

8 Questions About Health-Care Reform

Reporting by Ceci Connolly and Alec MacGillis, September 9, 2009

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President Obama will address a joint session of Congress on Wednesday in an attempt to restart his push for reform. Obama has said he hopes to provide affordable coverage to every American while reining in medical spending over the long term. Democratic lawmakers, who return to Washington on Tuesday, have been wrestling with the issue for months but are far from agreement. Here's a look at some ideas being considered and the impact they might have.

#1 If I don't have health insurance now, how will reform affect me?

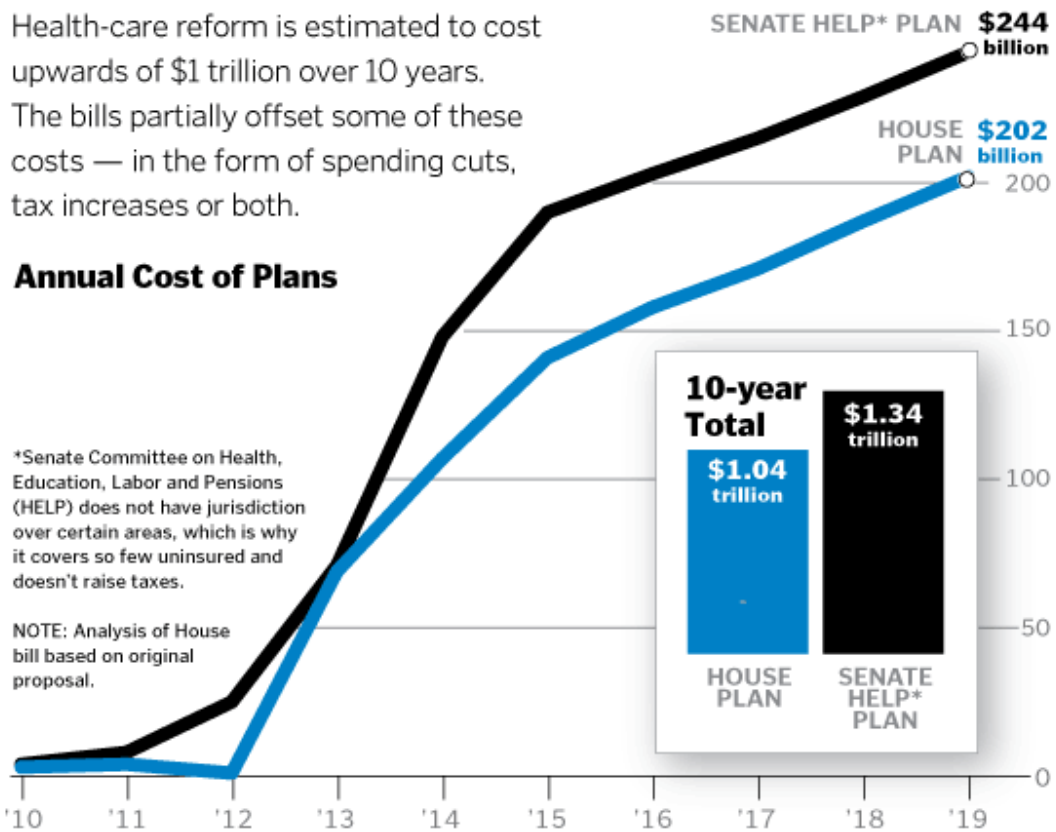
Under the proposals being considered, people without insurance will be required to get it. They will be able to buy coverage on a new "exchange," a marketplace in which private insurers will offer plans (possibly alongside a government-run option or a nonprofit cooperative). The government will subsidize the cost of plans, on a sliding scale, up to a certain income: Liberal Democrats want help extended to families earning as much as four times the poverty level (\$88,000 for a family of four); conservative Democrats want to limit help to families earning \$66,000 or less. Plans offered on the exchange will have to comply with much stricter rules than those that exist in today's Wild West individual insurance market — prohibitions on denying coverage based on preexisting conditions, limits on how much prices can be determined by people's ages, caps on out-of-pocket spending and limits on "rescissions," or the practice of voiding coverage based on technicalities after someone submits a big claim. Meanwhile, the poorest among the uninsured will probably be covered by expanded Medicaid eligibility.

#2 If I currently have health insurance, how will reform affect me?

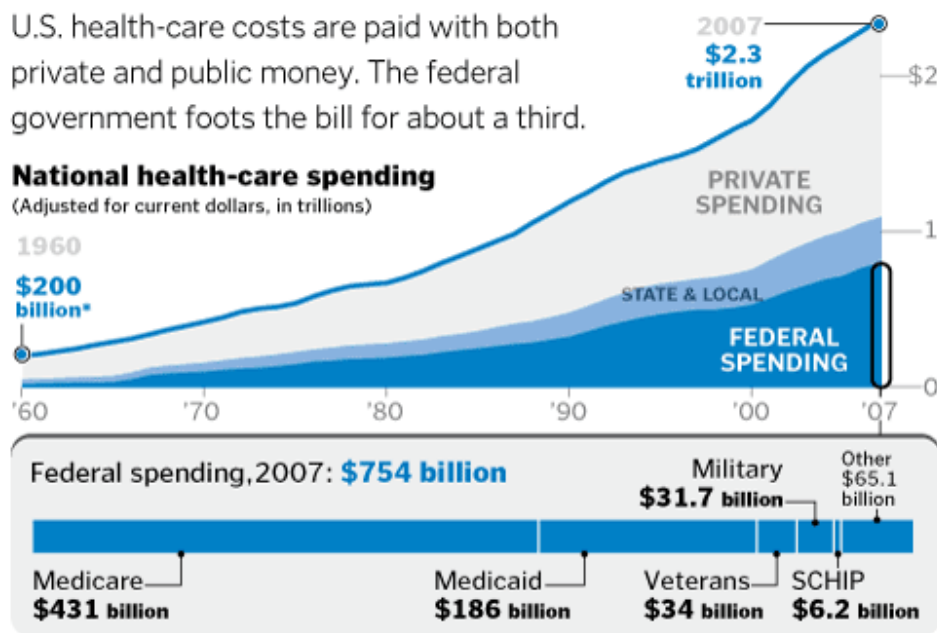
Not that much, at least initially. The legislation is intended to preserve the existing employer-based insurance system -- at first, only small businesses and people who aren't covered through their jobs will be allowed to buy plans on the new exchange. Over time, access to the exchange may be broadened, though this raises the possibility that if people buy insurance on the exchange instead of on the job, employer plans may be left with a smaller pool of employees who have greater health-care costs, a situation that could make those plans hard to sustain. The Democrats' hope is that your employer-based insurance premiums will grow more slowly if the health-care system as a whole is more rational and less wasteful. People now covered by individual plans will be able to get better-regulated plans on the new exchange, possibly with government subsidies. People now covered in the workplace won't have to worry as much about losing coverage if they lose their job or want to start their own business -- they would turn to the exchange for new coverage.

#3 How much is reform likely to cost?

The price tag for covering the uninsured comes in around \$1 trillion over the first 10 years, just under double what the new Medicare drug benefit was expected to cost. The proposals would pay for about half of this by squeezing money out of Medicare and Medicaid, including the subsidies that now go to private insurers that offer Medicare Advantage plans and the Medicaid payments that go to hospitals caring for a disproportionate share of the uninsured -- the hope is that more of these hospitals' patients would be covered after reform. Much of the remainder would be paid for through new tax revenue. House Democrats want an income tax surcharge on those earning more than \$1 million, President Obama wants to reduce the itemized deductions for wealthy taxpayers, and moderate Senate Democrats have talked about taxing the most costly of employer-provided health plans. The cost of covering the uninsured is separate from the related question of how to "bend the curve" of the country's overall health-care spending. The goal is to achieve this by expanding "comparative effectiveness" research into what treatments work best, and by nudging health-care providers into models in which they work closely together and are paid on salaries, instead of charging for each procedure provided.



#4 How much does the federal government now spend on health care?



#5 What will happen to small businesses under health-care reform?

Small businesses now have a difficult time buying coverage for employees. They have a smaller pool of people to cover than large companies do, so coverage costs can soar if the workers tend to be older or if even one person happens to get very sick. The proposals seek to solve this problem by letting small businesses buy coverage on the new exchange, where their workers would be pooled together with all the other people on the exchange, spreading the risks more broadly. The proposals also include various tax credits to help small businesses obtain coverage. At the same time, the proposals require businesses of a certain size to provide coverage or pay a penalty. The House bill originally mandated that companies with a payroll of at least \$250,000 offer insurance or pay a fine ranging from 2 to 8 percent of payroll depending on the company's size; conservative Blue Dog Democrats, however, demanded that companies with annual payrolls of \$500,000 or less be exempt from any mandate. The Senate Health, Education, Labor and Pensions Committee bill has a penalty of \$750 per full-time worker and exempts firms with fewer than 25 employees. The Senate Finance Committee is considering a lesser penalty -- charging businesses the cost of subsidizing those employees who qualify for public assistance in getting their own coverage.

#6 I keep hearing about plans to create a "public option" or health insurance cooperatives. How would those work?

The House Democrats' plan and the Senate health committee's plan both would offer a new government-run insurance plan, or "public option," on the new exchange. People would buy it just as they would a private plan on the exchange: They would pay premiums, and if their income is low enough, they would get government subsidies to help cover the cost. It would be available only to those people allowed access to the exchange -- initially, small businesses and people without employer-based coverage. Under the initial House plan, the public plan would pay doctors and hospitals reimbursement rates 5 to 10 percent higher than Medicare reimbursement rates. The thinking is that this would make the plan competitively priced compared with private plans -- spurring them, it is hoped, to reduce their own prices -- while somewhat allaying the concerns of providers who say

Medicare reimbursements are too low. Blue Dog Democrats in the House want the plan's reimbursement rates to be negotiated with each provider, instead of tied to Medicare, which would probably mean higher reimbursements and premiums. Moderate Senate Democrats opposed to a public option are considering creating nonprofit insurance cooperatives, which would be seeded with federal money but run by the people who belong to them, not the government. Supporters of the public option are questioning whether the co-ops would have enough heft to compete with private insurers.

#7 What is likely to happen to my Medicare coverage under current proposals?

The vast majority of benefits provided by Medicare to 45 million senior citizens and people with disabilities would not be changed. Under the House bills, premiums for Medicare prescription drug coverage, known as Part D, would increase slightly. That increase would be offset by deep discounts on medications bought in the coverage gap known as the "doughnut hole." Overall, the result would be lower out-of-pocket costs on prescription drugs for most seniors, according to the Congressional Budget Office.

Most of the bills Congress is considering would provide higher reimbursement to doctors, especially primary-care physicians. But hospitals and insurance companies that sell managed-care plans, called Medicare Advantage, would have lower-than-expected government payments.

Democrats initially included a provision to allow Medicare to reimburse physicians for end-of-life consultations. But false accusations that the provision would lead to government "death panels" have prompted lawmakers to rethink the idea.

#8 What do the current bills have in common, and what are the major legislative challenges that lie ahead?

Bills approved by the Senate health committee and three House panels are similar in many respects. All four versions would:

- Require every American to carry insurance, with discounts for people who cannot afford it and penalties for people who refuse to buy coverage.

- Require most employers to contribute to the cost of employee coverage or pay into a health fund, while small firms would be exempt or receive tax credits to reduce the price.

- Expand the Medicaid health program for the poor.

- Provide insurance discounts for people earning less than 400 percent of the federal poverty level, or about \$73,000 for a family of three.

- Impose new restrictions on insurance practices, such as prohibiting the denial of coverage because of preexisting conditions.

- Create a new marketplace, dubbed an "exchange" or "gateway," for individuals and small businesses to comparison-shop for insurance.

The Senate Finance Committee has yet to release a bill but is circulating a more modest draft that would cost less than \$900 billion over 10 years and provide smaller subsidies for purchasing insurance.

In the coming weeks, the three House versions will be merged into a single bill and brought to the floor for a vote. Any Senate Finance Committee bill would be merged with the health committee's version and sent to the floor. If both the House and the Senate approve bills, differences would be hammered out in a conference committee and sent to both chambers for final action.