

Healthcare Reform
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The recent attempts by the present administration to overhaul the healthcare delivery system in this country have pushed the movement further than it has been moved in the sixty plus years it has been discussed. Although, no single law has been passed, it is possible to look at the main issues being discussed, argued, protested, and advanced in Congress and to get a glimpse of the direction any final plan may go.

The ultimate goal of healthcare reform is to provide as many as possible with access to quality healthcare, and to control the rapid rise in health care costs; however, any form of single payer coverage or expansion of Medicare has been eliminated from the discussion. This Administration has determined that the best way to do this is to see that every person obtains health insurance to cover their medical bills.

Issues to be resolved include:

Individual Mandate – Reform would mandate that every person purchase health insurance. Subsidies would be provided to assist lower income persons paying for the coverage.

To insure that everyone purchases insurance, there would be tax penalties for not purchasing it. Various proposals put the penalties in the range of from several hundred dollars to 2.5% of income.

There is a principal in health insurance called the “spread of risk.” It states that the broader the group of people that purchase insurance, the greater the mix of healthy people to those incurring medical bills, and the lower the cost for each person.

This is why insurance companies are able to sell health insurance to a group of employees without reviewing each person’s health history. They know that from a large group of working people, there will be more healthy individuals who do not need much medical care, so the premiums collected from the overall group will cover the claims of a few.

Many younger, healthy persons will not see the need to purchase health insurance for themselves and won’t want to purchase it. The **individual mandate** assures that people will not wait until they get sick to purchase the insurance.

Employer Mandate – Health insurance in this country has historically been obtained through employers. To continue that practice and facilitate covering all persons, employers of a certain size will be required to provide health insurance for their employees and their dependents, with tax penalties imposed on those who do not comply.

For example, the current bill recently passed by the House of Representatives (HR3962, discussed more below) requires employers with payrolls in excess of \$500,000 to purchase insurance for its employees or face penalties up to 8% of payroll. The employer would be required to pay 72.5% of employee premiums and 65% of dependents' premiums.

Ban on Denying Coverage for Pre-Existing Conditions – Conversely, if everyone has to purchase insurance, then Insurance companies would be prohibited from refusing to cover a person because of his or her medical condition or health history. They would have to accept all applicants.

Insurance companies are only willing to agree to this provision if the Individual Mandate is enforced with penalties substantial enough to discourage people from not purchasing a plan. It is the Individual Mandate which will allow the insurance companies to accept all applicants; this “spread of risk” will prevent them from taking only unhealthy applicants and allow them to cover healthy and unhealthy persons alike.

Public Option – One of the more controversial topics in this discussion has been the idea that the federal government should offer an alternative plan to the private insurance plans. People in favor of it point to states where only two or three insurance companies insure 80% – 90% of the health insurance market. They insist that a government plan is needed to “keep the private carriers honest” and provide competition to help keep prices down.

Others say that a government program is simply the first step to the government taking over all health insurance, the slippery slope or the camel's nose under the tent, if you will.

Several alternatives of the Public Option have been proposed. One would open Medicare to persons under 65; others would have the government operate its own health plan. Yet others are proposing non-profit cooperatives or exchanges that aren't controlled by the government but would hopefully have enough members that they too could negotiate favorable fees with medical providers and compete with the insurance companies.

Funding the Program – How will the government provide the funds necessary to subsidize all the lower income families' premiums, the administration and

enforcement of the law, and all the other expenses involved? Things start getting even fuzzier here. Some proposals:

- Additional tax on high income individuals;
- Cuts in Medicare reimbursements to doctors and hospitals;
- A surcharge on very broad (Cadillac) health insurance plans;
- Other tax tweaking recommendations, and, of course;
- Eliminate the waste in the system.

Every effort is being made to fund this program without increasing taxes on middle income persons or increasing the size of the federal deficit.

Control of Healthcare Costs – One of the primary reasons for the urgency in passing some type of reform is the spiraling costs of medical care and the health insurance that pays for it. The solutions for this are even fuzzier. Some possibilities being discussed include:

- Reduction in payments to hospitals and doctors;
- An analysis of the most effective forms of diagnosis and treatment with successful outcomes and rewarding providers for following those guidelines;
- Limiting premiums that can be charged by insurance companies;
- Capping medical malpractice awards to eliminate the need for doctors to practice defensive medicine; and, of course;
- Eliminating the waste in the system.

Discussions of controlling healthcare costs inevitably lead to charges of Death Panels and talk of rationing of healthcare. *[It is the author's observation that rationing of healthcare exists now and will continue to exist under any system the country moves to – just that it will never be called rationing.]*

Those Pesky Details

It is impossible to say with any confidence just what the final reform bill will say. The only really solid decision so far is that the private health insurance industry will provide the foundation of the plan. Not even the major issues cited above are entirely settled.

Then there are all the details, which could become significant in the political arena:

- What benefits should be required? Should it be a broad, all-encompassing plan or a more limited benefit schedule that would cost less to purchase?
- Abortion – Should any government money be used to cover abortions?
- Undocumented residents – How will they be included or excluded and what effect would a total exclusion from coverage have on public health.
- Does the federal government even have a constitutional right to force individuals to purchase a privately provided product?

The House of Representatives recently passed a healthcare reform bill (HR3962). Knowing that any law that is ultimately passed will be considerably changed from the initial bill as it moves to the Senate and then to a Conference Committee, it is still helpful to see what it proposes:

- **Individual Mandate** – All persons are required to purchase insurance, with subsidies provided for lower income persons and families.
- **Employer Mandate** – All employers with a payroll in excess of \$500,000 are required to provide health insurance for employees and their dependents.
- **Ban on Denying Coverage** – Insurance companies are prohibited from refusing to cover persons because of a pre-existing condition.
- **Public Option** – Sets up an insurance market exchange through which individuals and small businesses can purchase insurance, including a government health insurance plan.
- **Funding** – Taxes on high income individuals, excise tax on medical devices, and revisions of several tax laws affecting foreign multinational companies, closing tax credits on shell or paper companies. There are also reductions in the amount private insurance companies are paid to provide benefits under Medicare Advantage Plans. Oh yes, and by eliminating waste.

In addition, HR3962 makes some changes to current Medicare and Medicaid programs:

- Expands Medicaid eligibility to cover persons with an income up to 150% of the Federal Poverty Level;
- Adjusts how payments are made to hospitals, basing payments on quality of care and outcomes rather than by the number of procedures performed;
- Gradually reduces the “donut hole” in Part D Medicare Prescription Plans, where no payments are made, so that it is totally eliminated by 2019.

Whatever law finally goes into effect will probably have some similarities to what is stated above, however, it could also vary substantially. Also, it should be kept in mind that, even if a law is passed this year or next, it will be several years before all of the provisions are implemented.

Watch this column for more updates as the legislation progresses.