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EDITORIAL

Health Care Reform and You

The health care reform bills moving through Congress look as though they would do a good job of providing coverage for millions of uninsured Americans. But what would they do for the far greater number of people who already have insurance? As President Obama noted in his news conference last week, many of them are wondering: “What’s in this for me? How does my family stand to benefit from health insurance reform?”

Many crucial decisions on coverage and financing have yet to be made, but the general direction of the legislation is clear enough to make some educated guesses about the likely winners and losers.

WHAT ARE THE ELEMENTS OF REFORM? The House bill and a similar bill in the Senate would require virtually all Americans to carry health insurance with specified minimum benefits or pay a penalty. They would require all but the smallest businesses to provide and subsidize insurance that meets minimum standards for their workers or pay a fee for failing to do so.

The reforms would help the poorest of the uninsured by expanding Medicaid. Some middle-class Americans — earning up to three or four times the poverty level, or \$66,000 to \$88,000 for a family of four — would get subsidies to help them buy coverage through new health insurance exchanges, national or state, which would offer a menu of policies from different companies.

IS THERE HELP FOR THE INSURED? Many insured people need help almost as much as the uninsured. Premiums and out-of-pocket spending for health care have been rising far faster than wages. Millions of people are “underinsured” — their policies don’t come close to covering their medical bills. Many postpone medical care or don’t fill prescriptions because they can’t afford to pay their share of the costs. And many declare personal bankruptcy because they are unable to pay big medical debts.

The reform effort should help ease the burdens of many of them, some more quickly than others. The legislation seems almost certain to include a new marketplace, the so-called health insurance exchange. Since there will be tens of millions of new subscribers, virtually all major insurers are expected to offer policies through an exchange. To participate, these companies would have to agree to provide a specified level of benefits, and they would set premiums at rates more comparable to group rates for big employers than to the exorbitant rates typically charged for individual coverage.

Under the House bill, the exchanges would start operating in 2013. They would be open initially to people who lack any insurance; to the 13 million people who have bought individual policies from insurance companies, which often charge them high rates for relatively skimpy coverage; and to employees of small businesses, who often pay high rates for their group policies, especially if a few of their co-workers have run up high medical bills. By the third year, larger businesses might be allowed to shift their workers to an exchange. All told, the Congressional Budget Office estimates that 36 million people would be covered by

policies purchased on an exchange by 2019.

IS THERE MORE SECURITY FOR ALL? As part of health reform, all insurance companies would be more tightly regulated. For Americans who are never quite certain that their policies will come through for them when needed, that is very good news.

The House bill, for example, would require that all new policies sold on or off the exchanges must offer yet-to-be-determined “essential benefits.” It would prohibit those policies from excluding or charging higher rates to people with pre-existing conditions and would bar the companies from rescinding policies after people come down with a serious illness. It would also prohibit insurers from setting annual or lifetime limits on what a policy would pay. All this would kick in immediately for all new policies. These rules would start in 2013 for policies purchased on the exchange, and, after a grace period, would apply to employer-provided plans as well.

WHO PAYS? Current estimates suggest that it would cost in the neighborhood of \$1 trillion over 10 years to extend coverage to tens of millions of uninsured Americans. Under current plans, half or more of that would be covered by reducing payments to providers within the giant Medicare program, but the rest would require new taxes or revenue sources.

If President Obama and House Democratic leaders have their way, the entire tax burden would be dropped on families earning more than \$250,000 or \$350,000 or \$1 million a year, depending on who’s talking. There is strong opposition in the Senate, and it seems likely that at least some burden would fall on the less wealthy.

Many Americans reflexively reject the idea of any new taxes — especially to pay for others’ health insurance. They should remember that if this reform effort fails, there is little hope of reining in the relentless rise of health care costs. That means their own premiums and out-of-pocket medical expenses will continue to soar faster than their wages. And they will end up paying higher taxes anyway, to cover a swelling federal deficit driven by escalating Medicare and Medicaid costs.

WHO WON’T BE HAPPY? Healthy young people who might prefer not to buy insurance at all will probably be forced to by a federal mandate. That is all to the good. When such people get into a bad accident or contract a serious illness, they often can’t pay the cost of their care, and the rest of us bear their burden. Moreover, conscripting healthy people into the insured pool would help reduce the premiums for sicker people.

Less clear is what financial burden middle-income Americans would bear when forced to buy coverage. There are concerns that the subsidies ultimately approved by Congress might not be generous enough.

WHAT IF I HAVE GOOD GROUP COVERAGE? The main gain for these people is greater security. If they got laid off or chose to leave their jobs, they would no longer be faced with the exorbitant costs of individually bought insurance but could buy new policies through the insurance exchanges at affordable rates.

President Obama has also pledged that if you like your current insurance you can keep it.

Right now employers are free to change or even drop your coverage at any time. Under likely reforms, they

would remain free to do so, provided they paid a penalty to help offset the cost for their workers who would then buy coverage through an exchange. Under the House reform bill, all employers would eventually be allowed to enroll their workers in insurance exchanges that would offer an array of policies to choose from, including a public plan whose premiums would almost certainly be lower than those of competing private plans.

Some employers might well conclude that it is a better deal — for them or for you — to subsidize your coverage on the exchange rather than in your current plan. If so, you might end up with better or cheaper coverage. You would probably also have a wider choice of plans, since most employers offer only one or two options.

WILL I PAY LESS? Two factors could help drive down the premiums for those who are insured. In the short-term, if reform manages to cover most of the uninsured, that should greatly reduce the amount of charity care delivered by hospitals and eliminate the need for the hospitals to shift such costs to patients who have private insurance. One oft-cited study estimates that cost-shifting to cover care for the uninsured adds about \$1,000 to a family's annual insurance premiums; other experts think it may be a few hundred dollars. In theory, eliminating most charity care should help hold down or even reduce the premiums charged for private insurance. When, if ever, that might happen is unclear.

In the long run, if reform efforts slow the growth of health care costs, then the increase in insurance costs should ease as well. And if the new health insurance exchanges — and possibly a new public plan — inject more competition into markets that are often dominated by one or two big private insurance companies, that, too, could help bring down premiums. But these are big question marks, and the effects seem distant.

WILL MY CARE SUFFER? Critics have raised the specter that health care will be “rationed” to save money. The truth is that health care is already rationed. No insurance, public or private, covers everything at any cost. That will not change any time soon.

It is true that the long-term goal of health reform is to get rid of the fee-for-service system in which patients often get very expensive care but not necessarily the best care. Virtually all experts blame the system for runaway health care costs because it pays doctors and hospitals for each service they perform, thus providing a financial incentive to order excessive tests or treatments, some of which harm the patients.

An earlier wave of managed care plans concentrated on reining in costs and aroused a backlash among angry beneficiaries who were denied the care they wanted. The most expensive treatment is not always the best treatment. The reform bills call for research and pilot programs to find ways to both control costs and improve patients' care.

The bills would alter payment incentives in Medicare to reduce needless readmissions to hospitals. They would promote comparative effectiveness research to determine which treatments are best but would not force doctors to use them. And they call for pilot programs in Medicare to test the best ways for doctors to manage and coordinate a patient's total care.

Any changes in the organization of care would take time to percolate from Medicare throughout the health care system. They are unlikely to affect most people in the immediate future.

WHAT DOES IT MEAN FOR OLDER AMERICANS? People over 65 are already covered by Medicare and would seem to have little to gain. But many of the chronically ill elderly who use lots of drugs could save significant money. The drug industry has already agreed to provide 50 percent discounts on brand-name drugs to Medicare beneficiaries who have reached the so-called “doughnut hole” where they must pay the full cost of their medicines. The House reform bill would gradually phase out the doughnut hole entirely, thus making it less likely that beneficiaries will stop taking their drugs once they have to pay the whole cost.

Not everyone in Medicare will be happy. The prospective losers are likely to include many people enrolled in the private plans that participate in Medicare, known as Medicare Advantage plans. They are heavily subsidized, and to pay for reform, Congress is likely to reduce or do away with those subsidies. If so, many of these plans are apt to charge their clients more for their current policies or offer them fewer benefits. The subsidies are hard to justify when the care could be delivered more cheaply in traditional Medicare, and the subsidies force up the premiums for the beneficiaries in traditional Medicare to cover their cost.

Reformers are planning to finance universal coverage in large part by saving money in the traditional Medicare program, raising the question of whether all beneficiaries will face a reduction in benefits. President Obama insisted that benefits won't be reduced, they'll simply be delivered in more efficient ways, like better coordination of care, elimination of duplicate tests and reliance on treatments known to work best.

The AARP, the main lobby for older Americans, has praised the emerging bills and thrown its weight behind the cause. All of this suggests to us that the great majority of Americans — those with insurance and those without — would benefit from health care reform.

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