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Melissa L. Bean
U.S Representative (IL-08)

April, 22 2010

Dear Melissa,

This letter is in response to the letter you wrote to your constituents in district 8 dated April 16, 2010. I have chosen to dissect your letter in paragraph format and respond to each statement you made based on emotion with factual responses beginning with paragraph number 2 of your letter in which you stated the following:

"After deliberate review of the final legislation in relation to (the concerns of the people of the 8th district) I supported it (the Patient Protection and Affordable Care Act) because it will provide the health care security, affordability and choice families and businesses seek, while utilizing the private market-not a government takeover-and yielding a significant federal deficit reduction of $1.3 trillion..."

I'm very surprised to here any one in Congress still stating that this legislation will "***yield a significant federal deficit reduction of $1.3 Trillion***" In fact, in order to make such a statement you can only be referring to the **initial** CBO score. However that score is months old and it did **not include** the following expenditures:

a.) **$70 Billion** for the "Class Act" (long term care coverage).
b.) **$53 Billion** that will be taken from the Social Security Trust fund.
c.) **$71 Billion** in appropriations needed to enforce the purchase of Insurance and to administer the new health care reform legislation (including $10 Billion for thousands of new IRS agents to "enforce" the Health Insurance purchase mandate and 159 new Federal Agencies.)
d.) **$308 Billion** that will be taken from the Medicare Trust Fund
e.) **$208 Billion** for the "doctor fix" that was passed on April 1st, 2010 **AFTER** the Patient Protection and Affordable Care Act was signed in to law on March 23rd 2010.

When the aforementioned expenditures are added back in to the total cost of the Patient Protection and Affordable Care Act, the legislation actually creates a $662 Billion NEW DEFICIT over the first decade alone. This being the case, it is fiscally IMPOSSIBLE for this legislation to "***yield a deficit reduction of $1.3 Trillion***".

Furthermore, this new legislation requires taxes and fees to begin immediately. However, the new health insurance purchase subsidies for families making up to $88,000 are deferred, so that the first decade of "revenue" is used to pay for only 6 years of spending.

Worse yet this new legislation requires corporations to deposit almost $8 Billion in higher ESTIMATED tax payments in 2014, making this money look like new revenue. However, this money will actually be RETURNED to these corporations the very next year because their actual tax rate will most likely be unchanged. This is what we call "fuzzy math".

We also can not forget that Social Security officially went broke last month. Meaning that it now pays OUT more than it takes IN. So it is FISCALLY IMPOSSIBLE to take $53 Billion from the Social Security Fund without RAISING Social Security taxes. Since there are millions of Americans (many making less than $200,000) who pay into the social security Trust Fund each year. This new legislation CLEARLY creates a "new tax". Namely, a HIGHER Social Security tax. It MUST do so, because our current Social Security program is broke & left with IOUs.
http://www.msnbc.msn.com/id/35865764/

This brings me to Medicare. The new legislation cuts Medicare spending by more than $500 Billion in order to finance the new health insurance purchase subsidies for families making up to $88,000 a year. So you see, this new legislation is not about cost CUTTING, it is instead about cost SHIFTING. In fact, there are very few, if any measures in the bill that tackle the $760 billion in ANNUAL waste and fraud that ALREADY exists in our health care system.

Why would we cut more than $500 billion in Medicare spending, which directly affects our senior citizens. who have paid in to the system their entire life? When we can simply cut the $760 billion in annual waste and fraud in our current health care system. In fact, if we just cut HALF of that annual waste we could buy EVERY ONE of the 47 Million uninsured a gold plated health care plan.

You refer to the 47 Million Uninsured in your letter. Whilst that number is correct. The question that should be asked is, who COMPRISE the 47 Million Uninsured? Thanks to the U.S. Census Bureau we know EXACTLY who they are.

HALF of the uninsured are TEMPORARILY uninsured for an average of 4 months. 38% of the Uninsured CAN AFFORD to purchase Health Insurance coverage but they CHOOSE not to do so. 18 Million make more than $50,000 a year and 10 million of those make more than $75,000 a year. 12 Million can not possibly be Uninsured Americans because they are ILLEGAL IMMIGRANTS.

Then there's the Statistic that's probably most disturbing: 14 Million are poor and low income American's who are FULLY eligible for Federal and State entitlements and CHOOSE NOT TO ENROLL! The saddest part is that another 5 Million of the uninsured are children who go without, only because their parents have not enrolled them. So how many American's are TRULY chronically uninsured? About 8 Million. Think we can insure them for less than $1 Trillion? YES WE CAN!

This entire legislation was predicated upon "everyone paying their fair share." How is it fair that 51.3 million tax returns filed last year paid NO INCOME TAX? Some of these filers made as much as $50,000 a year. Maybe we should have addressed "reforming" the convoluted tax code that allows for such abuse so that everyone ACTUALLY DOES pay their fair share before creating a $1 Trillion new entitlement.

In paragraphs 3,4 & 5 you state "***Across the district, I've heard of countless health care challenges families have been struggling with: A mother fearing for her son's life because he's hit his lifetime cap on benefits at age 14, contemplating bankruptcy to provide him care. A man unable to start his own company because his pre-existing condition makes it impossible to afford health insurance in the individual market. Moms and dads who have been laid off from work, dreading the expiration of COBRA benefits and access to health insurance for their families. I'm proud to have voted to end these uniquely American stories.***

The top priorities I have heard from families in the Eighth district are affordability, portability and security of healthcare coverage. American families with insurance have seen their premiums increase while benefits shrink, and too many have been driven into health care related bankruptcies because of benefit caps or being dropped from coverage when they needed it most. This legislation changes that.

Illinois currently has the highest number of rescissions, or "drops by insurance companies, in the country. Beginning in September, insurance companies will no longer be able to drop coverage of an individual or family when they make a claim, and will not be able to impose lifetime caps on care.."

Firstly, it is ALREADY illegal in ALL 50 STATES to "drop" a policy holder's coverage when they "*make a claim*". In fact, the only time a policy rescission can occur is in the case of fraud. Meaning that a policy holder did not disclose a condition that existed PRIOR to policy purchase. Rescissions are also ONLY ALLOWED by the State Insurance commissioner IF such a "pre-existing" condition were severe enough to have warranted that the applicant be declined for coverage had he or she disclosed the condition at the time of application. To state that an Insurance company can simply "***drop***" you because you "***file a claim***" is simply untrue.

That being said, rescissions do occur. But the question we should ask ourselves is WHY? How did the term "pre-existing condition exclusion" even enter our vernacular? For many years now the Insurance industry has been demonized for allowing such rescissions and for denying coverage for those with said "pre-existing conditions". Is it really their fault? Or does the fault lie with the Federal legislators?

Currently 90% of the American Insured are insured on GROUP Health Insurance policies under HIPAA portability laws that were written 14 years ago. HIPAA Portability law states that if you have had 18 months of prior coverage with no lapse of more than 63 days, the new GROUP health insurance policy you are enrolling in MUST cover your pre-existing conditions from day one. Such is the case with all GROUP health insurance policies.

Yet 10% of the American insured purchase their health insurance on the Individual market. As such, they are not protected in the majority of States under existing HIPAA Portability laws. WHY? Why did the federal legislators not include protection for Individual Health Insurance policy holders 14 years ago? If they had done so, the term "pre-existing condition exclusion" would never have entered our vernacular and millions of American's would have been protected against the exact abuses that you mention in your letter. This is one of MANY reasons why so many American's no longer TRUST their government to do the right thing.

This brings me to your statement regarding "***a man unable to start his own company because his pre-existing condition makes it IMPOSSIBLE to afford health insurance in the individual market. Moms and dads who have been laid off from work, dreading the expiration of COBRA benefits and access to health insurance for their families."***

We ALREADY have STATE RUN High Risk Health Insurance pools in 35 States. 10 States have Guaranteed Individual Health Insurance mandates and the ability to purchase Group Health Insurance is available in all 50 States. These State run High Risk Health Insurance pools provide protection to those with pre-existing conditions. In fact, in our State of Illinois, the risk pool is called ICHIP (Illinois Comprehensive Health Insurance Plan). If you visit www.chip.state.il.us you will find an easy to use premium calculator. On that page, you will find that a 40 year old man can obtain guaranteed issue health insurance coverage REGARDLESS of his pre-existing conditions for as little as $235 a month and 50 year old man can do so for $386 a month. This is HARDLY "***impossible to afford."*** In fact, these prices are MUCH cheaper than what it will cost in 2014 and beyond once we started subsidizing insurance premiums for 33 Million more Americans. How do we know this? Just look at Massachusetts where a typical family of four today faces total annual health costs of nearly $13,788, the highest in the country. Per capita spending is 27% higher than the national average. Hospital costs are 55 percent above the national average and more than half of the 408,000 newly insured residents pay NOTHING. Another 140,000 remained UNINSURED in 2008 and were either assessed a penalty or exempted from the individual mandate because the state deemed they couldn't afford the premiums. Shades of things to come!

Furthermore, NO ONE in the State of Illinois has to "***dread the expiration of COBRA benefits and access to health insurance for their families***." EVERY family in Illinois and EVERY citizen in Illinois can ALREADY continue their health insurance coverage by enrolling in the aforementioned ICHIP High Risk Health Insurance Pool. In fact, ICHIP's HIPAA PLAN 5 guarantees those who are coming off of an exhausted Cobra plan IMMEDIATE coverage for their pre-existing conditions. To state anything else is simply untrue.

You further state in paragraph 5 that "***Starting in 2014, those limited to the Individual market will be able to choose from a variety of benefit plans in a state-wide Exchange. By pooling together, they will have more benefit options, volume pricing, and reduced risk. An Estimated 31,500 uninsured Eighth District families will get access to affordable coverage***."

Illinois residents ALREADY have a plethora of options from a multitude of health insurance carriers. In fact, the Exchanges will be offering them coverage from the exact same Insurance companies that they have access to today. Their choices may be even LESS in 2014 due to the onerous 85/15 medical loss ratio and increased taxation forced upon health insurance companies under this new legislation.

The only difference in the Exchanges will be that the Illinois tax payer will be subsidizing large portions of those 31,500 uninsured family's premiums. The LAST thing we need is another tax burden on the Illinois tax payers brought about by providing "subsidies" to 31,500 uninsured Eighth district families, some making as much as 88,000 a year.

This is why 35 States are now attempting to legally remove themselves from the fiscal burdens placed upon them by this new legislation: http://atlanticsentinel.com/2010/03/states-fighting-health-care-bill/ If they are successful, the fiscal burden on the other 15 States will be catastrophic.

In fact, the new legislation puts increased burden on the majority of tax payers by expanding Medicaid spending by $48 Billion. Medicaid itself (thanks in part to the "stimulus") grew by 23% last year. Such a course is unsustainable. Expanding Medicaid is not the answer, most especially to a State like Illinois that is already facing a "historic" fiscal crisis. This is, in part, why the former CBO director stated last month that U.S. Fiscal Policy is UNSUSTAINABLE! http://www.politico.com/news/stories/0410/35546.html

In Paragraph 7 you state: ***"With this legislation, insurance companies will be banned from dropping coverage or increasing rates arbitrarily after a claim from an employee. Premium increases will be more predictable as they will need to be justified bases on paid claims."***

This is another categorically UNTRUE statement. I have already addressed the FACT that it is illegal in all 50 States to "**drop coverage after a claim**" without evidence of fraud. That being said, it is also untrue that an insurance company can just "***arbitrarily increase rates after a claim***" In fact, NOTHING could be FURTHER from the truth. The LAW in Illinois (and in most States) is very clear when it comes to raising health insurance premiums. Health Insurance premium increases MUST BE FILED WITH THE STATE DEPARMENT OF INSURANCE. When an increase in premiums is necessary due to the assessment of a trained actuary, an insurance company must FILE said rate increase with the State Department of Insurance BEFORE any such rate increase is passed on to policy holders. Small Group Health Insurance rate increases must also be reviewed by an Actuary at the State Department of Insurance prior to passage. These rate increases can not be just "***raised arbitrarily***".

In paragraph 8 you state: ***"America keeps its commitment to its seniors. Contrary to some reports, the bill does not reduce Medicare benefits. In fact, senior benefits will increase with savings on prevention and wellness services, which will be provided without a co pay starting in September. It closes the Part D donut hole, allowing the 6,800 Eighth District beneficiaries who enter the donut hole each year to receive a $250 rebate in 2010 and 50 percent discounts on brand name drugs beginning in 2011, fully closing the donut hole over the next decade. This bill also ensures that Medicare stays solvent for an additional nine years, by removing over $400 billion in overpayments and eliminating waste, fraud, and abuse from the system.***

Do you really think that by removing a small co pay and issuing a $250 rebate check will make our Seniors "forget" about the following Medicare cuts coming soon under this legislation?
Medicare cuts to hospitals begin: long-term and inpatient and rehabilitation facilities (FY10)
Medicare cuts to inpatient psych hospitals (7/1/10)
$132 Billion in Medicare Advantage Cuts Begin (2011)
Medicare cuts to home health (2011)
"Wealthy Seniors" (making $85k to $170k) begin paying higher Part D premiums (not indexed for inflation in Parts B/D) (2011)

Medicare reimbursement cuts when seniors use diagnostic imaging like MRIs, CT scans and other Nuclear Medicine Scans. (2011)
Medicare cuts begin to ambulance services, ASCs, diagnostic labs, and durable medical equipment (2011)
Prohibition on Medicare payments to new physician-owned hospitals (2011)
Seniors prohibited from purchasing power wheelchairs unless they first RENT for 13 Months (2011)
MORE Medicare cuts to long-term care hospitals begin (7/1/11)
MORE Medicare cuts to hospitals and cuts to nursing homes and inpatient rehab facilities begin (FY12)
Medicare cuts to dialysis treatment begins (2012)
Medicare to reduce spending by using an HMO-like coordinated care model (Accountable Care Organizations) (2012) We ALREADY know how WELL HMO's work!
MORE Medicare cuts to inpatient psych hospitals (7/1/12)
Medicare cuts to hospitals with high readmission rates begin (FY13
Medicare cuts to HOSPICE begin (FY13)
New Tax of 2.3% on Medical Devices (2013)
Medicare cuts to hospitals who treat low-income seniors begin (2013)
MORE Medicare cuts to home health begin (2014)
MORE Medicare cuts to home health begin (2015)

Yeah that sure sounds like "***America keeps it's commitments to its seniors. Contrary to some reports, the bill does not reduce Medicare benefits***" Oh I'm quite sure all of our seniors will thank you SO MUCH for the $250 rebate check on their Part D prescription drug "donut hole". I'm sure that will MORE than offset all the aforementioned other cuts.

In paragraph 9 you state: ***"Taxpayer expect accountability. Health Insurance reform is as important to America's fiscal health as it is to our physical health. Currently the U.S. spends twice as much, as a percentage of GDP, than other industrialized nations on health care, while an estimated 45 million people are uncovered. At a time when our nation's debt exceeds $12 trillion, H.R. 3950 provides the most significant deficit reduction in more than a decade. According to the non-partisan Congressional Budget Office, this bill cuts our federal deficit by $1.3 trillion over 20 years…"***

Firstly, I know of no economist, actuary or accountant in the private sector that would ever attempt to score the cost of a piece of legislation (certainly one of this size) out over a 20 year period and we've already exposed the "fuzzy math" used by this administration to hide the REAL cost of this legislation. President Harry Truman's famous words apply perfectly to the scoring of this legislation. He said : "*Those who do not know history are doomed to repeat it*.

In 1965 the Fed projected that costs for Medicare Part A would be $9 Billion. It ended up costing $67 BILLION! The Medicaid special hospital subsidy was supposed to cost $100 MILLION. Instead the real cost was $11 BILLION! That's ONE HUNDRED TIMES GREATER!

Government has NO HISTORY of fiscal responsibility. Once a new entitlement is established it grows exponentially as time passes. These are simply the historical facts. We need only look at the current insolvency of Medicare, Medicaid, Social Security, Fannie Mae, Freddie Mac & even the Post Office. In fact, Social Security & Medicare alone have a combined unfunded liability of $84 Trillion.

In Paragraph 11 you make the most shocking statement of all when you state: ***"This law ensures that no insurance company or government bureaucrat interferes with doctor and patient decisions."***

The fact that this legislation contains more than $500 Billion in Medicare cuts is a PERFECT example of government bureaucrats INTERFERING with doctor and patient decisions. The 21% reduction in payments to physicians who accept Medicare will most certainly guarantee less doctors accepting Medicare. This will have a DIRECT affect on both the quality of care that our seniors enjoy now and the ABILITY to even OBTAIN care. Add to that the SWEEPING powers given to the Secretary of Health & Human Services, Kathleen Sebelius (an ATTORNEY NOT A PHYSICIAN) and we are GUARANTEED to see a reduction in services based on cost.

Insuring 33 million more people without establishing ANY MEASURES to fix our current doctor shortage is another PERFECT example of government bureaucrats INTERFERING with doctor and patient decisions. We need only look to the State of Massachusetts for proof of that.

Speaking of Massachusetts, the recently established Romney Care has incorporated a "no pre-existing clause in it's State Health Insurance mandates. However, it does not require proof of prior insurance coverage as the current HIPAA portability laws do (for Group coverage only). Because of this, there is no impetus to CONTINUE remaining insured. For this reason, millions of Massachusetts residents are "gaming the system" by buying a health insurance policy when they are sick, receiving treatment and then "dumping" the policy shortly after their treatment has been received. This has left Massachussets with a MASSIVE deficit in their program for which they are seeking EVEN MORE "relief" from the U.S Tax payer. As it stands now, HALF of their health insurance program is subsidized by the U.S. Tax payer.

Since the criminal prosecution for NOT purchasing health insurance was REMOVED from the final health care "reform" legislation prior to passage. There is now no impetus for ANYONE to purchase health insurance until they get sick. There is also no impetus for anyone to STAY insured under this new legislation. Consider a healthy single man of thirty-five who earns $35,000 a year. Under the new legislation, he would have a choice of enrolling in a subsidized plan at an annual cost of $2,700 or paying a fine of $875. He will MOST LIKELY just take his chances, and report to the local emergency room if he gets really sick. (E.R.s will still be legally obliged to treat everyone.) If this happens, as it does NOW in Massachusetts the new insurance exchanges will be deprived of the healthy people they need in order to bring down prices. Who will pick up the tab? The U.S. Tax Payer! JUST LIKE we do NOW in Massachusetts.

You also stated that under the new Exchanges consumers will have ***"reduced risk".*** This is also not the case for many consumers since the Exchange will subject policy holders to the same maximum out of pocket costs that are allowed now under current HSA laws.

For example:
The Bronze plan which will pay 60 percent of medical costs
The Silver plan which will pay 70 percent of medical costs
The Gold plan which will pay 80 percent of medical costs
The Platinum plan which will pay 90 percent of medical costs.

However, all family members will still be subjected to the maximum out of pocket costs that are allowed for an HSA qualified plan now. How much is that? **$11,600**. That is MUCH more risk than many families are carrying now, most especially those who are insured on Traditional (Non HSA qualified plans).

You also stated in paragraph 6: "***When small business succeeds, America prospers***" How exactly does America prosper when John Deere, Boeing, Caterpillar, Prudential Life, 3M, Honeywell, AK Steel Holding Corp, ITW, Valero Energy and Allegheny Technologies have ALL announced that this new legislation will cost them hundreds of millions every year?

In closing, you also stated that "***Taxpayers expect accountability***" To that I must state 2 things:

1.) President Obama promised us that "*If your family earns less than $250,000 a year, you will not see your taxes increased a single dime. I repeat: not one single dime.*"

In reality, taxpayers earning less than $200,000 a year will pay roughly $3.9 billion more in taxes in 2019 alone due to this new legislation, according to the Joint Committee on Taxation. The new law raises $15.2 billion over 10 years by limiting the medical expense deduction, a provision widely used by taxpayers who either have a serious illness or are older.

Taxpayers can currently deduct medical expenses in excess of 7.5% of their adjusted gross income. Starting in 2013, most taxpayers will only be able to deduct expenses greater than 10 % of AGI. Older taxpayers are hit by this threshold increase in 2017. Once the law is fully implemented in 2019, the Joint Committee on Taxation estimates the deduction limitation will affect 14.8 million taxpayers! 14.7 million of them earn less than $200,000 a year. These taxpayers are single and joint filers, as well as heads of households. Loss of this deduction will mean higher taxes for 14.7 million individuals and families making under $200,000 a year in 2019. For breaking this promise, we the taxpayers of Illinois WILL INDEED hold the President ***"accountable"*** in 2012.

2.) For making 400 of us tax payers stand outside your office in Schaumburg on a FREEZING COLD day in March and then STILL voting YES on this legislation, we WILL ALSO HOLD YOU ***"accountable"*** in November!

Sincerely,

C. Steven Tucker

Insurance Broker & Subject Matter Expert for the:
Wall Street Journal & Fortune Small Business Magazine
President, www.SmallBusinessInsuranceServices.com
www.TRUTHaboutpreexistingconditions.com