serving in the Armed Forces.

Status: Speaker Pelosi and the Democrat majority have not considered this bill in committee or on the House floor.

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