DRAFT

How Will the New Health Care Law Affect You?

National Center for Policy Analysis

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What Are the Facts?

During the nine month period leading up to the passage of the Patient Protection and Affordable Care Act, Americans were subjected to more than $200 million worth of TV, radio, newsprint and Internet ads. Almost all of these — the pro and the con — were pure propaganda.

Even today, the White House and leaders of both political parties offer us little more than sound bites, crafted for the evening news. A taxpayer-funded mailing to Medicare enrollees has been accused of selling more than informing. The government's own Web site, while containing much valuable information, touts only the *benefits* of reform and ignores the *costs*. It focuses on what *might go right* and ignores what *might go wrong*.

As a result, many people are rightly confused about what to expect and why. We hope this publication will clear the air. Its goal is a balanced overview, with all important content sourced from government reports and other reputable documents.

Overview: A Better Health Care System?

Recently enacted legislation will radically transform the U.S. health care system. These changes will occur over time, however. The most significant changes (e.g., a requirement that most people obtain health insurance) will not become law until 2014. A tax on employee "Cadillac" health plans does not take effect until 2019. This means there will be many elections and many opportunities for voters to express their will before most provisions become law. In the meantime, here is a brief summary.

Structural Features of Reform

- Beginning in 2014, you will be required by law to have health insurance and to attach proof of insurance to your tax return.
- If you fail to insure, you will be fined — with the amount rising to $695 ($2,085 per family) in 2016 or 2.5% of income, whichever is greater.
- If your employer fails to offer you health insurance, the fine can be as high as $2,000 per employee per year.

- The type of insurance you must have — including copays, deductibles and the employee's share of the premium — will all be determined by federal regulations, rather than by you and your employer.
- If you are not covered by an employer plan, Medicare, Medicaid or other government plan, you will be required to buy insurance in a government-regulated health insurance exchange, where competing insurers will offer the government-mandated health insurance benefit package.
- How your doctor practices medicine and how you obtain care are likely to substantially change.

Some Major Benefits of the Reform

Some of the touted benefits of reform are not new. For example, since 1996 federal law has barred insurers from dropping your coverage just because you get sick. However, the following changes are new:

- You may be able to buy insurance you cannot now afford. Beginning in 2014, for example, a couple with an income of twice the poverty level (currently $29,000) will be

able to buy insurance for an annual premium no higher than 6.3% of their income ($1,827).

- If you have a pre-existing condition, you will be able to buy insurance for the same premium as that paid by people in good health.
- Over the next four years, newly created risk pools will offer subsidized insurance to some of the people who have been turned down by health insurers because of a pre-existing condition.
- If you have a very expensive and continuing health problem, there will be no lifetime limits on your health insurance coverage.
- Overall, the Congressional Budget Office (CBO) expects 32 million otherwise uninsured people (about 60% of the total) to obtain health insurance. Medicare's chief actuary puts the estimate at 34 million.

Some Major Costs of the Reform

In general, for every benefit there is an offsetting cost. More than half the costs of this reform, for example, will be borne by the elderly and disabled on Medicare:

- $523 billion of health reform's first 10-year cost will be paid for by cuts in spending on Medicare enrollees, according to Congressional Budget Office.
- In addition, there are new taxes on drugs and on such medical devices as wheelchairs, crutches, pacemakers, artificial joints, etc. — items disproportionately used by Medicare enrollees.

There are other taxes that will reach the more general population:

- A new tax on health insurance is likely to cost the families of employees of small businesses more than $500 a year in higher premiums.
- A 40% tax on the extra coverage provided by expensive "Cadillac" plans will apply to about one-third of all private health insurance in 2019; and because the tax threshold is not indexed to medical inflation, over time the tax will eventually reach every health plan.

There are also hidden costs of certain benefits:

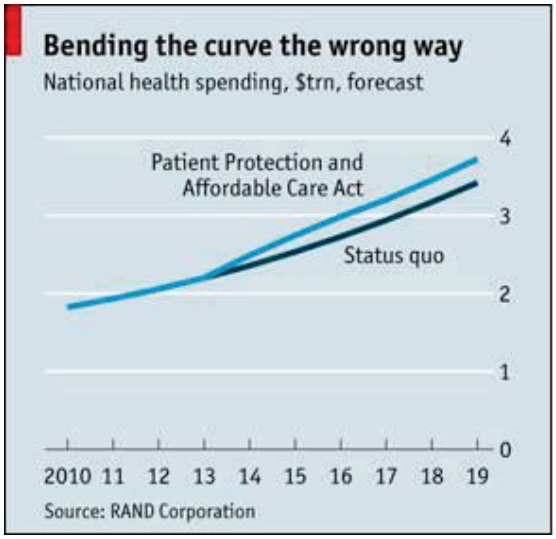
- Health insurers will have to raise premiums for everyone else in order to charge people with pre-existing conditions less than the expected cost of their care. Young people, for example, could see a doubling or tripling of their premiums, according to industry estimates.
- In order for employers to provide health insurance (or more generous insurance) to their employees, they will have to reduce what they pay in wages and in other benefits.
- By one estimate, the new burdens for employers could result in a loss of as many as 700,000 jobs by 2019.

What Health Reform Does Not Do

During the debate leading up to health reform legislation, participants discussed many problems and many goals. Here are some goals that will not be achieved:

Health care costs may rise, rather than fall. Although the CBO initially predicted a slight lowering of overall health care costs in future years, it is now expressing doubts. Medicare's chief actuary and most private forecasts expect overall costs as well as the

government's costs to be higher than otherwise. The graph below shows the prediction of the RAND Corporation, a respected private think tank.



One of the great uncertainties in this regard is whether the federal government will actually follow through on cuts in Medicare spending in future years — as called for under the new law. These cuts imply that:

- Medicare fees paid to doctors and hospitals will fall increasingly behind what private insurers are paying.

- As a result, seniors and the disabled will have increasingly less access to care, as providers tend first to the better-paying patients.

- In the worst case, the fate of Medicare patients would come to resemble that of Medicaid enrollees — with seniors and the disabled having to seek care at community health centers and safety net hospitals.

Will future Congresses and future presidents actually allow this to happen? The current Congress and the current president have certainly committed to it. But other actions suggest that their commitment may be weak. For example, current federal law is supposed to limit Medicare fee increases to doctors to no more than the rate of growth of national income. But for the past seven years Congress has stepped in to prevent these limits and allow Medicare fees to doctors to rise at about the same rate as private sector fees.

Health insurance will not become portable for most people. The vast majority of people with private health insurance will continue to get job-based insurance. This means that when you leave your job — because of, say, a layoff or retirement — you will lose your coverage and be forced to find new insurance elsewhere.

People with the same incomes will not be treated the same under the tax law. One of the complaints about the current system is that while employer-provided health insurance may be purchased with pretax dollars, people who buy insurance on their own must pay with after-tax dollars. In fact, the after-tax cost of insurance for middle-class families who purchase their own insurance can be twice as high as it is if they get insurance at work! This inequity will not only continue under health reform, a new system of subsidies will create new inequities.

Access to care may become more difficult for some patients. Health economists estimate that people with health insurance consume twice as much health care as people without it. This means that 34 million newly insured people will probably try to double their use of health care resources. Millions of others will be required to obtain insurance that is more generous than what they now have; and the more generous coverage will induce them to consume more care.

The result: The demand for medical care is likely to greatly exceed the supply. Although there is disagreement about the size of the coming physician shortage, Medicare's chief

actuary and some private sector economists are predicting major problems in access to care, including increased waiting. In Massachusetts, with a similar health reform:

- New patients in Boston wait 63 days to see a family doctor.
- There are more people going to hospital emergency rooms for nonemergency care in Massachusetts today than there were before that state's health reform was enacted.

The quality of care may fall, rather than rise, for some patients. To address the problem of quality, the new law authorizes "pilot" demonstration projects, funds research to discover "best practices," and gives Medicare new powers to try to force doctors and hospitals to change how they practice medicine. Serious scholars are skeptical of how well this will work. In the meantime, new problems will arise as doctors try to deal with a surge in demand for their services. In Britain, Canada and other developed countries, doctors often deal with these problems by reducing the amount of time they spend with each patient.

The Role of Government

By far the most significant change in health reform will be the new role of government. You, your family and your employer will no longer be able to make many of the decisions you have been making on your own. Instead, the power to make those decisions will be shifted to 159 new federal agencies, exerting unprecedented control over almost one-sixth of the economy. Here are a few especially important examples:

More Mandated Benefits. Under the current system, most employees have health insurance that is exempt from state regulation and is subject to very few federal regulations. For most people, this is a blessing. Health insurance regulated by state government is often burdened by cost-increasing mandated benefits. These include requirements to cover providers ranging from marriage counselors to naturopaths, services ranging from acupuncture to in vitro fertilization and even requirements to cover contraceptives without any deductible or copayment. By some estimates as many as one in four uninsured people have been priced out of the market for insurance because of the high premiums these regulations lead to.

Under the new law, all insurance that is not grandfathered will have to have benefits determined by the federal government. This will give interest groups that have successfully lobbied at the

state level the opportunity to lobby at the national level for inclusion in the insurance package everyone has to buy.

Less Patient Power. Employers will not be able to let employees make many decisions they are making today. For example, there is considerable controversy over who should get mammograms, Pap smears, prostate cancer tests and other procedures — and at what age and how often. Instead of dictating a one-solution-for-everyone approach, some employers put money in a savings account for their employees and let the employees make their own buying decisions. Under the new law, that will no longer be possible. Who is eligible for what test and when will be determined by the federal government.

Less Freedom of Medical Practice. The federal government will conduct extensive "comparative effectiveness research," evaluating what works, what doesn't work and what's worthwhile. A similar agency in Britain gives local health authorities "cover" to deny patients such care as cancer drugs that are routinely available in the United States and Europe. Critics worry the same could happen here.

Where Will I Get My Health Insurance?

You may get it the same place you get it today — through an employer, or through Medicare or Medicaid, or through a Medicare or Medicaid contractor (e.g., a Medicare Advantage plan).

If you buy your own insurance, however, you will have to obtain it through a "health insurance exchange" in which competing insurers will offer government-mandated packages of benefits. States may have flexibility in how the exchanges operate. You may be able to obtain insurance online, for example.

If your income is below 133% of the poverty level (currently $14,404 for an individual and $29,326 for a family of four), however, you will be required to enroll in Medicaid and you will not be allowed access to the exchange.

Will I Be Able to Keep the Insurance I Now Have?

You may not.

Your Employer May Be Forced to Switch to Another Plan. In general, if employers make very few changes to their current plan, that plan will be "grandfathered," in keeping with President Obama's promise that, "If you like the plan you are in, you can keep it." But most plans will be unable to qualify for grandfather status. A government memorandum predicts that:

- More than half of all employees with employer-provided health insurance will have to switch to a more expensive, more regulated plan and the number may be as high as two-thirds.
- Among those who will be required to switch plans are as many as 80% of employees in small businesses.
- Within three years, more than *100 million people* are expected to be in a health plan substantially different from the one they have today.
- Moreover, grandfathering is only a temporary phenomenon. The memorandum suggests that eventually all plans will lose their grandfather status.

Your Employer May Drop Coverage Altogether. Most employers will be required to provide health insurance or pay a fine. But since the fine will be much smaller than the cost of health

insurance, many employers — especially small employers — may drop their coverage altogether. This will force their employees to go to the "health insurance exchange" for their health insurance. This is already happening in Massachusetts with a similar health reform law, and the reaction is likely to be more pronounced in other states. Overall:

- The Congressional Budget Office estimates that 9 million employees will lose their employer plan.
- Medicare's chief actuary estimates that 14 million employees will lose the coverage they now have and, of those, about 2 million will enroll in Medicaid.
- A former CBO director is predicting a much larger employer response, with 35 million employees losing their current coverage.

Loss of Medicare Advantage Coverage. About half of the enrollees in Medicare Advantage (MA) plans are likely to lose their coverage and will be forced to return to conventional Medicare. If you are able to keep your MA plan, expect higher premiums and fewer benefits.

How Much Will Health Insurance Cost?

Unless you qualify for an exception, beginning in 2014, the new law will require you to obtain a health insurance plan. Although the exact features of this insurance have yet to be determined (the Secretary of Health and Human Services (HHS) has a lot of discretion in this regard), the benefits will be mandated under federal law. In all likelihood, this new mandatory coverage will be more extensive and more costly than the insurance you currently have. The typical coverage for a family of four in 2016, for example, will average about $5,800 (individual) and $15,000 (for a family of four), according to the Congressional Budget Office.

Your Share of the Cost in the Exchange. The out-of-pocket premium you will have to pay will be no more than 3% of your income for someone at the poverty level (currently $14,404 for an individual and $29,327 for a family of four), rising to 9.5% of income at 400% of poverty (currently $43,320 for an individual and $88,200 for a family). However, if you earn above that level, you will have to pay the full premium yourself.

Your Share of the Premium at Work. These same out-of-pocket limits will also apply to the employee's share of the premium if insurance is obtained from an employer. There is a big

difference between the limits in the exchange and the limits at work, however. In the exchange, your share of the premium will be kept low by a refundable tax credit — a gift from the government that will pay the remaining premium expenses. But there will not be any new subsidies for employer coverage. So if your employer is required to reduce the amount of the premium you pay at work, the extra cost to your employer will have to be made up by reducing other compensation (cash wages and other benefits). In the exchange, someone else (the government) pays to keep your premium low; but at work it's likely that you will pay.

Unequal Subsidies. As the table below shows, you will get very different subsidies from government, depending on your income and depending on where you acquire health insurance. In general, the new system is much more generous to lower-income families if they obtain insurance in the exchange and is much more generous to higher-income families if they obtain insurance at work. Some of these differences appear very strange:

- A family earning $30,000 per year will get a $19,400 subsidy (covering most of the premium plus most out-of-pocket expenses) if purchasing coverage in the exchange, but only a $2,811 subsidy for coverage through an employer.

- A family earning $60,000 per year will get $12,400 if purchasing coverage in the exchange, more than four times the subsidy available to a family with half as much income getting insurance at work.
- A family earning $90,100 per year will get $3,900 if purchasing coverage in the exchange, nearly 40 percent more than the subsidy available to a family earning one-third as much and getting insurance at work.

Health Reform Tax Subsidies in 2016

Income (AGI)	Subsidy In the Exchange	Subsidy at Work
$30,000	$19,400	$2,811
42,000	17,400	3,921
54,000	14,300	4,497
66,000	10,500	4,796
78,000	6,700	4,661
90,100	3,900	4,545
102,100	0	4,545

Source: National Center for Policy Analysis/
Congressional Budget Office

Increases in Costs Over Time. A big problem with health reform is that you will be forced to buy insurance, the cost of which is going to grow faster than your income. In fact, if we stay on the path we have been on for the past 40 years, health care costs (and, therefore, premiums) will rise at twice the rate of growth of our incomes.

Limited Ability to Control Costs. In the past, individuals and their employers have done a number of things to try to control their health insurance costs. These include higher deductibles (letting people manage their own small-dollar expenses), more limited benefits or even a shift to catastrophic-only insurance. However, many of these responses will no longer be allowed under the new reform law. Out-of-pocket spending (on covered items) is limited, for example, and preventive services must be available with no deductible or copayment.

What if I Buy Insurance in a Health Insurance Exchange?

A health insurance exchange is an artificial market where insurance plans compete for customers, usually during an annual enrollment period called an "open season." Federal employees, for example, get their health insurance this way. The federal government pays about

75% of the cost and the employees pay the other 25%. The employees can typically choose among a dozen or so plans. Many employees of state and local government, including many public colleges and universities, also participate in health insurance exchanges. In addition, two states (Massachusetts and Utah) have established exchanges for broad-based populations. The one in Massachusetts is said to be the model upon which the new federal health reform law is based.

Unlike the system for federal employees, however, in the state-based exchanges to be created under health reform every insurer will have to offer the same basic package of benefits, although they may differ in how those benefits are obtained. For example, some plans may be Health Maintenance Organizations (HMOs), while others have provider networks. Plans may also differ with respect to deductibles and copayments.

Attractive Features of Exchanges. Competition and choice must rank high on the list of favorable features. Plans are forced to community rate — charging everyone at the same age the same premium, regardless of health status. Also, when all the employees in the exchange work

for the same employer (e.g., federal employees) the employer acts as a "regulator" of sorts — solving problems and making sure the insurance companies abide by the rules of the exchange.

Unattractive Features of Exchanges. Offsetting these benefits are some negative features:

Opportunities for people to game the system. Federal and state employee exchanges cater to self-contained groups. Employees rarely ever go outside of the exchange (because they can't use their employer subsidy on the outside) and outsiders (nonemployees) can't get it. In a system-wide exchange (like Massachusetts), however, people have perverse incentives to game the system. They can remain uninsured while they are healthy (paying a small fine perhaps) then enroll in a health plan after they get sick; get their health care; get their medical bills paid; and then drop their coverage after they get well. This opportunity to game the system, which is becoming a major problem in Massachusetts, raises the costs and makes insurance very expensive for everyone.

Opportunities for insurance companies to game the system. Since every buyer in the exchange pays the same premium (regardless of expected cost), insurers have perverse incentives to attract the healthy and avoid the sick — much more so than under the

current system. Moreover, once enrollment is complete, the health plans will find they make profits on healthy enrollees and losses on sick ones. Thus, they will have an incentive to overprovide to the healthy (to keep the ones they have and attract more of them) and to underprovide to the sick (to encourage the exodus of the ones they have and discourage any new ones). The effects of these incentives are already becoming apparent in the federal employees' health plan. They would be more pronounced in a system-wide exchange.

The changing nature of insurance. Remember the TV ads that end with the statement, "You're in good hands with Allstate"? These ads ask you to focus on how the insurer will treat you if something goes wrong. They promise you that you will get really good treatment if you are ever unlucky enough to need the insurer to pay claims. Federal employees almost never see health insurance ads like this. During the "open season," for example, insurance company advertisements tend to picture young, healthy families with children. They never mention what would happen to you if you were unlucky enough to have heart disease, cancer or AIDs. That's because health insurers don't want enrollees

who are focused on expensive-to-treat problems. Since there are no pre-existing illness limitations in an exchange, the healthy employees may assume that if they ever get sick they can always switch to a plan that is good at treating their particular illness. Unfortunately, they may find out too late that plans skilled in treating expensive problems have been driven from the market.

The Effects of Low Reimbursement Rates. We do not know many details about how the exchanges will work under the new health reform law. In Massachusetts, however, subsidized health plans are paying providers fees equal to Medicaid rates plus about 10%. Since these rates are well below the market rates, doctors prefer to see private-paying patients first and then Medicare patients — pushing patients from the exchange to the rear of the waiting line. This may make it more difficult for you to obtain the care you need, when you need it.

How Will My Employer or Health Insurer Know What My Income Is?

You're going to have to give them your most recent income tax return.

Both at work and in the newly created health insurance exchanges, out-of-pocket premiums will be limited to a percent of your income. In order to enforce that requirement, however, your employer or the operator of the exchange will have to know what your income is.

Note: Under the new law, the income-based premium limits are not based on the wages your employer pays you. They are based on *your family income* — including nonwage income (dividends, interest, trust income, etc.), your spouse's income (from all sources) and, if your children are dependents, their incomes as well.

How Will the Government Enforce the Requirement to Buy Insurance?

The enforcer of health reform is the Internal Revenue Service.

On your annual tax return you will be required to show proof that you and other members of your family have the minimum insurance the government is going to require almost everyone to have. Failure to provide proof will subject you to additional tax penalties that will reach $695 (individual) or $2,085 (family) or 2.5% of income, whichever is greater, in 2016.

Further, providing fake information (claiming you had insurance when you didn't) will subject you to the same penalties that would apply to other types of fake IRS reporting.

Some analysts estimate the IRS will need to hire 16,000 additional agents to enforce the requirement that everyone obtain individual health insurance.

What If My Income Has Changed Since My Last Tax Return?

On January 1, 2014, you will have to have insurance. But your subsidy in the exchange will be based on your income tax return for 2012. What if your income is very different in 2014 than it was in 2012? In that case, the subsidy you are awarded could be too high or too low. In fact, it's almost certain that it will be too high or too low, unless every member of your family is living with a two-year wage freeze and doesn't change jobs.

In general, this problem will be dealt with when you finally file your 2014 tax return. If it turns out that your 2014 subsidy was too high, given your actual income that year, the IRS will be able to reclaim part of the unwarranted portion by collecting additional taxes from you. If it turns out that your subsidy was too low, you can file for a refund for the amount of the underpayment.

Strangely, these outcomes are not symmetrical. There is a limit on what the IRS can reclaim from you (up to $250 in overpayments for an individual and $400 for families) but no limit on the underpayments you can reclaim from the IRS.

What If I Get a Raise?

Individuals and families who do not have employer-provided health insurance or other government coverage will be required to obtain coverage through a health insurance exchange, where you will be eligible for subsidies based on your income.

If you earn 133% of the federal poverty level (currently, $14,404 for an individual and $29,327 for a family of four), the subsidy will limit the premium you will have to pay to 3% of your income. The subsidy will limit the premium you must pay to 9.5% of your income, at 400% of the federal poverty level (currently, $43,320 for an individual and $88,200 for a family of four). Above that level, you will receive no subsidy and you will have to pay the full price yourself.

As your income rises, the subsidy falls and the premium you must pay rises. This rising premium is like a tax and the marginal rate will be very high.

For example, the CBO estimates that a family of four with an income of $54,000 will receive a health exchange subsidy of $14,300. The subsidy would drop to $10,500 as the family's income rises to $66,000. Over this range, for each extra dollar of income the family earns, it must pay an extra 32 cents in higher health insurance premiums.

When the effects of the subsidy withdrawals are added to income and payroll taxes, most people will lose more than 50 cents for each $1 they earn. It will be about a 60 cent loss for people with incomes between about $24,000 and $35,000.

What If I Have My Own Insurance?

During the debate over health reform, the most talked-about problems with the current system were “abuses” in the market where people buy their own insurance. Purportedly, insurers were rescinding policies for enrollees after they became sick and denying coverage to people with pre-existing conditions. The irony is that over the next four years you are now more vulnerable if you own your own health plan.

One reason is that many insurers that sell insurance to individuals are leaving the market precisely because of new regulations. A limit on insurance company overhead (called the "medical loss ratio"), for example, has already caused some companies to leave the market and many more are expected to follow. In fact, one company is predicting that only a small number of insurers will still be around in a few years.

Another problem: A new requirement that insurers can no longer have an annual limit on benefits will cause more than 1 million people to lose their limited benefit plans in September when the provision takes effect. And regulations governing insurance for children are causing some insurers to quit selling children's policies altogether.

If you lose your current plan and you have a pre-existing condition, you could be in trouble. The new law authorizes $5 billion dollars in federal funds for states to establish temporary high-risk pools for the next four years. Estimates vary, but more than 2 million people are probably eligible. Yet the CBO estimates enrollment will have to be limited to 200,000. At this rate, the amount of funding is expected to cover only about 10% of those who will need risk pool insurance.

Beginning in 2014, you will be able to buy insurance in a health insurance exchange. Competing insurers will be required to offer coverage to the healthy and the sick for the same premium, regardless of pre-existing conditions. If you are healthy, the premiums in the exchange may be much higher than the premiums you pay today. In fact, families purchasing health insurance on their own are likely to pay an additional $2,100 a year in premiums, according to the CBO.

What If I Am Uninsured?

You will have to show proof that you have insurance on your income tax return. The fine you will have to pay if you fail to comply will begin at $95 ($285 per family) or 1% of income in 2014 and rise to $695 ($2,085 per family) in 2016 or 2.5% of income, whichever is greater.

There are several ways you may obtain health insurance that qualifies:

- If your employer offers health insurance, you may sign up for an employer-provided plan (but this is not a requirement).

- Provided your income is not lower than 133% of the poverty level, you may obtain insurance in the health insurance exchange.
- If you qualify for Medicaid or some other government insurance plan, those plans will generally automatically qualify.

What If I Am Uninsurable?

The new law provides funds for the creation of risk pools for otherwise uninsurable people — to bridge the gap from where we are now to 2014, when health plans will have to accept everyone regardless of health condition.

The new risk pools will be cheaper and more generous than what the states currently have. For example, they will charge people the same premiums that healthy people pay for insurance, in contrast to existing state risk pools which charge from 125% to 200% of market rates. Also, the new risk pools will have no waiting period. You get full coverage from day one.

That is not necessarily good news if you are one of the 199,000 people who are currently enrolled in a state risk pool. The new law is explicitly designed to keep you from moving out of the risk pool you are in to a new one. Also, you cannot enroll in one of the new risk pools unless you've been uninsured for at least six months.

Another problem is funding. Although the newly enacted health reform legislation has allocated $5 billion for this project, the Medicare chief actuary says this is too little money to meet the need. It will likely cover only about 200,000 out of a potential population of more than 2 million. This is why 18 states are refusing the money to create these pools. By ceding the problem to the federal government, these states are concluding that inadequate financing will be a federal problem rather than the state's problem in future years.

Can I Keep My Doctor?

If government estimates are correct, as many as 34 million uninsured people will acquire health insurance. If economic studies are correct, these 34 million people will try to double their consumption of health care.

What if there aren't enough doctors? In addition to the newly insured, many people will be required to be in health plans with more generous coverage than they have today. All told, as many as 100 million people may acquire health insurance benefits they do not have today. These 100 million people may be expecting annual physicals, mammograms, Pap smears, prostate cancer (PSA) tests, colonoscopies and other services they are not currently getting. Yet with no increase in supply, there is no realistic way for doctors to meet this demand. Moreover, more than one in five Americans already lives in an under-doctored area.

A new government Web site claims there will be 16,000 new providers by 2015. Yet Congress has never appropriated the funds to do that. In fact, all funds for training new providers were

zeroed out of the Affordable Care Act. (That was one of the ways Congress kept the spending total from being unacceptably high.) Apparently, HHS Secretary Kathleen Sebelius plans to use $250 million targeted for "prevention and public health" in the bill to instead train 500 physicians, 600 physician assistants and 600 nurse practitioners. Also, she plans to use an additional $500 million of "stimulus" money available under the American Recovery and Investment Act. Yet even if Congress allows these decisions to go forward, the additional supply will still fall way short of the 16,000 figure (which appears to count students who are already in medical school and will largely replace doctors who are expected to retire).

Meanwhile, the Association of American Medical Colleges predicts a 21,000 primary care physician shortfall by 2015, and the Health Resources and Services Administration estimates a shortage of between 55,000 and 150,000 physicians by 2020 — and that was before health care reform passed! The state of Texas is predicting a nursing shortage of 18,000 by 2015 in that state alone.

How Will Doctors Decide Which Patients to Treat? When demand for care expands faster than increases in supply, doctors will have to decide which patients they see first. You will be at a disadvantage if you are in a health plan that pays below-market rates. Nationwide:

- Medicare pays doctors about 19% less than private plans.
- Medicaid pays about 28% less than Medicare.
- Subsidized plans in the Massachusetts health insurance exchange (the model for the new federal law) pay doctors only about 10% more than Medicaid rates and this practice may be repeated in the exchanges set up in other states.

What About the Emergency Room? Because of the access-to-care problems, the National Center for Policy Analysis and another academic study are predicting that there will be a substantial increase, rather than a decrease, in the number of patients who seek care at hospital emergency rooms.

In general, emergency room use by the uninsured and the privately insured are about the same. Medicaid enrollees, on the other hand, have more than twice as many visits, and about half of all newly insured people will be enrolled in Medicaid. Consequently, the NCPA projects that

enrolling 16 million to 18 million new people in Medicaid will generate *between 848,000 and 901,000 additional emergency room visits every year*.

Will My Relationship with My Doctor Change?

It may.

Unanswered Questions. Here are just a few of the questions doctors are hearing from their patients these days about health reform:

- Will I be able to choose the doctor who treats me, or will I have to accept whatever doctor is available — like in a hospital emergency room?
- Will I be required to stay in a network of doctors, or will I be free to see doctors outside the network?
- Will there be a limit on the number of times I can see a doctor?
- Will doctors be pressured to limit the time they spend with me?

- Will doctors be free to prescribe the drugs I need, the tests I require and the procedures that are indicated?
- Will doctors be free to exercise their best judgment in treating me? Or will doctors be forced to conform to guidelines written by people who may be more concerned with controlling costs than curing disease, treating illness and saving lives?

Unfortunately, at this point, no one can be sure of the answers.

Vision of the Supporters of Reform. Some of the supporters of the Affordable Care Act have been very explicit. Harvard Medical School professor Atul Gawande, for example, thinks that medicine should be more like engineering — with all doctors following the same script, rather than exercising their individual judgments:

> This can no longer be a profession of craftsmen individually brewing plans for whatever patient comes through the door. We have to be more like engineers building a mechanism whose parts actually fit together, whose workings are ever more finely tuned and tweaked for ever better performance in providing aid and comfort to human beings.

Karen Davis, president of The Commonwealth Fund, envisions a complete reorganization of the practice of medicine:

> The legislation also includes physician payment reforms that encourage physicians, hospitals, and other providers to join together to form accountable care organizations [ACOs] to gain efficiencies and improve quality of care. Those that meet quality-of-care targets and reduce costs relative to a spending benchmark can share in the savings they generate for Medicare.

Worries of the Critics of Reform. Critics worry that in actual practice reform efforts will fall very short of the goals. That practice guidelines, rather than representing the best that medicine has to offer, will become cookbook recipes. That while these recipes may work for most patients most of the time, doctors will not feel free to make exceptions for patients that don't fit the norms. Rather than resemble a finely honed machine, the health care system will come to resemble the U.S. Postal Service — even more than it already does.

Accountable Care Organizations (ACOs), for example, have been described as “HMOs on steroids.” On paper, it sounds as though doctors will be rewarded for providing higher-quality services. In practice, ACOs may reward doctors for under-providing care, just like traditional HMOs were accused of doing.

Moreover, the entire business model of the ACO requires that patients see only the doctors that the ACO employs. If your doctor is in an ACO, therefore, you won’t be allowed (your insurance won’t pay for you) to see doctors outside the ACO. Also, part of the ACO vision is that all doctors and nurses will practice medicine in the same way. This means that when you visit an ACO clinic you will not necessarily see the same doctor you saw on your last visit. ACOs will probably be given a lot of freedom to limit the terms and circumstances under which you can see doctors.

Where Private Insurance is Headed. Even if you are not enrolled in a traditional HMO or an ACO, you can expect a return to some of the heavy-handed health insurance industry practices that were so unpopular in the 1990s and gave rise to the “patient bill of rights” proposals. The reason? The new health care reform takes away just about every other tool insurers have to

control costs. In response to the new law, for example, health insurers are already trying to keep premiums down by offering policies that cover, say, only half the doctors in the area where you live. In some of these plans, you get no reimbursement whatsoever if you see a doctor outside the insurer's network.

Levers of Government Power: Medicare. Will the federal government be able to tell doctors how to practice medicine? An undisguised goal of health reform is to change what most doctors do. The Medicare payment system, for example, will be used to push doctors to use electronic medical records, join group practices and ultimately join ACOs. Doctors who do these things will be paid more. Doctors who don't will be paid less. In addition:

- A Federal Coordinating Council for Comparative Effectiveness Research will study alternative ways to treat various conditions and Medicare itself could refuse to pay doctors and hospitals who refuse to follow the guidelines.
- There will almost certainly be national guidelines governing who should get diagnostic tests, under what conditions and how often. Medicare doctors are likely to have much less

discretion about such diagnostic tests as mammograms, Pap smears, PSA tests, colonoscopies, etc.

- Medicare doctors are also likely to have much less freedom to order CT scans, MRI scans, PET scans, sonograms, etc.

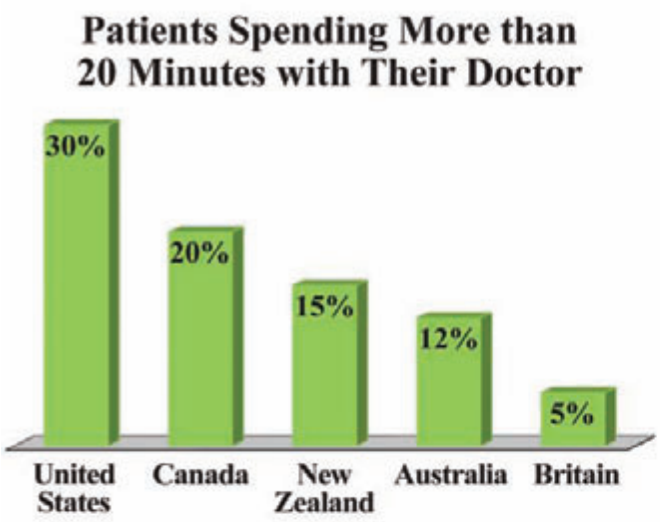
Levers of Government Power: The Private Sector. The government will have much less control over the way in which doctors practice medicine for patients who are privately insured. However, health plans in the exchange will face competitive pressure to limit what they spend on people with expensive health problems. Undoubtedly, federal guidelines for Medicare will give these plans cover to adopt the same payment strategies for physicians seeing the privately insured. Ultimately, whatever happens under Medicare is likely to spread to the entire private sector.

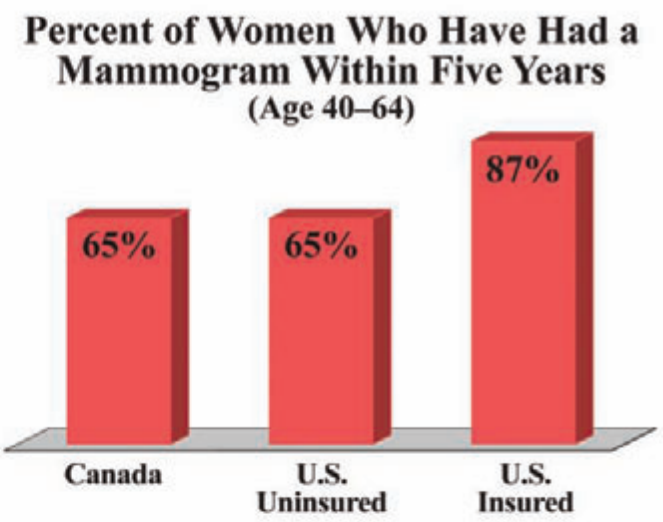
What Other Countries Have Done. President Obama has said many times that the overriding problem in health care is cost. Health care spending is rising at twice the rate of growth of our incomes. If this trend continues, health care will eventually crowd out every other form of consumption. In this respect, the experience of the United States is not worse than that of other

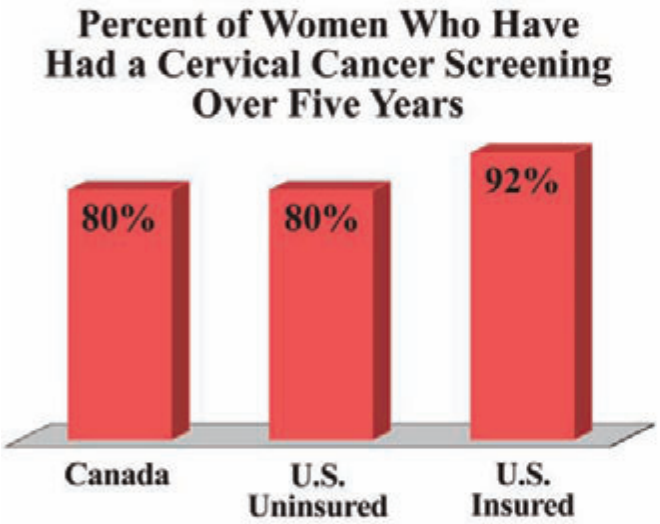
countries. In fact, the real rate of growth of per capita health care spending is right below the average for all developed countries. What makes our country different is that our government has been less involved in cost control efforts.

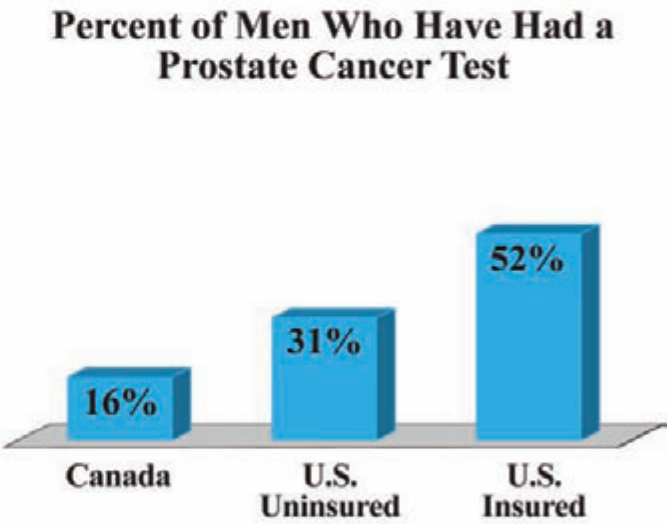
How have other countries tried to control health care spending? In general, they have substituted inexpensive services for expensive ones. Citizens of Britain and Canada, for example, see physicians more often than we do. But as the graph below shows, doctors in other countries spend less time with patients on each visit. Also, patients in Britain and Canada have less access to diagnostic tests, even though on paper they are supposed to get all the health care they need for free. Surprisingly, *uninsured patients in the United States* appear to get as much or more preventive care than *insured Canadians*.

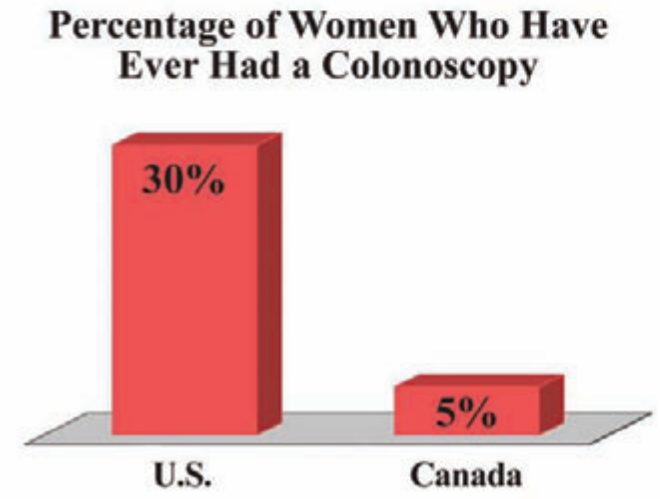
(continued on next page)

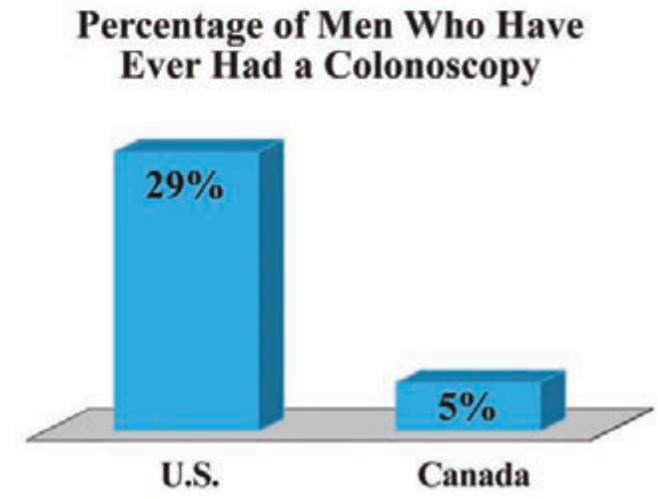

Patients Spending More than 20 Minutes with Their Doctor
30%
20%
15%
12%
5%
United States
Canada
New Zealand
Australia
Britain


Percent of Women Who Have Had a Mammogram Within Five Years
(Age 40–64)
65%
65%
87%
Canada
U.S. Uninsured
U.S. Insured


Percent of Women Who Have Had a Cervical Cancer Screening Over Five Years
80%
80%
92%
Canada
U.S. Uninsured
U.S. Insured


Percent of Men Who Have Had a Prostate Cancer Test
16%
31%
52%
Canada
U.S. Uninsured
U.S. Insured


Percentage of Women Who Have Ever Had a Colonoscopy
30%
5%
U.S.
Canada


Percentage of Men Who Have Ever Had a Colonoscopy
29%
5%
U.S.
Canada

Source for chart, "Patients Spending More than 20 Minutes with Their Doctor": Karen Donelan et al., "The Cost of Health System Change: Public Discontent in Five Nations," *Health Affairs*, May/June 1999.

Source for charts on mammogram, cervical cancer screening and prostate test: June E. O'Neill and Dave M. O'Neill, "Who are the Uninsured? An Analysis of America's Uninsured Population, Their Characteristics and Their Health," Employment Policies Institute, June 2009.

Source for charts on colonoscopies: June E. O'Neill and Dave M. O'Neill, "Health Status, Health Care and Inequality: Canada vs. the U.S.," NBER Working Paper No. 13429, September 2007.

What about Preventive Care?

The new health care law promises people on Medicare annual wellness exams, mammograms, prostate cancer screenings and other preventive services — without any copayment or deductible. The rest of the population will also have access to a lengthy list of preventive services. Unfortunately, the law that mandated these benefits contained no provision to make sure doctors will be able to supply them.

What Services Will I Be Entitled To? The law requires that after September 23, 2010, all new health plans (plans that are not "grandfathered") must cover the preventive services

recommended by the U.S. Preventive Services Task Force, without cost-sharing. Depending on your age and sex, the following preventive services will be covered by your health insurance:

- Blood pressure, diabetes, and cholesterol screening
- Cancer screenings
- Counseling on weight loss, healthy eating, smoking cessation, alcohol use, depression
- Vaccines for measles, polio, meningitis and HPV
- Shots for flu and pneumonia prevention
- Screening, vaccines, and counseling for healthy pregnancies
- Well-baby and well-child visits up to the age of 21, as well as vision and hearing, developmental assessments, and body mass index (BMI) screenings for obesity
- Mammograms for women over age 40
- Pap smears for cervical cancer prevention
- Colon cancer screening tests for adults over age 50

Will I Be Able to Get the Preventive Services Promised Me? The answer is probably not. Providing preventive care takes time; and most primary care physicians already have their hands full. Ask yourself this question: The last time you were in a primary care facility, did you observe a lot of idle resources? Were there doctors and nurses standing around with nothing to do? If the answer is "no," your experience is not unique. Nationwide, more than one out of every five people is living in an underdoctored area and the shortage of primary care physicians is expected to grow worse in future years.

A study published in the American Journal of Public Health analyzed how much time it would take physicians to arrange for and counsel patients about all the screening tests recommended by the U.S. Preventive Services Task Force. The bad news: It would require 1,773 hours of your doctor's time each year, or 7.4 hours per working day. And all of this time is time spent searching for problems and talking about the search. If the screenings turn up a real problem, there will have to be more testing and more counseling. Bottom line, to provide all the services being promised, your doctor would have to work twice as long! To meet this promise

nationwide, every doctor in America would have to work full-time delivering them — leaving no time for all of the other things doctors do!

Furthermore, since preventive screenings are often reimbursed at lower rates than other services, when you call your doctor for a preventive care appointment, you may find there is long wait. Increasing the demand for doctors without significantly increasing the supply will lead to increased rationing of their time.

Is Preventive Medicine Cost-Effective? Much rhetoric suggests that preventive care pays for itself. If a disease is caught in its early stages, treatment costs will be lower. So can wider access to preventive care lower the nation's health care costs? In general, no.

At the individual level, the old adage that an ounce of prevention is worth a pound of cure is true. For the few patients who are diagnosed with a disease, preventive screenings are definitely worth the cost. But the cost of screening thousands of healthy patients in order to find one patient with a problem usually swamps any savings on patients whose diseases are diagnosed early.

In general, preventive medicine adds to health care costs, rather than reducing costs.

Mammograms don't pay for themselves. Nor do Pap smears. Nor prostate cancer tests. Nor general checkups for healthy people. That doesn't mean we should avoid these tests. But since these tests add to total spending on health care, we should obtain them judiciously.

There are some exceptions — childhood immunizations and prenatal care for at-risk mothers, for example. But the exceptions are few and far between. Louise Russell, who has studied the economics of preventive care for years, explained this in a recent article [gated, but with abstract] in *Health Affairs*:

> "Over the past four decades, hundreds of studies have shown that prevention usually adds to medical spending. [Data] from 599 studies published between 2000 and 2005 [show that] less than 20 percent of the preventive options (and a similar percentage for treatment) fall in the cost-saving category — *80 percent add more to medical costs than they save*." [Italics added]

Can We Use Medical Science to Decide What Preventive Care People Should Get? Who should get a mammogram? At what age? How frequently? Ditto for Pap smears and prostate cancer tests and colonoscopies? Aren't these questions experts can decide? Unfortunately, no. Any reader of daily newspapers knows that we are forever getting conflicting advice from well-meaning people. Part of the problem is that people differ in their attitude toward risk. They also differ in their willingness to spend money to reduce risk. A danger in a one-size-fits-all approach fashioned in Washington, D.C., is that the experts may not share your values. Their attitude toward risk reduction may be different from yours.

The Danger of Cookbook Medicine. Another danger is that doctors harried by far more requests for services than they can possibly deliver will take a routine approach to all their patients and ignore what makes you unique as an individual. What if you feel you are at a heightened risk for breast cancer because your mother or grandmother had breast cancer — but you fall outside the guidelines for early breast cancer screening before age 40? Women at higher risk of breast cancer might want to begin them at age 25, as recommend by the Komen

Foundation. But will you be allowed to do so? If necessary, will you be allowed to pay for the test yourself? These questions need to be asked and answered.

The Dangers of the Politics of Medicine. Both Congress and the administration have already shown that they are unwilling to let experts set the guidelines for preventive care. For example, the new law stipulates that seniors are entitled to an annual physical and that males are entitled to an annual prostate cancer test — even though neither is recommended by the Preventive Services Task Force. Also, HHS Secretary Sebelius has chosen to include annual mammograms for women in their 40s, even though the task force recommended against it.

Expect more politics to come. Women's groups are pushing for free contraceptives under the guise of "prevention." While more "free" services may sound good, remember that the doctor's time is limited, as are the number of health care dollars. Granting more marginal care to one person may mean less really serious care for another.

Letting Individuals Make Their Own Choices. There's a better way. Instead of one-size-fits-all medicine, individuals can make a lot of their own choices in these matters. Instead of giving

all of your health care dollars to an impersonal, bureaucratic insurance company, you should be allowed to put some of those dollars in a Health Savings Account that you own and control.

That way, you could consult the advice of the Preventive Services Task Force on your own. You could also consider the advice of other experts, including your doctor, and take into consideration personal data about you and your family.

Ultimately, no one cares about you more than you care about you. So if you control more of the money and if you are allowed to make more of your own decisions, the system is likely to work better for you than if you cede that power and control to others.

Preventive care is not like an *investment good* that pays a positive rate of return. Instead, it's like a *consumption good*. Preventive care leads to better health. But the enjoyment of that result must be compared with the benefit of other goods and services we could have purchased with the same money.

Are Electronic Medical Records Safe, Effective and Private?

Doctors who see Medicare and Medicaid patients will face financial penalties if they fail to adopt electronic medical records (EMRs), under the 2009 federal stimulus bill. This is the first step the government has taken toward a goal of universal EMRs by 2014.

When you visit your doctor, a record of the visit will be stored electronically. The record will contain all of the information exchanged between you and your doctor, your doctor's notes, any drug prescriptions you receive, and any disease prognosis you are given. Your EMR will even contain a government-approved obesity rating — a body mass index measuring your body fat percentage. These obesity ratings will be sent automatically to federal health agencies such as the Department of Health and Human Services and the Centers for Disease Control, and will also be posted on a national exchange. (To insure privacy, your name will be withheld.) Another government goal is to make sure your EMR is compatible with other records and kept in a format that can be accessed by other doctors and hospital personnel, regardless of where you seek care.

Is this a good idea?

Will EMRs Improve the Quality of My Care? Maybe. Or maybe not. Formal evaluations are generally lacking and the jury is still out. Potentially, EMRs could enhance the coordination of care among diverse doctors and hospitals. They would be able to see which tests you have already undergone and their results, thereby saving you the money and inconvenience of duplicate tests. They would be alerted to prescription drugs you are taking, any drug allergies you may have and other vital information. This information should allow doctors to deliver safer and more effective care.

On the other hand, if your EMR is not properly maintained, doctors could make serious mistakes that could be hazardous to your health. For example:

- In one case, mother of three died of cancer after going three to six months untreated because the report from her radiologist was not filed properly in the her EMR, leaving her referring physician completely unaware of her condition.

- Another lab test result that was not properly filed in a patient's EMR ultimately caused the patient to suffer from acute renal failure.

- Records that were entered into the wrong EMR left another patient untreated for congestive heart failure, from which he later died.

- A woman's baby was born brain dead and later died due to umbilical strangulation when her OB/GYN, monitoring the baby's birth from his home using the patient's EMR, was unaware of software glitches that concealed vital patient information.

- In another case, three days passed before patient's care team realized the results entered into his EMR were for a biopsy they did not order of a lesion the patient did not have.

These mistakes are more common than you might suppose. There have been more than 200 adverse events associated with EMRs reported to the FDA in the past two years.

Another problem is information overload. The time your doctor spends entering your data can detract from your care. A doctor struggling to enter patient information into multiple screens — each with multiple check boxes — could miss subtle clues that might have been observed if she were interacting with you face-to-face. Furthermore, some EMRs automatically generate

redundant information that can clutter a record containing important problems or create false-alarm alerts for minor drug interactions.

Will EMRs Save Money? In two highly influential studies by the RAND Corporation and the Center for Information Technology Leadership estimated health information technology — including EMRs — could potentially save $77 billion to $78 billion per year if adopted by virtually all doctors and hospitals. However, most doctors and most hospitals find that the adoption of EMRs adds to their costs rather than reducing them. So as with the question of quality, the jury is out.

How Well are EMRs Working Where They Have Been Adopted? That depends. EMR systems seem to work well where they have been voluntary chosen by doctors trying to solve their own information flow problems. They do not seem to work well when they are imposed top-down, against the doctors' wishes.

Will My Privacy Be Protected? Some of the information in your EMR may be potentially embarrassing. It could also be used against you — say, by an employer trying to avoid workers with costly health conditions, or even by a rival coworker. Almost everyone who knows anything

about the subject knows that no matter how much effort is made to secure the records, EMRs always entail a risk to patient privacy. Hospital or medical office employees, for example, have been known to steal electronic medical records. And EMRs will always be susceptible to hackers motivated by voyeurism or out to steal personal information in order to cash in by making false claims.

- A California Health Department investigation of incidents of patient "snooping" at the UCLA Medical Center found that over a five year period more than 100 hospital workers had inappropriately viewed the records of 1,041 patients —including California first lady Maria Shriver.

- Actress Farrah Fawcett's EMR was hacked into while she was undergoing treatment for cancer, resulting in details of her treatment being made available to the public.

- After Dallas Cowboys Pro Bowl defensive tackle Erik Williams suffered a season-ending knee injury in a car accident, his electronic records were viewed online by 1,754 separate Parkland Hospital employees. Less than a few dozen people had a medical reason to view them.

- In Britain, computer hackers were even able to obtain the medical records of British Prime Minister Gordon Brown.

What About Identity Theft? Electronic medical records make this type of crime much easier. In 2006, an individual whose cousin provided him with the EMRs of 1,100 Medicare patients from a clinic where he worked made $2.8 million in fraudulent claims. The federal government reports more than 250,000 incidents of medical identity theft in 2007 alone. The real number of victims of medical identity theft is probably much higher, however. Most patients are unaware of any misdeed until they see their credit report or are informed by their insurance company that their lifetime cap on benefits has been reached.

What Will Happen to My Taxes?

You will join other Americans in paying nearly $670 billion in additional taxes and fees over the next decade to fund health reform. Some of the new taxes will be indirect and will be passed on to you in the form of higher prices, higher premiums or lower wages. You will pay others directly.

According to the Joint Committee on Taxation, about 73 million taxpayers earning less than $200,000 will see their taxes rise as a result of various health reform provisions. For example, the Committee's Republican staff estimates the new taxes could push up health insurance premiums for a typical family of four by nearly $1,000 per year.

Tax on medical devices. These taxes will reach everything from surgical instruments and bedpans to wheelchairs and crutches. Even pacemakers and artificial hips and knees are taxed, as well as such drug store items as bandages and tooth brushes. All told, the tax on medical devices will collect nearly $20 billion over the next decade.

Tax on insurance. A $60 billion tax on health insurance, beginning in 2014, will ultimately be reflected in higher premiums. For those who purchase insurance on their own in the individual market, the effect of all new taxes, regulations and mandated benefits will push the cost of covering a family of four up by $2,100.

Tax on drugs. The new tax on drugs will collect about $27 billion. In anticipation, some drug makers have already started raising their prices.

Tax on medical savings accounts. If you have a Flexible Spending Account (FSA), a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA), you will no longer be able to use these tax free accounts to purchase over-the-counter drugs. That means you will have to buy such items as the Claritin, aspirin or Advil with aftertax dollars — making the cost to you, say, 30% higher or more. In addition, tax free contributions to a FSA will be capped at $2,500 annually. People setting aside funds for chronic care, corrective eye surgery or other out-of-pocket medical expenses will be limited to $2,500 regardless of medical need. Taken together, these two actions are expected to cost consumers $18 billion over the next decade.

Taxes on indoor tanning. If you plan to use an indoor tanning bed, expect to pay 10% more thanks to a new excise tax expected to raise nearly $3 billion.

Taxes on Cadillac plans. A 40% excise tax will also be levied on so-called “Cadillac” health plans for the amount in excess of $27,500 for families and $10,200 for single coverage. About one-third of health plans will be subject to the tax beginning in 2019. But since these thresholds are not indexed to increase as fast as medical costs, over time virtually all plans will be subject to the tax.

Taxes on illness. If you have a lot of medical expenses, today's tax law allows you to deduct from your taxable income the amount that exceeds 7.5% of your adjusted gross income (AGI). Under the new law, this threshold is being raised to 10% of AGI — making your deductible much smaller.

Additional taxes on wages, investment income and even home sales. The Medicare payroll tax will increase by almost one-third for individuals and couples — from 2.9% today to 3.8%, on wages over $200,000 for an individual or $250,000 for a couple. In addition, the 3.8% Medicare payroll tax will be levied on investment income (capital gains, interest and dividend income) at the same income levels. This tax will not merely reach the rich, however. Under some circumstances, the sale of a house could trigger the provision, making you "paper rich" for a single year and forcing you to pay a 3.8% levy on your home's appreciated value.

What If I Am On Medicare?

Seniors as a group are probably going to be more affected by the new health reform law than any other population group.

Benefits of Reform. There are a number of new benefits, including:

- Medicare will pay for an annual checkup.
- Deductibles and copayments for many preventive services and screenings (colonoscopies, mammograms and bone mass density tests, etc.) will be eliminated.
- If you are in the prescription drug "doughnut hole" and you are not getting other drug subsidies, you may qualify for a $250 rebate.
- Eventually (in 2019) the doughnut hole will be eliminated.

Meeting the Promises of Reform. How do we know that when you and millions of other elderly and disabled patients try to get your free annual checkups, your mammograms, your colonoscopy, etc., that there will be enough doctors, nurses, laboratories and testing equipment to supply these new services? We don't. Unfortunately, there are no provisions in the new health reform law to provide the funding needed to make sure these promises can be kept. If everyone on Medicare took advantage of a free annual checkup, for example, we would need 23,000 additional doctors just to meet the demand.

Costs of Reform. There will also be significant costs for the elderly and the disabled:

- More than half the cost of health reform will be paid for by $523 billion in spending on the elderly and the disabled over the next 10 years.
- In general, these Medicare spending cuts exceed the new benefits by a factor of more than 10 to one.
- More than $200 billion in spending cuts are directed at Medicare Advantage plans.
- More than half of all the people (7.4 million of 14 million) expected to participate in Medicare Advantage (MA) over the next 10 years will lose their coverage entirely, according to Medicare's chief actuary; and those who retain their MA coverage will face steep cuts in benefits or hefty increases in premiums, or both.
- In addition to these direct costs there are indirect costs, including new taxes on drugs and medical devices, items that are disproportionately used by seniors and the disabled.

To make matters worse, the planned cuts in Medicare fees may cause some doctors to retire and force some hospitals out of business. According to Medicare's chief actuary:

- As many as one in seven hospitals will be in financial distress — especially as their Medicare fees are reduced in the future.

- Many patients may find doctors reluctant to accept them as new patients.

Moreover, as 100 million newly and more generously insured people try to increase their consumption of medical care, access problems for seniors may become even more acute. The reason: Medicare's fees are lower than what private insurance pays and this may make Medicare patients even less desirable to doctors.

Another change that may affect you is the loss of your employer's retiree drug plan. Under current law, employers who provide their employees with postretirement health care benefits can set up and administer retiree drug plans as an alternative to Medicare Part D. In return, employers get subsidies worth about $665 per retiree, and tax breaks push up the value even higher. The Patient Protection and Affordable Care Act removes these subsidies, however.

- AT&T estimates the change will cost it $1 billion.
- John Deere estimates it stands to lose $150 million.
- Caterpillar puts the loss at $100 million.
- A Credit Suisse report estimates that S&P 500 companies face losses of $4.5 billion.

In response, many large firms will completely do away with their retiree drug plans.

Size of the Cuts in Medicare Spending. The table below lists the expected spending reductions for Medicare enrollees over the next several years. As the table shows, cuts in Medicare spending will average $22 per enrollee beginning next year, rising to $290 in 2014. Medicare Advantage members will face more severe cuts: $195 per enrollee beginning next year, rising to $1,267 in 2014. For those who retain their coverage, these cuts will lead to equivalent increases in premiums and/or reductions in benefits.

Cuts in Medicare Spending per Person

	Conventional Medicare	Medicare Advantage
2011	$22	$195
2012	112	585
2013	201	877
2014	290	1,267

Sources: National Center for Policy Analysis and the Congressional Budget Office

The Obama administration claims that it will target these cuts to eliminate waste — to encourage low-cost, high-quality care and discourage high-cost, low-quality practices. Critics are not

hopeful. The cuts in Medicare Advantage subsidies were actually written into the legislation and appear to be based on special interest politics alone. At one point, for example, there was a provision that would exempt Florida seniors from losing their Medicare Advantage benefits. The provision derided as "Gator-aid" was deleted from the final bill.

How Cuts in Medicare Spending Will Be Made. The new law assumes that the federal government can make Medicare grow at about half the rate of growth of health care spending overall and eventually no faster than the rate of growth of national income. To achieve this goal, the law gives an Independent Payment Advisory Board (IPAB) the power to recommend spending cuts. Congress must either accept these cuts or propose its own plan to cut costs as much or more than the IPAB's proposal. If Congress fails to substitute its own plan, the IPAB's cuts will become effective.

This approach gives an independent agency much more power than any similar agency has had before. However, there are two problems. First, the IPAB is barred from considering just about any cost control idea other than cutting the fees to doctors, hospitals and other suppliers. Second, this implies that Medicare fees will fall further and further behind private payments, making

Medicare patients less desirable customers to the medical community. In some parts of the country, doctors are increasingly reluctant to take Medicare patients — including the Mayo Clinic in Arizona. In time, Medicare patients could find themselves in the same position as Medicaid enrollees — who often are forced to get all their care at community health centers and safety net hospitals.

Do Medicare Advantage Plans Deserve a Smaller Subsidy? Critics of the program argue that the government is paying these plans about 13% more than what enrollees would cost if they were in conventional Medicare. While that appears to be true, there is another side to the story:

- Part of the overpayment is due to Congress's desire to make MA plans available in rural areas, where they are less economical.
- Elsewhere, overpayments are creating benefits for enrollees of up to $825 per person per year, such as extra coverage for drugs.
- Even as Congress cuts MA payments, it is expanding drug coverage for Medicare enrollees — indicating that the pressure to provide the benefits will remain after the MA plans are gone.

- MA enrollees tend to be moderate-income seniors who do not have Medigap insurance; thus, MA coverage is solving a social problem that will have to be solved in some other way if MA plans do not solve it.
- And if millions of seniors go from MA plans back into conventional Medicare, paying discounted rates to providers, all seniors may find access to care more difficult.

Moreover, the MA plans that are headed for extinction are ostensibly doing many of the things President Obama says he wants to accomplish with health reform:

- They provide subsidized coverage to low- and moderate-income people who could otherwise not afford it.
- They control costs better than conventional insurance by eliminating unnecessary care.
- They provide higher quality care.
- They have no pre-existing condition limitations, and some plans actually specialize in attracting and caring for patients with multiple illnesses.
- They provide an annual choice of plans.
- They even compete against a public plan (conventional Medicare).

What About AARP? The organization that claims to represent seniors has been fully supportive of the new law. But the interest of AARP and the interest of seniors are not the same. For example, AARP markets its own Medigap insurance, collecting more in premiums and other revenue from other commercial ventures than it collects in member dues. With fewer seniors in MA plans, the market for Medigap insurance will greatly expand. Moreover, AARP is getting special treatment under health reform. Specifically, AARP's Medigap insurance is:

- Exempt from the prohibition on pre-existing condition exclusions.
- Exempt from a $500,000 cap on executive compensation for insurance industry executives.
- Exempt from the tax on insurance companies.
- Exempt from a requirement imposed on MA plans to spend at least 85% of their premium dollars on medical claims.

What If I Have to Be in Medicaid?

If you are under 65 years of age, your income is less than 133% of the federal poverty level and you do not have employer coverage, you will have to enroll in Medicaid. In fact, half of the newly-insured under the health care reform are headed for Medicaid — many losing private coverage in the process.

Worse Access to Care. On paper Medicaid is attractive. You are promised coverage for most medical services with no premium and usually no out-of-pocket payments.

Medicaid pays physicians only about 60% as much as private insurers pay and many Medicaid patients have difficulty finding doctors who will see them. Studies show that even the uninsured have an easier time making doctors' appointments than Medicaid enrollees. One survey finds that:

- In Dallas and Philadelphia, only 8% of cardiologists accept Medicaid patients; in Los Angeles, it's only 11%.

- In both Dallas and New York City, only 14% of OB/GYN specialists will see Medicaid patients; the figure is 28% in Miami and 33% in Denver.
- Among general practitioners, the lowest figures are 30% (Los Angeles), 40% (Miami) and 50% (Dallas and Houston).

This may be why Medicaid enrollees seek care in the emergency room twice as often as patients covered by private plans. Emergency room visits are likely to increase in the future as millions of people swell Medicaid's rolls.

Worse Health Outcomes. Numerous studies have found that Medicaid enrollees fare worse than patients with private insurance and even worse than patients with no insurance at all! For example:

- A University of Virginia study found that enrolled in Medicaid are almost twice as likely to die as privately insured patients and about 1/8th more likely to die than the uninsured after surgery.

- A study published in the Journal of the National Cancer Institute found that Florida Medicaid patients were 6% more likely to be diagnosed with prostate cancer at less treatable, later stage than the uninsured. Medicaid enrollees were nearly one-third (31%) more likely to be diagnosed with late-state breast cancer. They were 81% more likely to be diagnosed with melanoma at a late-stage (Medicaid patients did outperform the uninsured on late-stage colon cancer).

- A study in the journal *Cancer* found that the mortality rate for Medicaid patients undergoing surgery for colon cancer was more than three times as high as for the privately insured; and more than one-fourth higher than for the uninsured.

- A study in the *Journal of Vascular Surgery* found that Medicaid patients treated for vascular problems, including plaque in their carotid (neck) arteries that pump blood to the brain and obstructions in the blood vessels in their legs, fared worse than did the uninsured (however, the uninsured with abdominal aneurysms did fare worse than Medicaid patients).

New Payment Rates. The federal law will increase Medicaid reimbursement rates to Medicare levels (i.e. 80% of what private insurers pay) for primary care physicians in 2013 and 2014. While this change should improve access to primary care services, it will do nothing to improve access to specialists! Moreover, in 2015 states may lower their payment rates for primary care back to the original levels — a likely outcome considering that many states will face large budgetary problems precisely because of Medicaid expansion.

What If I Have an HSA?

If you are one of nearly 18 million people enrolled in a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) or if you work for the one of every two employers who now offers one of these consumer-driven health plans, in the future you will have fewer options. The new health care law does not outlaw HSA-eligible plans, but it takes away HSA options and future regulations could make these plans impractical and undesirable.

Current Law. Instead of giving all of your health care dollars to an insurance company, the current law now allows you to choose a plan with a high deductible and more limited benefits and put the premium savings in an account you own and control. Deposits to these accounts may be made with pretax dollars, just like employer-paid premiums, and the accounts grow tax free. Because you get to keep the money you don't spend, self-insuring in this way allows you to directly benefit from being a prudent consumer in the medical marketplace.

Lower Deductibles. The new law reduces the allowed deductible for small group plans (those with fewer than 100 employees) to $2,000 for singles and $4,000 for families, beginning in 2014. This is roughly one-third the level allowed under current HSA law. This will limit your ability to save on insurance premiums by joining a higher deductible plan.

Larger Penalties. If you take money out of your HSA for a nonmedical purpose, the law increases the penalty from 10% to 20%, and you will have to pay ordinary income taxes as well. In addition, patients may not use their HSA funds to purchase over-the-counter (OTC) drugs beginning in 2011. This is especially unfortunate, since there is a trend for off-patent drugs to become less expensive, OTC drugs.

Additional Risks. The Secretary of Health and Human Services has the authority to review health plan benefits on an annual basis and determine the "essential" benefits that should be included in all health plans. If the Secretary determines that all plans must have a benefit that violates the regulations for HSA-eligibility, HSAs could essentially be outlawed by the stroke of a (regulatory) pen.

Other restrictions could make HSA plans impractical. For example, one proposal would require your employer to verify that every single HSA withdrawal is for medical care. This would greatly increase the paperwork cost of administering these accounts.

What If I Have an FSA?

The most significant change is an annual limit on contributions you can make to a flexible spending account (FSA). Estimates vary, but about 30 million people are using FSAs. These accounts pay for such things as medical expenses, dental insurance premiums, long term care and child care with pretax dollars. Funds must be used in the year they are set aside, however.

Although most employers limit the amount you can contribute to $5,000, the new law will limit contributions to no more than $2,500 a year — indexed to inflation for future years.

The new law also changes the definition of a “qualified medical expense,” making over-the-counter (OTC) medications and products no longer eligible for payment through an FSA. Virtually everything in your medicine cabinet that is now tax free (through an FSA) will be taxable in 2011. The list includes: aspirin, bandages, cough syrup, cold medications, antibiotic ointment, first aid creams, pain relievers, cough drops, antacids, sinus medications, allergy medications and nasal sprays. This will affect millions of people who suffer from chronic conditions.

The impact may even be greater on the millions of people who use these accounts for long-term care for family members with chronic illnesses.

What If I Am Young?

Like all other individuals, you will be required by federal law to purchase health insurance with the specific benefits the federal government says you must have, regardless of whether you want to pay for them and regardless of whether they are useful. For instance, young single males will be required to purchase a plan that has maternity benefits and well-baby coverage.

Benefits of Reform. Beginning on September 23, 2010, young adults up to age 26 (whether married or unmarried) will be able to enroll in their parents' health plans. Initially, this option will be limited to children who do not have access to an employer plan. However, beginning in 2014, children will be able to join or stay on their parents' plan even if they have access to an employer plan of their own.

Costs of Reform. Young people tend to be healthy and have lower expected costs than older adults. For example, people in their 20s today typically face premiums that are only one-fifth or one-sixth as high as people in their 60s. The likelihood of ill health, and therefore the cost of

health insurance, tends to rise with age, but fortunately so does income. People in their 50s and 60s typically pay higher premiums, but their higher incomes allow them to pay higher premiums.

New regulations that take effect in 2014 will dramatically change things, however. Insurers will be required to accept all applicants at rates that are not adjusted for health status. Also, premiums can be adjusted for age but the highest premium can exceed the lowest one charged by no more than a ratio of three to one. This means that young adults will face premiums that will be much higher than their expected cost so that older, less healthy adults can pay premiums that will be much lower than their expected costs.

The result: You will have to pay a lot more for your coverage, perhaps even double or triple your current premium. For example, studies based on actual insurance claims data show:

- The premium for a healthy 25-year-old in California would more than double — rising from $107 per month to $221.
- The family premium for a 40-year-old husband and wife with two children in California would more rise by 42 percent — from $536 per month to $763.

- By contrast, a 60-year old, less healthy couple living in California would only see a drop in their premiums of about 41 percent — from $1,979 to $1,165.

Exceptions for Young Adults. If you are under the age of 30 you will have access to health plans that have fewer mandated benefits than the standard plans. These plans will be allowed to have higher deductibles and higher cost-sharing, but your out-of-pocket exposure will be no higher than Health Savings Account limits (currently $5,950 for an individual and $11,900 for a family). Presumably, these plans will have lower premiums. They will not qualify for premium subsidies in the exchange, however.

Does Marriage Help or Hurt?

It almost always hurts. The reason: Subsidies in the newly created health insurance exchange will treat two singles better than a married couple. Suppose you are earning 200% of the federal poverty level (currently $21,660). You will be required to pay a premium equal to 6.3% of your income in the exchange — or about $1,365 for a health plan that has an actual cost of, say, $5,000. Thus, you and a cohabitating partner who also earns 200% of the federal poverty level

could both obtain health coverage for about $2,730. However, if you marry your partner, the two of you will be required to pay 9.5% of your income in premiums — or about $4,115. Being married will cost the two of you $1,385 a year.

In some cases, getting married may be worth the financial penalty, however. If you and your partner each earn 100% of the federal poverty level (currently $10,830), you would (individually) qualify for Medicaid and would not be allowed to purchase private coverage in the exchange. However, if you are married, your combined income would disqualify you for Medicaid. If you bought insurance in the exchange, you would be required to pay 4% of your household income (or $866). The ability to get out of Medicaid (which pays low doctor fees) and into a private plan (which pays market rates) may be worth the extra premium you have to pay — especially if you value more ready access to care.

What If I Run a Small Business?

On the plus side, if your company employs fewer than 51 fulltime workers, you will be exempt from penalties for failing to offer health coverage. The 51st worker, however, could be a very expensive hire.

Mandated Health Insurance. If you employ 51 or more workers, failure to provide insurance subjects you to tax penalties. There is a complicated formula, but the net result will be a fine of $2,000 for each additional uninsured employee. Another plus is a provision allowing you to retain your current health plan by claiming “grandfather” status. This would make you immune from cost-increasing regulatory burdens, since the mandated benefit package is likely to be more generous and more costly than what you have now.

A Catch-22. Any substantial change in your health plan, however, such as switching to a new insurance carrier, will cause you to lose your grandfather status — even though changing insurers is the main way small firms keep premiums down. As a result you can accept double-digit premium increases for your existing insurance — currently averaging 10% to 18%

nationwide, or you can shop around for new coverage, in which case you will lose your "grandfather" status and have to comply with dozens of costly new mandates.

- Under a "mid-range" estimate, two-thirds of small business employees will lose their grandfather status by 2013 and will no longer be able to keep the plan they now have.
- Under the worst case scenario, as many as 80% will lose their grandfather status.
- By contrast, a self-insured, large company plan or union plan is free to change its third-party administrator as often as it likes and still keep its grandfather status.

Access to an Exchange. If you have fewer than 100 employees, you will be able to purchase coverage in a health insurance exchange rather than buy insurance in the small group market. However, your employees will not be able to obtain the subsidies that individuals will receive if they are buying their own insurance. Also, just as insurers selling in the exchange will not be allowed to buy their premiums based on health status, that same requirement will also govern the small group market outside the exchange. So at this point, it is unclear whether there will be any financial advantage to using the exchange.

Potential Benefit: A New Small Business Subsidy. The new law includes a health insurance tax credit that may help you purchase health insurance for your employees. However, most businesses will not meet the strict (and complex) criteria for claiming the credit — which is only available for six years and only for firms that have 25 or fewer employees and pay wages that average less than $50,000. As a result, fewer than one-third of small businesses will qualify according to the Federation of Independent Business. Also, the credit is not available to sole proprietorships and their families.

Potential Cost: Increased Paperwork. Currently, businesses are required to report to the IRS on form 1099 the amounts paid to all contract workers with more than $600 in business dealings. Beginning in 2012, you will also have to file a 1099 form for all businesses for purchases in excess of $600. This means that you will have to fill out a federal form, even if you are only buying paper at Wal-Mart.

A business networking organization in Pennsylvania surveyed its members and found most only file 10 form 1099s per year, on the average. Under health reform, the average number of annual 1099s a typical small business would be required to file would rise to more than 200. According

to the National Taxpayer Advocate, which operates inside the IRS, these new paperwork burdens will affect 30 million sole proprietorships and subchapter S corporations, two million farms and one million charities and other tax-exempt organizations.

What If I Am an Early Retiree?

Under the current law, there are three public policy barriers that may stand between you and affordable health insurance:

- Although tax law allows employers to pay premiums for group insurance for active employees with untaxed dollars, employers cannot make premium contributions to the individually-owned insurance of their retirees with untaxed dollars. (You must pay taxes on the employer's contribution and buy insurance with what's left over.)
- Although many employees are able to pay their share of health insurance premiums using premium-only plans set up by their employers, retirees must pay their premiums with after-tax dollars. (This can double the cost of health insurance if you live in a middle-income household.)

- Although the ability to pay premiums with untaxed dollars makes employer-paid health insurance for current medical expenses more affordable, there is no easy way for employers and employees to save for future medical expenses — including postretirement expenses.

Some employers have made promises of postretirement health care. Yet these tend to be all-or-nothing propositions. That is, employers can keep their retirees in their group insurance plan — paying with pretax dollars — or they can do nothing. It's hard to be in between. If an employer cannot afford, say, a $12,000 family plan for a retiree, the employer cannot split the difference and contribute $6,000 to the employee's individually-owned insurance. Such a contribution would be treated as taxable income.

Unfortunately, the new law solves none of these problems. It does create new subsidies for employer-provided insurance for retirees, but these new subsidies phase out in 2014. Moreover, the subsidies go not to individuals, but to employers. And because higher-income employees are more likely to have an employer promise of postretirement care, the subsidies will go to those who least need them.

When these subsidies end in 2014, insurers — selling in a newly created health insurance exchange — will have to accept all applicants regardless of health condition. Since the difference in premiums an insurer changes in the exchange cannot exceed three to one (rather than the more normal cost ratio of six to one), the likely impact will be that young people will be overcharged so that 50- and 60-year-olds can be undercharged.

One problem: It appears the mandate may be weakly enforced. If people wait until they get sick to insure, the average premium in the exchange will have to be quite high to cover the costs. As a result, retirees could face higher premiums in the exchange than they would have faced with no reform at all.

What If I Am an Immigrant?

If you are a legal resident alien you will be required to obtain the same government mandated health coverage that U.S. citizens must obtain. However, if you have been here for less than five years, and if your income falls below 133% of the federal poverty level, you will not be allowed to enroll in Medicaid. Instead, you will be able to do something low-income U.S. citizens cannot

do: obtain highly subsidized insurance (paying a premium, say, of ten cents on the dollar) in a health insurance exchange. If, as we expect, Medicaid insurance is lower-quality insurance, you will have access to better insurance than a U.S. citizen with the same income!

If you are an undocumented immigrant you will not be subject to the individual insurance mandates and you will not be fined if you fail to purchase health insurance. Nor will you be allowed to enroll in Medicaid or buy insurance in the health insurance exchange.

However, hospital emergency rooms will not be able to deny you health care if you are in need. What makes this surprising is that the most common argument for an individual mandate is that the uninsured should have to contribute to their own health care instead of getting it for free in the emergency room. This is why U.S. citizens will be required to pay hefty fines if they do not obtain insurance. If you are here illegally, however, you’re an exception to this rule.

What If I Am a Doctor?

On the plus side, as many as 34 million uninsured people are expected to gain health coverage by 2014 and about half will have private insurance. Some physicians may find they can opt to treat more privately insured patients (paying higher fees) by reducing the number of Medicaid and Medicare patients they see.

There are two caveats, however. First, if poor and elderly patients find it increasingly difficult to see doctors, the government will probably be forced to make major changes in the law — perhaps even forcing you to accept an "all-payer" system, where the fee will be the same for all patients. Second, in Massachusetts the subsidized plans sold in the health insurance exchange pay physicians only 10 percent above Medicaid rates — and that is far below what private insurers pay.

Another plus if you are seeing Medicaid patients: The law provides that Medicaid fees will be raised to Medicare levels in 2013 and 2014 for primary care (but not for specialists!). Unfortunately, the fees are likely to go back to their old level in 2015.

The biggest near-term uncertainty is how much you will be paid by Medicare. A planned 21.5% Medicare fee cut that was scheduled to take effect in 2010 (due to the Sustainable Growth Rate Formula) has been delayed until November, when Congress is likely to revisit the issue again.

A new Medicare Independent Payment Advisory Board (IPAB) will have the authority to fast-track changes in Medicare payment rates in order to reduce the growth of Medicare spending. Similar to the sustainable growth formula, future cuts in Medicare will likely target doctors. The reason? All other methods of cost control are prohibited in the legislation. The IPAB's proposals may not "ration health care, raise revenues or Medicare beneficiary premiums, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria."

These spending reductions will begin to be implemented in 2015, although reductions in hospital payments will not begin until 2020. Also, the IPAB's decisions will not need Congressional approval. Congress can only block the decisions and even then it can only do so by substituting a Congressional plan that saves more money than the IPAB plan.

The biggest long-term uncertainty is how much Medicare will interfere with the practice of medicine. Almost certainly the Medicare payment system will be used to promote electronic medical records, coordinated care, managed care, integrated care and bundled care. At the extreme, you may be forced to join an ACO, which is an HMO-type practice with conditional fees based on a checklist of performance measures. You will be paid more if you conform; less if you don't conform — even if the end result is not good for patients. Expect private insurers to piggyback on Medicare's initiatives.

There is also a new moratorium on additional physician-owned specialty hospitals, despite evidence that these facilities lower costs and raise quality.

Is the New Long-term Care Insurance a Good Deal?

A new federal program for long-term care, called the Community Living Assistance Services and Supports (CLASS) Act, will provide benefits to you if you become functionally disabled and are unable to perform such daily living activities as eating or bathing. The CLASS program will pay some of the costs of an aide at home or some of the costs of nursing home care. This program is

voluntary. However, your employer has the option to automatically enroll you and to deduct the premiums from your paycheck, although you will be allowed to opt out. If you work for nonparticipating employers, you will have the option to enroll individually.

Is CLASS Act insurance a good deal? If you are healthy, you can probably get better insurance for less money elsewhere. Because the premium will be the same regardless of your expected costs, if you are healthy, you will pay higher premiums than are actuarially fair, while those who are more likely to need benefits due to chronic conditions or unhealthy habits will pay less. As a result, the program can be expected to disproportionately attract high-risk participants while low-risk individuals will likely opt out. Since the program is supposed to be self-supporting, enrollees could face benefit cuts or increased premiums as the program becomes increasingly insolvent. According to the Medicare chief actuary, the program faces "a significant risk of failure" because the high costs will attract sicker people and lead to low participation.

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