

Issue	<u>Affordable Health Care for America Act – House Bill</u>	<u>Patient Protection and Affordable Care Act – Senate Bill (as modified by Reid Manager’s Amendment)</u>	Why This is Important
<i>Prevention and Screening Services</i>			
Cost-sharing requirements for prevention and screening services	<p>Eliminates cost sharing requirements for all preventive services (including colorectal cancer screening) that have a United States Preventive Services Task Force (USPSTF) A/B rating, and requires coverage of these tests by private insurance.</p> <p>Waives all Medicare cost-sharing (both co-insurance and deductibles) for preventive services.</p> <p>Requires state Medicaid programs to cover (without cost-sharing) preventive services that are recommended by the USPSTF and appropriate for Medicaid beneficiaries.</p>	<p>Eliminates cost sharing requirements for all preventive services (including colorectal cancer screening) that have a United States Preventive Services Task Force (USPSTF) A/B rating, and requires coverage of these tests by private insurance.</p> <p>Waives coinsurance for most preventive services, requiring Medicare to cover 100 percent of the costs. Services for which no coinsurance or deductibles would be required are the personalized prevention plan services and any covered preventive service if it is recommended with a grade of A or B by the USPSTF.</p> <p>Allows the Secretary of Health and Human Services (HHS) to withdraw Medicare coverage for a service not rated as A, B, C, or I by the USPSTF.</p>	Eliminating cost sharing requirements for preventive colorectal cancer screening will lower the cost of screening services for individuals which will help to increase population-based screening rates.
Funding for public health activities (including preventive screenings)	Establishes a Prevention and Wellness Trust. Authorizes \$15.4 billion in funding over FY2011-FY2015 to fund prevention task forces, prevention wellness research, delivery of community-based prevention and wellness services, and core public health infrastructure and activities.	<p>Establishes a prevention and public health fund to be administered through the Office of the Secretary at the Department of HHS to provide for an expanded and sustained national investment in prevention and public health programs. This new fund will support public health activities including prevention research and health screenings.</p> <p>Also has a section regarding community preventive screenings, and specifically lists cancer screenings as one of the community interventions needed to improve public</p>	Funding for initiatives that incorporate colorectal cancer screening are important to increasing population-based screening rates.



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United States Preventive Services Task Force (USPSTF)	Converts the existing USPSTF into the “Task Force on Clinical Preventive Services.” The task force is charged with conducting evidence based systemic reviews of data and literature to determine which clinical preventive services (i.e., preventive services delivered by traditional health care providers in clinical settings) are scientifically proven to be effective.	health. Defines clear duties for both the USPSTF and the Task Force on Community Preventive Services (the Task Force on Community Preventive Services is an existing task force that deals with preventive programs and services outside of the doctor-patient relationship). Provides for better coordination between the two task forces.	The United States Preventive Services Task Force (USPSTF) is the entity that set screening guidelines for colorectal cancer.
<i>Affordability of Care</i>			
Annual and lifetime limits	No annual or lifetime limits for benefits offered under the “essential benefits package.” Sets limits on maximum annual cost sharing - \$5,000 for an individual and \$10,000 for a family.	Prohibits all plans from establishing lifetime limits, and annual limits beginning in 2014. Prior to 2014, plans may not have lifetime limits and may only establish restricted annual limits as defined by the Secretary of Health and Human Services.	Many colorectal cancer patients face a lifetime of cancer treatment. Caps on insurance result in very difficult decisions about the care they will receive and how they are going to pay for it.
<i>Affordability of Insurance</i>			
High-risk pool	Establishes a temporary three year high risk plan to help those currently uninsured gain coverage. Includes subsidies for those under 400% of the federal poverty level. Provides \$5 billion to fund this program.	Establishes a temporary four year high risk health insurance pool to provide coverage to individuals until Jan. 1, 2014. Provides \$5 billion to fund this program.	Many of the provisions in both the House and Senate bills will not take effect immediately. Establishment of a high risk insurance pool will help those individuals with pre-existing conditions afford health insurance until the provisions in the bill eliminating pre-existing condition exclusions take effect.
Pre-existing conditions exclusions	No denial of coverage based on pre-existing health conditions in the plan.	A group health plan and a health insurer offering individual or group insurance may not impose any pre-existing condition exclusion with respect to such coverage.	Eliminating pre-existing conditions exclusions is very important for cancer patients. Pre-existing condition exclusions lock the millions of Americans with at least



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			one chronic illness (nearly one third of the population) into existing plans and employment.
<i>Expanding Access to Insurance</i>			
Increase number of Americans with access to health insurance	<p>Creates a public option, financed through premiums. It would use negotiated rates no lower than Medicare rates.</p> <p>Beginning in 2013, permanent private health insurance market reforms would greatly benefit cancer patients and survivors including the establishment of a national health insurance exchange which would enable individuals who cannot get insurance through their employer to comparison shop.</p>	<p>Creates a new system of national, private insurance plans (“multi-state plans”) supervised by the Office of Personnel Management (OPM), which already administers health benefits for federal employees.</p> <p>Requires OPM to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) through exchanges in each state. Requires OPM to negotiate contracts in a manner similar to which it negotiates contracts for the Federal Employees Health Benefits Program (FEHBP), and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multi-state plans to offer additional benefits, but must pay for the additional cost. Multi-state plans must comply with 3:1 age rating, except states may require more protective age rating. Multi-state plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the PPACA. Guarantees that FEHBP will maintain a</p>	Increasing the number of Americans with health insurance will help reduce mortality rates from colorectal cancer. Many studies show that people who are uninsured are substantially less likely to be screened for colorectal cancer. In addition, insurance status strongly influences survival among those diagnosed with colorectal cancer – individuals with private insurance who are diagnosed with stage II colorectal cancer have better survival outcomes than individuals who are uninsured and are diagnosed with stage I colorectal cancer.



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		separate risk pool and remain a separate program.	
<i>What Services and Treatments Will Be Covered</i>			
Effect on state mandated colorectal cancer screening benefits	Nothing in the bill addresses the preemption of state mandated colorectal cancer screening benefits.	Provides that insurers offering multi-state plans must clearly notify consumers that the policy may not contain some benefits otherwise mandated and provide a detailed statement of the benefits offered and the benefit differences in that state.	Currently, at least 26 states and the District of Columbia require coverage of colorectal cancer screening tests. A few other states require that they be offered or available through Medicare Supplemental policies.
Required benefits package	<p>The minimum services to be included in the essential benefits package include preventive services including those services recommended with the grade of A or B by the United States Preventive Services Task Force (USPSTF).</p> <p>The specifics of the plan would be based on benefit standards recommended by the Benefits Advisory Committee and adopted by the HHS Secretary.</p> <p>Plans outside the exchange must offer at least the essential benefits package.</p>	<p>The benefits covered in the essential benefits package will be defined by the HHS Secretary. The package will include, at a minimum, the following general categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services; and vision care.</p> <p>The HHS Secretary will determine the scope of the essential benefits package. The scope of the package should be equal in scope to the benefits provided under a typical employer plan. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers and report the results of the survey to the HHS Secretary.</p>	<p>This provision determines how coverage is defined and what it will look like.</p> <p>C3 strongly believes that colorectal cancer screening and treatment should be a part of the minimum benefits package.</p>



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		Requires plans seeking certification by exchanges to publically disclose information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing, and enrollee rights. Requires such plans to provide information to enrollees on the amount of cost-sharing for a specific item or service.	
Benefits advisory panel	Establishes a Health Benefits Advisory Committee chaired by the Surgeon General with private members appointed by the President, the Comptroller General, and representatives of relevant federal agencies.	Does not include a benefits advisory panel or committee. The HHS Secretary will determine the scope of the essential benefits package. Requires GAO to study the cost and affordability of qualified health plans offered through exchanges.	Cancer patient advocates and health care professionals providing cancer care should be included in the benefits package advisory panel. The work of defining a benefits package should not be left solely to government officials, health plan officials, and health economists without patient and provider input. Patients and health care providers bring important expertise and experience to inform benefit design and ensure that the benefit package reflects the needs of patients. The advisory panel should also have procedures for public participation and to allow for rapid revision of the benefits package, if medical evidence supports such changes.
<i>Medicare Payment and Reimbursement</i>			
Clinical trials	Provides that the first \$2,000 per year received by an individual for participation in a clinical trial shall not be counted as income for the purpose of calculating Social Security benefits. Establishes an Office of Women’s Health at the Food and Drug Administration	Prohibits insurers from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer	Cancer advocates have worked steadily for more than a decade to ensure that third-party payers cover the routine patients care costs incurred in clinical trials. The Medicare clinical trials coverage policy has been in place since 2000, and more than half of the states have enacted clinical trials coverage laws. These coverage standards ensure that cancer patients can receive their

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	(FDA) to look at (among other things) women’s participation in clinical trials.	<p>or other life-threatening diseases.</p> <p>Establishes an Office of Women’s Health at the FDA to look at (among other things) women’s participation in clinical trials.</p> <p>Establishes a new nonprofit corporation, the “Patient-Centered Outcomes Research Institute,” charged with conducting comparative effectiveness research. Provides that the institute shall appoint expert advisory panels to advise the Institute during clinical trials.</p>	<p>care in clinical studies, providing them access to all treatment options and ensuring that the pace of clinical research is not slowed by reimbursement issues. C3 worked with Senators Brown and Hutchison on a clinical trials amendment, and was pleased that the provisions of the clinical trials amendment were included in Senator Reid’s manager’s amendment.</p>
Medicare Date of Service Rule (14 Day Rule)	Nothing in bill addresses this issue.	Provides for a two year demonstration project for separate and direct payments to independent laboratory for complex diagnostic laboratory tests performed after a patient has left the hospital.	<p>When patients are in the hospital, blood or tissue samples are often collected for testing. Medicare regulations state that the laboratory performing the test must bill the hospital, rather than Medicare, for testing on these samples. This regulation remains in place except for tests ordered 14 days or more after a patient has left the hospital. This regulation can impede timely patient care. Medicare has said that it won’t recognize and pay directly for independent laboratory services unless they come 14 days after a patient has left the hospital.</p> <p>C3 supports including the provisions from H.R. 1699, the <i>Patient Access to Critical Lab Tests Act of 2009</i> in the final health reform bill since it will eliminate barriers to timely access to care by allowing independent laboratories that offer</p>



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			advanced diagnostic testing to bill Medicare directly.
<i>Long Term Savings from Increased Colorectal Cancer Screenings</i>			
Recognition of colorectal cancer screening as a cost saver	Colorectal cancer screening is not specifically mentioned as a cost-saving measure. However, there is a mention of a waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, and ancillary tissue removal.	Colorectal cancer screening is not specifically mentioned as a cost-saving measure.	While colorectal cancer screening is not specifically mentioned as a cost-saving measure in either bill, other initiatives such as the national prevention and wellness trust funds would increase population-based colorectal cancer screening rates and this has the power to focus on colorectal cancer screening as a preventive and cost-saving measure.