



120 Myths and Facts in America's Affordable Health Choices Act, H.R. 3200

A Comprehensive Fact Check

America's Affordable Health Choices Act, H.R. 3200, is the product of a historic collaboration between all three House committees—Education and Labor, Energy and Commerce, and Ways and Means—that have jurisdiction over issues with health care. The bill addresses many of the problems in our current health care system by making improvements in the areas of access, affordability, and adequacy of health care coverage. It makes quality, affordable coverage available to all Americans by reforming the insurance market so insurance companies cannot deny coverage to those who seek it; helping individuals, families, and small businesses with premium costs; expanding Medicaid coverage for the lowest-income Americans; and ensuring that covering everyone is a shared responsibility between individuals, employers, and the government.

The bill also modernizes our health system by reducing costs and improving the value and quality of medical services, by reforming our payment system so it rewards positive health outcomes, and using health information technology to improve care, among other things. It passed all three House committees, and the entire House will consider it on the floor following August recess.

Antihealth reform activists, however, have been circulating the following page-by-page claims about H.R. 3200—which came from Twitter user “Fleckman”—to their email lists. The vast majority of these claims are blatantly false or are a misreading of the bill's contents. These claims play on people's fears and completely mischaracterize the contents and intent of the bill.

Below are point-by-point refutations of these false claims as they appeared on “Fleckman's” page, as well as clarifications of the bill's purpose.

CLAIM #1: Pg 22 mandates that the Government will audit books of ALL EMPLOYERS that self insure. So every employer in the United States will be subjected to a health insurance audit just as all taxpayers are subject to audit. Of

course, we will have to pay for an entire new bureaucracy to do this—the Internal Health Revenue Service?

This claim is false. There is no language within this section or the bill that calls for an audit of employers. The provision referred to (Div A, Title 1, Sec 113) requires a study by the health choices commissioner to monitor large group insurers and self-insured employers so that new rules don't create incentives to separate sick people from healthy ones. The commissioner will be responsible for establishing qualified health plans within the health insurance exchange, a newly established market where the uninsured and other individuals who aren't offered health insurance through an employer can get well-regulated, affordable coverage. This person will also be in charge of the exchange's operation.

CLAIM #2: Pg 30, Sec 123 states that there will be a government committee that decides what treatments you are allowed and what your overall benefits are.

This is untrue. You and your doctor will decide what treatments you receive. The Health Benefits Advisory Committee will make recommendations that will assure that all insurers provide meaningful benefit packages within the health insurance exchange. This committee has no role in making decisions about treatments for individuals.

CLAIM #3: Pg 29, lines 4-16 basically mandates the rationing of health care as is being done in Canada.

There is no rationing in this bill. In fact, this provision (Div A, Title I, Sec 122) does quite the opposite. It prohibits out-of-pocket costs on preventive care and limits out-of-pocket spending for individuals and families.

CLAIM #4: Pg 42 recognizes the power of the Health Choices Commissioner to determine your health benefits. You will have no choice.

False. The health choices commissioner will help ensure that individuals within the health insurance exchange can choose from a range of plans that meet certain benefits standards. These standards will make sure that people getting insurance through the exchange can't be turned away because of pre-existing conditions and that they get a basic level of coverage.

CLAIM #5: PG 50, section 152 states that free, taxpayer-paid health care will be given to the 30 million non-citizens in the USA, even illegal aliens.

Not true. This bill only covers individuals who are lawfully present in the United States. This provision (Div A, Title I, Sec 152) prohibits health care providers from discriminating against individuals who are eligible for high-quality care and services under this bill.

CLAIM #6: Pg 58 states that government will have possession of all your health care records & history including finances and you will have to have a National ID Healthcard.

This claim is false. The purpose of this provision (Div A, Title I, Sec 163) is to minimize paperwork and maximize financial transparency by letting patients know how much they owe up front instead of ending up with unexpected, astronomical medical bills later. There is nothing in the bill about accessing health records or history. There is nothing in the bill that would require a national ID health card.

CLAIM #7: Pg 59, lines 21-24 gives direct access to your banks accounts to compel you to pay any out-of-pocket or premium costs electronically without your previous consent.

This is not what the bill says. The purpose of this provision (Div A, Title I, Sec 163) is to make certain administrative simplifications that will develop standards for transactions between insurance companies and providers so providers can spend more of their time delivering care and less time haggling with insurance companies.

CLAIM #8: Pg 65, sec 164 provides for a political payoff from the Democrats and Obama; a special subsidized plan for retirees and their families in unions and community groups like ACORN.

This claim is false and grossly misleading. This provision (Div A, Title I, Sec 164) provides temporary help to individuals aged 55-64 who are either retired or have been laid off, to pay for a portion of their health insurance. It will help people stay healthy and insured before they qualify for Medicare.

CLAIM #9: Pg 72, lines 8-14 creates a Health Care Exchange to bring private health insurance plans under government control. This part of the bill reveals Obama's lies about being able to keep your plan if you like it. Any health insurance plan which does not completely rework itself to conform to these regulations will be dropped from the exchange and those insured will have to pick one of the plans in the exchange. This is

why the Congressional Budget Office determined that over 20 million will lose the coverage they are now enjoying if Obamacare is implemented.

False. The bill clearly states that if you like the coverage you have you can keep it (Div A, Title I, Sec 102). The health insurance exchange will start out as a market for people who currently do not have insurance and small businesses. This provision makes sure that people who buy insurance in the exchange are buying plans that provide meaningful coverage and meet certain standards.

CLAIM #10: Pg 85, line 7 provides specifics for benefit levels for all health plans, giving government the right to ration everyone's healthcare.

Untrue. There is no rationing in this bill. This provision (Div A, Title II, Sec 203) ensures that plans sold within the health insurance exchange are truly providing coverage by meeting certain standards.

CLAIM #11: PG 91, lines 4-7 mandates that doctor's offices, clinics and hospitals provide language-appropriate services, basically ordering them to hire translators at the expense of the American taxpayer.

This claim is incorrect and grossly misleading. This provision (Div A, Title II, Sec 204) ensures that the health choices commissioner provides explanations that are understandable to individuals who are eligible to participate in the health insurance exchange.

Elsewhere in the bill there is a provision that requires doctor's offices, clinics, and hospitals to provide language-appropriate services that will enhance the quality of care providers deliver to their patients.

CLAIM #12: Pg 95, lines 8-18 allows the government to hire non-profit community groups like ACORN and AmeriCorps to sign up people for the government health plan.

This claim is false and grossly misleading. This provision (Div A, Title II, Sec 205) ensures the health choices commissioner conducts thorough outreach—which could include hiring qualified organizations—that targets all individuals and businesses eligible for the health insurance exchange and makes sure they are aware of their private and public options.

CLAIM #13: PG 85, line 7 provides for specifics on benefit levels for Medicare recipients, basically rationing the care of every senior citizen in the United States.

Not true. Again, there is no health care rationing in this bill. This provision (Div A, Title II, Sec 203) refers to benefits standards within the health insurance exchange, not Medicare. Its purpose is to make sure health plans within the exchange keep people healthy by meeting certain standards.

CLAIM #14: PG 102, lines 12-18 mandates that all Medicaid eligible will be automatically enrolled in Medicaid based upon income and insurance status. No choice.

False. People who are eligible for Medicaid under current law will still have the same choices under this bill. Individuals in categories that are newly made eligible for Medicaid may have the choice of enrolling in Medicaid, or in one of the private or public options within the health insurance exchange.

CLAIM #15: Pg 124, lines 24-25 states that no private company or individual can have the right to sue the federal government for medical price fixing, basically eliminating your right to seek redress in the courts regarding your medical care.

Nothing in this provision (Div A, Title II, Sec 223) applies to private insurance companies or individuals. This provision only applies to payment rates within the public health insurance option.

CLAIM #16: Pg 127, lines 1-16 dictates doctors' payment and therefore income which will reduce what doctors earn and lead to greater shortages of doctors and more rationing of care.

The bill does not ration care. This section (Div A, Title II, Sec 225) about payment rates only applies to those providers who CHOOSE to participate in the public health insurance option. Providers are not required to participate in the public health insurance option.

CLAIM #17: Pg 145, line 15-17 any employer not currently insuring their employees must enroll employees into public plan option, with no choice of private insurance allowed.

This claim is false. No one is required to enroll in the public health insurance option. Employers are required to provide insurance coverage to their employees or pay a tax, but the insurance coverage employers provide can be private or public. Further, employees have the choice of opting out of their employer-provided insurance.

CLAIM #18: Pg 126, lines 22-25 mandates that employers must pay for health insurance even for part-time workers and their families, which will certainly lead to massive layoffs.

Employer contributions to health insurance will be proportional to the number of hours an employee works, or the employers will have to pay a tax penalty. In other words, an employer is not required to contribute the same amount for a part-time employee as a full-time employee.

CLAIM #19: Pg 149, lines 16-24 all employers with an annual payroll bigger than \$400k who does not pay to enroll employees in public insurance option will pay an 8% tax on all payroll.

No one is required to enroll in the public health insurance option. Employees who are not offered workplace insurance can enter the health insurance exchange and choose from private and public options.

CLAIM #20: Pg 150, lines 9-13 mandates that employers with an annual payroll between \$251K & \$400K who does not pay to enroll employees in public insurance option will pay a 2-6% tax on all payroll.

This is grossly misleading. No one is required to enroll in the public health insurance option. Employees who are not offered workplace insurance can enter the health insurance exchange and choose from private and public options.

CLAIM #21: Pg 167, lines 18-23 any individual who is self-employed and does not have health insurance will be taxed 2.5% of income and forced to accept public health insurance. So paying for health care out of pocket will be banned from the face of the earth.

Again, no one is required to enroll in the public health insurance option. This provision requires that individuals who do not opt for either a private or public insurance plan pay a tax. Further, there is nothing in this bill that keeps an individual from paying for certain kinds of services out of pocket.

CLAIM #22: Pg 170, lines 1-3 exempts non-resident aliens from the individual health care taxes, so Americans citizens will pay for these aliens, legal and illegal alike.

False. This bill only covers individuals who are lawfully present in the United States.

CLAIM #23: Pg 195 officers & employees of the new Health Care Administration will have access to all Americans personal financial records and accounts.

Not true. The bill only allows access to tax return information—information the government already has—in order to verify the eligibility of individuals seeking affordability credits. The credits are subsidies that would help lower-income individuals and families pay for health coverage. There are restrictions on how this information can be used, and this provision only applies to those who are potentially eligible for affordability credits.

CLAIM #24: PG 203, line 14-15 actually says that “The tax imposed under this section shall not be treated as tax.” Yes, it says that.

This quote was taken out of context and refers to calculations used in the bill.

CLAIM #25: Pg 239, line 14-24 mandates that available physician services will be reduced for Medicaid recipients. Many poor people including many seniors will be affected.

There is nothing in the bill that will reduce physician services to Medicaid (or Medicare) recipients. This statement is so confused that it fails to recognize what the legislative language is about. The provision referred to (Div B, Title I, Sec 1121) is about reforming the sustainable growth rate, or SGR, formula under which payments are made to physicians who participate in Medicare. This reform to SGR will protect doctors participating in Medicare from the 21-percent cuts in reimbursement rates that were due to be implemented in 2011.

CLAIM #26: Pg 241, line 6-8 mandates that all doctors receive the same pay, regardless of specialty. This will vastly reduce the number of specialists available in the United States, a common problem where medicine is socialized like Canada.

This claim is false. This provision actually ensures that doctors will be reimbursed by Medicare for the preventive health services they provide—regardless of their specialty.

The provision this comment refers to (Div B, Title I, Sec 1121) revises the way Medicare pays physicians, by allowing greater increases in payments for primary care and prevention services. This is part of a change in the sustainable growth rate formula, which sets annual increase in rates Medicare pays physicians.

CLAIM #27: PG 253, line 10-18 allows the federal government to set the value of doctor's time, professional judgment.

This statement is correct—but it fails to state that this provision is a big improvement in Medicare. For the first time, Medicare will now reimburse doctors for the time they spend with patients, their professional judgment, and other cognitive skills, as well as their technical skills.

The particular provision objected to (Div B, Title I, Sec 1122) requires the secretary of Health and Human Services, when reviewing payment rates for physician services under Medicare, to consider “..work elements (such as time, mental effort, and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service.”

CLAIM #28: Pg 265, Sec 1131 mandates and controls the productivity of all health care providers including surgeons!

False. Providers, including surgeons, are free to practice as they always have been. This claim distorts the meaning of the term “productivity adjustment,” which in reality is a factor in setting annual changes in Medicare payments to facilities such as inpatient hospitals, outpatient hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, psychiatric hospitals, and hospice care.

CLAIM #29: Pg 268, Sec 1141 regulates the rental & purchase of power-driven wheelchairs.

Currently patients have an option under Medicare to purchase a power-driven wheelchair during the first month of its use. This provision would require Medicare beneficiaries to rent the power-driven wheelchair for 13 months—thus establishing their long-term need for the chair—before ownership transfers to the patient—all of which Medicare will pay for.

CLAIM #30: Pg 272, Sec 1145 regulates the operation of certain types of cancer hospitals, again rationing the care of cancer patients.

This claim is false. This provision does not regulate the operation of certain cancer hospitals and does not ration care to cancer patients. It will in fact benefit some cancer hospitals and their patients by recognizing that increasingly cancer treatments such as chemotherapy are provided on an outpatient basis and adjusting Medicare payment rates accordingly.

CLAIM #31: Page 280, Sec 1151 allows the government to penalize hospitals for what is deemed to be preventable readmissions. So instead of being sued for malpractice, the government will be the punitive body when mistakes are made.

It is correct that this provision will financially penalize hospitals if they don't take steps to address preventable hospital readmissions—but these are mistakes that shouldn't happen. Currently one out of five Medicare hospital patients returns to the hospital within 30 days. Many readmissions are the result of infections acquired in the hospital, a medical error, or a failure to ensure that patients get referred to the outpatient care they need.

This provision (Div B, Title 1, Sec 1151) implements a new program, beginning in 2012, which will help improve Medicare beneficiaries' quality of care after their discharge from an acute-care hospital. This provision also provides hospitals with funding for transitional care services for patients to help prevent unnecessary readmissions.

CLAIM #32: Pg 298, lines 9-11 mandates that if a doctor treats a patient during initial admission and that result in a re-admission, the doctor will be subject to federal penalties. Gee do you think that's going to drive up the cost of malpractice?

There is no such mandate in the bill. This provision in the bill (Div B, Title I, Sec 1151) requires the secretary of HHS to conduct a study on how the policy to prevent avoidable hospitals readmissions could be applied to doctors.

CLAIM #33: Pg 317, lines 13-20 will create prohibitions on ownership and investment in the health service industry for doctors.

Untrue. The bill does not prohibit doctors from owning and investing in health facilities. The bill does have some prohibitions on doctors making referrals to health facilities in which they have a financial interest because this practice has been demonstrated to increase health care costs. However, this is not a blanket prohibition.

CLAIM #34: Pg 317-318, lines 21-25, and 1-3 will prohibit the expansion of all hospitals.

CLAIM #35: Pg 321, lines 2-13 allows hospitals apply for an exception to the expansion rule but they must seek community input first!

These two claims are false and clearly show that the person making them has not read the legislation. The particular provisions referred to (Div B, Title I, Sec 1156) prohibits rural facilities owned by doctors and which are exempt from the prohibition on self-referrals from expansion—a way of increasing the level of ownership—but allows the secretary of HHS to grant an exemption for any such expansion. In granting such an exemption, the secretary should allow an opportunity for local community input.

CLAIM #36: Pg 335, lines 16-25, Pg 336-339 mandates the establishment of outcome-based health care and insidious idea that actually limits the treatment choices made by patients with their doctors, based upon the patient's health and condition. This will result in the oldest, weakest and sickest patients being denied treatments simply because the statistics for success in their demographic category are poor! This is a form of health care rationing that will save money at the expense of seniors to help buy insurance for the uninsured, most of whom are young and healthy!

False. This provision in the bill (Div B, Title I, Sec 1162) creates an incentive system to increase payments to reward high-quality Medicare Advantage plans and plans that demonstrate improvement in quality. There is nothing in this provision that would ration health care or limit choice, and in fact this measure provides a means of ensuring that private providers of Medicare Advantage plans do not deny patients needed care.

CLAIM #37: Pg 341, lines 3-9 allows the government to disqualify Medicare Advantage Plans and HMO forcing people into the government run public plan.

This is extremely misleading. No one is required to enroll in the public health insurance option. This provision guarantees that if a Medicare Advantage plan does not meet reporting rules and is disqualified, the beneficiaries on the plan would continue to receive their care under Medicare.

CLAIM #38: Pg 354, Sec 1177 will arbitrarily restrict the enrollment of special needs children and adults.

This provision (Div B, Title I, Sec 1177) makes no changes to current law—established in 2004—about who can enroll in Special Need Plans, or SNPs, a type of Medicare Advantage plan targeting individuals who are institutionalized, severely disabled, or very low-income—for example, eligible for both Medicaid and Medicare. It extends the current enrollment requirements for SNPs through to 2012 and for certain integrated care SNPs through to 2015.

CLAIM #39: Pg 379, Sec 1191 mandates the creation of even more bureaucracy in the Telehealth Advisory Committee.

This allows health care providers and patients in rural areas to better access specialist services and advice, mental health services, and to assist with medical education and training. The Telehealth Advisory Committee will provide the secretary of health and human services with advice and expertise on how to expand telehealth services and benefits. These services, which are delivered through communication technologies such as telephone, video, or the Internet, particularly benefit patients and their doctors in areas lacking access to specialists or other health care services.

CLAIM #40: Pg 425, lines 4-12 mandates "Advance Care Planning Consultation," another insidious vehicle to save money by encouraging seniors who are in poor health to be more accepting of death rather than fighting to stay alive and healthy and with their loved ones.

Nothing in the bill mandates advance care planning consultations, which are discussions between patients and physicians on end-of-life care. The provision referred to (Div B, Title II, Sec 1233) requires Medicare to cover advanced care planning, or ACP, consultations for the first time, but it does not mandate doctors or individuals to undertake ACP consultations—this is a decision made between a doctor and their patient.

CLAIM #41: Pg 425, lines 17-19 mandates that all senior patients will be consulted regarding living wills, durable powers of attorney.

This is inaccurate. This provision gives the patient, in consultation with their doctor, the right to make any decisions regarding living wills and durable powers of attorney.

CLAIM #42: Pg 425, lines 22-25, 426 lines 1-3 provides an approved list of end of life resources, to help guide seniors about the process of dying!

This provision requires that providers give patients and their families a wide-ranging list of national and state-specific resources on advanced care planning to help them better understand end-of-life care options.

CLAIM #43: Pg 427, lines 15 mandates program for orders on the end of life, actually giving the government a say in how your life ends!

The bill does not mandate orders on the end-of-life or in anyway give the government a say in end-of-life decisions.

CLAIM #44: Pg 429, lines 1-9 dictates the frequency with which an Advance Care Planning Consultant will have to meet with patients as their health deteriorates.

False. There is nothing in this bill that dictates the frequency with which an advance care planning consultant has to meet with patients as their health deteriorates.

CLAIM #45: Pg 429, lines 10-12 give an Advance Care Planning Consultant the power to order end of life plans for a patient.

Under the bill an advanced care planning consultant does not have the power to order end-of-life plans for a patient.

CLAIM #46: Pg 429, lines 13-25 will only allow certain doctors, not necessarily your own physician, to write an end of life order.

Untrue. There are no limitations imposed on which properly licensed doctors can write or sign an end-of-life order, and the choice of doctor is up to the patient.

CLAIM #47: Pg 430, lines 11-15 allows the government to decide what level of treatment you will have at end of life.

The government will not be able to decide what level of end-of-life treatment can be provided. The section referred to (Div B, Title II, Sec 1233) outlines what should be included in an order regarding life-sustaining treatment.

CLAIM #48: Pg 469 mandates "Community Based Home Medical Services" through nonprofits like ACORN. Happy yet that we elected a community organizer to the White House?

Only groups that provide community-based home medical services and meet the very specific requirements laid out in the legislation can qualify under this provision.

CLAIM #49: Pg 489, Sec 1308 force taxpayers to pay for Marriage & Family therapy under the public insurance plan.

False. The specific section referred to (Div B, Title III, Sec1308) enables Medicare to reimburse marriage and family therapists for the diagnosis and treatment of mental illnesses, but only if they are legally authorized to provide such services under state law

and if such services would otherwise be covered if furnished by a physician. This provision will help increase the availability of mental health services in underserved areas.

CLAIM #50: Pg 494-498 allows government to define mental illnesses and what services will be allowed to treat, again rationing this care.

This provision has nothing to do with defining mental illnesses or rationing care. It is about extending Medicare cover for mental health services by allowing appropriately qualified mental health counselors to be reimbursed for their services.

CLAIM #51: Pg 502 Section 1181 Center for Comparative Effectiveness Research Established. - Hello Big Brother - Literally.

CLAIM #52: Pg 502 Line 5-18 Government builds the "Center" to conduct, support, & synthesize research to define our HealthCare Services.

These two claims are grossly misleading and inaccurate. The bill does not allow comparative effectiveness research—which compares the range of treatments for a particular condition for specific patient populations—to be used to define, limit, or mandate treatment and services.

CLAIM #53: Pg 503 Line 13-19 Government will build registries and data networks from YOUR electronic medical records.

CLAIM #54: Pg 503 Line 21-25 Government may secure data directly from any department or agency of the US including your data.

CLAIM #55: Pg 504 Line 6-10 The "Center" will collect data both published & unpublished (that means public & your private info)

All of these are false. The bill won't undermine the current protections in law for privacy, data ownership, and medical records. Because greater use of health IT will demand strong and robust protections of health data—not just within government, but by private providers—the HITECH Act, which was part of the economic stimulus bill, contained a number of significant new privacy protection measures.

CLAIM #56: Pg 506 Line 19-21 The Center will recommend policies that would allow for public access of data

Again, the bill will not undermine current protections in law for privacy, data ownership, and medical records.

CLAIM #57: Pg 518 Line 21-25 The Commission will have input from HealthCare consumer reps - Can you say unions & ACORN?

This seems to be arguing against transparency and public input into the work of the Comparative Effectiveness Research Commission, which will develop priorities for and monitor the quality of comparative effective research conducted by the government. This provision ensures that patients, health care providers, health care consumer representatives, and other appropriate stakeholders with an interest in the research will be active participants in guiding and reacting to the research process.

CLAIM #58: Pg 524 18-22 Comparative Effectiveness Research Trust Fund set up. More taxes for ALL.

This is a gross mischaracterization. The Comparativeness Effectiveness Trust Fund is funded by minimal fees for this essential work that will be paid by all health insurance plans, public, and private.

CLAIM #59: Pg 525-620 deals with the Government basically taking over nursing homes

CLAIM #60: Pgs 525-620 deals with the Govt basically taking over nursing homes, long-term care facilities (think assisted living) through regulations of the facilities, the owners of sd facilities, the employees of sd facilities and even the land owners of that sd facilities reside on.

Additionally as you read these 90+ pages you can come to the conclusion that any Health related svcs will be determined and rationed by the Govt for our senior citizens and others in nursing homes. This one post should do enough to raise awareness of the control the Govt is exerting over the older population of American citizens.

These claims are false and play on peoples' fears. The provisions in the bill are aimed at protecting the sickest and frailest Americans who are in nursing homes.

CLAIM #61: Pg 620 Line 1-9 The Government will define, prioritize, and nationalize your Health Care Services.

There isn't a single word in the bill that would have the government define, prioritize, or nationalize health care services.

CLAIM #62: Pg 621 Lines 20-25 Government will define what Quality means in HealthCare. Since when does Government know about quality?

The provision referred to (Div B, Title IV, Sec 1441) is about the secretary of health and human services establishing national priorities for developing, funding, and measuring improvements in health.

CLAIM #63: Pg 622 Lines 2-9 To pay for the quality Standards Government will transfer \$\$ from to other Government Trust Funds. More Taxes.

If we're going to have better quality health, then we need to invest resources to make sure the needed changes occur. The spending measures in this bill are fully offset by savings.

CLAIM #64: Pg 624 "Quality" measures shall be designed to assess outcomes & functional status of patients.

Correct—quality measures will be based on patient health outcomes.

CLAIM #65: Pg 628 Section 1443 Government will give "Multi-Stake Holders" Pre-Rule Making input into Selection of "Quality" Measures.

This statement is correct. This provision (Div B, Title IV, Sec 1443) will ensure that stakeholders—such as hospitals, health care providers, employers, and consumer advocates, among others—are able to have input into the work on quality measures at an early time before final decisions are made.

CLAIM #66: Pg 630 9-24/631 1-9 Those Multi-stake holder groups including Unions & groups like ACORN deciding HealthCare quality.

Grossly misleading. The provision (Div B, Title IV, Sec 1443) clarifies the composition of multistakeholder groups. It makes fairly specific determinations among those who will be affected by the use of quality measures in the health care world and makes sure they are eligible to participate.

CLAIM #67: Pg 632 Lines 14-25 The Government may implement any "Quality measure" of HealthCare Services as they see fit.

CLAIM #68: Pg 633 14-25/ 634 1-9 The Secretary may issue non-endorsed "Quality Measures" for Physician Services & Dialysis Services.

This is inaccurate. This provision (Div B, Title IV, Sec 1444) states that the secretary of HHS must implement only quality measures that have been endorsed in a consensus process by the stakeholder groups involved, and to initiate that process where this is required.

CLAIM #69: Pg 635 - 653 Physicians Payments Sunshine Provision - Government wants to shine sunlight on Docs but not Government.

This provision promotes transparency and helps prevent conflicts of interest.

CLAIM #70: Pg 654-659 Public Reporting on Health Care-Associated Infections - Looks okay.

Correct. This provision (Div B, Title IV, Sec 1461) requires that hospitals and ambulatory surgical centers report information on health-care associated infections to the Centers for Disease Control and Prevention. This step is more than OK—it is essential if the high rate of these infections is to be tackled. Every year there are an estimated 1.7 million infections in American hospitals and 99,000 associated deaths.

CLAIM #71: Pg 660-671 Doctors in Residency - Government will tell you where your residency will be, thus where you'll live.

Residents will not be told where they will practice or where they will live. The provision retains current medical education practices and reallocates unfilled training positions to primary care doctors in areas where there's a doctor shortage.

CLAIM #72: Pg 676-686 Government will regulate hospitals in EVERY aspect of residency programs, including teaching hospitals.

Medicare is the primary source of funds for medical education, which is defined by medical institutions. This provision allows hospitals for the first time to be compensated for the time residents spend in conferences and scholarly activities.

CLAIM #73: Pg 686-700 Increased Funding to Fight Waste, Fraud, and Abuse. You mean the Government with an \$18 mil website?

This is very misleading. This provision will provide mechanisms to prevent waste, fraud, and abuse in health programs that costs billions of taxpayer dollars.

CLAIM #74: Pgs 701-704 Section 1619 If your part of HealthCare plan that isn't in Government HealthCare Exchange but you qualify for Federal aid, no payment.

This provision (Div B, Title VI, Sec 1619) clarifies that health care providers excluded from providing services for Medicare and Medicaid are excluded from all federal health care programs.

CLAIM #75: Pgs 705-709 SEC. 1128 If Secretary gets complaints (ACORN) on HealthCare provider or supplier, Government can do background check.

The provision (Div B, Title VI, Sec 1631) gives the secretary of HHS tools to prevent waste, fraud, and abuse through extra screening procedures for new providers such as licensing checks, background checks, and site visits.

CLAIM #76: Pg 711 Lines 8-14 The Secretary has broad powers to deny HealthCare providers/suppliers admittance into Health Care Exchange.

This statement is misleading. The provision's (Div B, Title VI, Sec 1632) goal is to prevent waste, fraud, and abuse by requiring new suppliers or providers of services to public programs to disclose affiliations within the past 10 years with any provider or supplier that has uncollected debt or has been suspended from these programs. The secretary can then institute safeguards or deny participation—thereby preventing further abuse.

CLAIM #77: Pg 719-720 Section 1637 ANY Doctor who orders durable medical equipment or home medical services MUST be enrolled in Medicare.

This claim is misleading. The provision (Div B, Title VI, Sec 1637) applies only to Medicare. It requires that any doctor or other health care professional who orders durable medical equipment or home health services for a Medicare beneficiary – services that will be paid for by Medicare – must be Medicare-enrolled or Medicare-recognized.

CLAIM #78: Pg 722 Section 1639 Government Mandates Doctors must have face-to-face with patient to certify patient for Home Health Services.

CLAIM #79: Pg 724 Lines 16-22 Government reserves right to apply face-to-face certification for patient to ANY other HealthCare service.

CLAIM #80: Pg 724 23-25 PG 725 1-5 The same Government certifications will apply to medicaid & CHIP (your kids)

Correct. Patients in consultation with their doctors will determine whether certain health services are appropriate for them.

CLAIM #81: Pg 735 lines 16-25 For law enforcement purposes, the Secretary of Health & Human Services will give Attorney General access to ALL data.

Nothing in this provision gives either the secretary of HHS or the attorney general access to all data that is not in accordance with current laws governing privacy.

CLAIM #82:Pg 740-757 Government sets guidelines for subsidizing the uninsured (That's your tax dollars peeps)

This provision is about extending Medicaid coverage to individuals with income less than 133.3 percent of the federal poverty level and newborns up to the first 60 days of life who do not otherwise have acceptable coverage at birth. Medicaid programs are already required to meet state and federal guidelines.

CLAIM #83: Pg 757-762 Fed Government will shift burden of payments to Disproportionate Share Hospitals (DSH) to States. (Taxes)

False. This provision requires the secretary of HHS to report to Congress by January 2016 on the continuing role of Medicaid's disproportionate share hospital payments as health reform is implemented. The payments compensate the hospitals, which provide coverage to a significant number of low-income patients. The expectation is that payments will be able to be reduced as more people have health insurance coverage.

CLAIM #84: Page 763 1-8 No DS/EA hospitals will be paid unless they provide services without regard to national origin

This provision will not deny payments for services on the basis of patient characteristics to hospitals that are not disproportionate share or essential access hospitals—both of which serve a high proportion of uninsured and low-income patients.

CLAIM #85: Pg 765 Section 1711 Government will require Preventative Services including vaccines. (Choice?)

Nothing in this provision requires patients to receive preventive care. However, it does require Medicaid to cover preventive care if its beneficiaries want it.

CLAIM #86: Pg 768 Section 1713 Government – Nurse Home Visitation Services (Hello union paybacks)

This provision supports nurse home visits to first-time pregnant women or children that are eligible for Medicaid or CHIP in efforts to improve maternal and child health.

CLAIM #87: Pg 769 3-5 Nurse Home Visit Services –“increasing birth intervals between pregnancies.” Government Abortions anyone?

This is grossly misleading and inaccurate. This provision extends nurse home visitation services to first-time pregnant women or children in order to encourage positive maternal and child health—not enact them directly.

CLAIM #88: Pg 769 11-14 Nurse Home Visit Services include-economic self-sufficiency, employment advancement, school-readiness.

The provision extends nurse home visitation services to first-time pregnant women or children in order to encourage positive maternal and child health, which includes promoting self-sufficiency.

CLAIM #89: Pg 770 SEC 1714 Federal Government mandates eligibility for State Family Planning Services. Say abortion & State Sovereign.

This provision only applies to how states determine the eligibility of individuals for family planning services.

CLAIM #90: Pg 789-797 Government will set & mandate drug prices, controlling which drugs will brought to market. Bye innovation

This assures that Medicaid is not overpaying for prescription drugs. It does not affect the broader marketplace.

CLAIM #91: Pgs 797-800 SEC 1744 PAYMENTS for grad medical education. The government will now control Drs education.

Medicare is the primary support for graduate medical education, and this provision does not affect the education's content. This provision extends education support outside the hospital and requires transparency on how funding is spent.

CLAIM #92: PG 801 Sec 1751 The Government will decide which Health care conditions will be paid. Say RATION!

The provision extends existing policies that refuse to pay providers for well-recognized, inexcusable doctor or hospital errors.

CLAIM #93: Pg 810 SEC 1759. Billing Agents, clearing-houses, etc. required to register. Government takes over private payment system.

This is inaccurate. The provision improves accountability in Medicaid by requiring billing agents, clearinghouses, or other alternate payees to register with the government. Nothing in this provision applies to the payment system for those insured under private plans.

CLAIM #94: Pg 820-824 Sec 1801 Government will identify individuals ineligible for subsidies. Will access all personal finances.

This provision allows the commissioner of the Social Security Administration to access the tax returns of low-income individuals—which the government already has—who may be eligible for Medicare prescription drug program subsidies. There are also safeguards in the provision that restrict the use of disclosure information.

CLAIM #95: Pg 824-829 SEC 1802. Government Sets up Comparative Effectiveness Research Trust Fund. Another tax black hole.

This is a blatant mischaracterization of this provision. The provision assures transparent funding for comparative effectiveness research, by establishing minimal fees to be paid by all health plans—public and private.

CLAIM #96: Pg 829-833 Government will impose a fee on ALL private health insurance plans including self insured to pay for Trust Fund! COMBINE WITH ABOVE

CLAIM #97: Pg 835 11-13 fees imposed by Government for Trust Fund shall be treated as if they were taxes.

This provision raises funds for the Comparative Effectiveness Research Trust Fund that will be a resource to private and public entities alike. The public health insurance plan will NOT be exempt from this fee. Also, under this bill, private stakeholders will have a say on comparative effectiveness research priorities, making an even more compelling argument for them to contribute to the fund.

CLAIM #98: Pg 838-840 Government will design & implement Home Visitation Program for families with young kids & families expecting kids.

CLAIM #99: Pg 844-845 This Home Visitation Program includes Government coming into your house & telling you how to parent!!!

Under this provision, states will have the opportunity to offer new families support if they want it.

CLAIM #100: Pg 859 Government will establish a Public Health Fund at a cost of \$88,800,000,000. Yes thats Billion.

This ignores the need to rebuild public health support—in services, disease tracking, prevention, and emergency service—after years of neglect. The public health investment fund will pay for a wide range of health care workforce and public health programs.

CLAIM #101: Pg 865 to 876 The NHS Corps is a program where Drs. perform mandatory HealthCare for 2 years for part loan repayment.

The National Health Service Corps gives doctors an opportunity to reduce their loan repayments by serving in underserved areas. If an individual joins the NHSC and works part-time, half of their loans will be paid off. Further, NHSC is a completely voluntary program.

CLAIM #102: Pg 876-892 The Government takes over the education of our Medical students and Drs.

This is completely false. Nothing in this provision or any other in this bill or existing laws allows the government to take over medical education at any level.

CLAIM #103: Pg 898 The Government will establish a Public Health Workforce Corps. to ensure supply of public health professionals.

Correct, our current supply of public health professionals is insufficient.

CLAIM #104: Pg 898 The Public health workforce corps shall consist of officers of Regular & Reserve Corps of Service.

Since 1798 officers in the Public Health Service Commissioned Corps have served and protected our country against disease.

CLAIM #105: Pg 898 The Public health workforce corps shall consist of civilian employees of the U.S. as Secretary deems.

Civilians have played an important role in public health infrastructure. A larger workforce will increase our health status.

CLAIM #106: Pg 900 The Public Health Workforce Corps includes veterinarians.

Veterinarians protect us from many diseases. Emerging infectious diseases are often transmitted through animal to human contact. Maintaining a healthy animal population helps prevent the spread of diseases such as rabies, swine flu, and Lyme disease. Veterinarians are also crucial to maintaining the health of the economy in rural areas.

CLAIM #107: Pg 901 The Public Health Workforce Corps WILL include commissioned Regular & Reserve Officers. HealthCare Draft?

Nothing in this bill requires civilians or uniformed officers to join the Public Health Service Corps. It's voluntary.

CLAIM #108: Pg 910 The Government will develop, build & run Public Health Training Centers.

False. Accredited schools will build, develop, and run these Public Health Training centers.

CLAIM #109: Pg 913-914 Government starts a HealthCare affirmative action program thru guise of diversity scholarships.

Untrue. Discrimination based on race, sex, disability, or age is prohibited when distributing these educational scholarships.

CLAIM #110: Pg 915 SEC 2251. Government MANDATES Cultural & linguistic competency training for HealthCare professionals.

The competency training is not mandatory and the government will not penalize people who do not participate.

CLAIM #111: Pg 932 The Government will establish Preventative & Wellness Trust fund - initial cost of \$30,800,000,000-Billion.

This is a gross mischaracterization. The initial cost of the Prevention and Wellness Trust Fund averages \$3 billion annually over 10 years. And prevention is the best investment in keeping Americans healthier and reducing health care spending in the long term.

CLAIM #112: Pg 935 21-22 Government will identify specific goals & objectives for prevention & wellness activities. Control You!

The provision continues to require the surgeon general to set national goals that have led to decreases in cancer and increased automobile safety.

CLAIM #113: Pg 936 Government will develop "Healthy People & National Public Health Performance Standards" Tell me what to eat?

The surgeon general sets goals to increase safety, decrease disease, and eliminate toxic chemicals from your food. The government will not tell you what to eat.

CLAIM #114: Pg 942 Lines 22-25 More Government? Offices of Surgeon General -Public Health Services, Minority Health, Women's Health - THIS MEANS TAX DOLLARS USED TO PAY FOR ALL ABORTIONS.

These claims are false. This provision sets the membership of the community preventative services task force that will recommend ways to prevent disease.

CLAIM #115: Pg 950- 980 BIG Government core public health infrastructure includes workforce capacity, lab systems; health information systems, etc.

This gives money to prevention, which is the best way to fight disease and lower health care costs. These infrastructure improvements will stop diseases before they spread, create jobs, and increase efficiency.

CLAIM #116: Pg 993 Government will establish school-based health clinics. Your kids wont have a chance.

This provision creates needed onsite health care services to assure that children have ready access to care.

CLAIM #117: Pg 994 School Based Health Clinic will be integrated into the school environment. Say Government Brainwash!

False. This provision keeps children safe and healthy while attending school.

CLAIM #118: Pg 1001 The Government will establish a National Medical Device Registry. Will you be tracked?

CLAIM #119: Pg 1003 9-11 National Medical Dev Reg. ``(iii) other postmarket device surveillance activities'' you WILL be tracked.

No one will be "tracked" through this registry. The provision ensures patient privacy. The registry will keep you safe by keeping dangerous devices out of your body.

CLAIM #120: Pg 1018 States give up some of their State Sovereignty.

This claim is grossly misleading. This provision requires states, like other employers, to provide health insurance to their employees, or contribute to the cost of their exchange-based coverage through the Health Insurance Exchange Trust Fund.