

Health Bills: What's At The Core

Editor's Note: This is the second of three guest columns from Prof. Leflar about health policy. 11/30/09

Most anyone willing to inspect content would find plenty to like about the health reform bills before Congress. The controversial issues — public option, abortion coverage — have more symbolic than practical importance. The practical issues — who pays, how much — can be resolved.

Here's what the House and Senate bills do, and how they differ:

Both bills end discriminatory insurance practices based on health status, such as coverage rejections for preexisting conditions and unaffordable premiums for high-risk patients.

Both bills expand Medicaid to cover the near-poor (incomes up to about \$30,000 for a family of four), provide support for disabled beneficiaries, and offer preventive care such as quit-smoking programs for pregnant women. Both bills provide tax credits for premium costs to many middle-class Americans (incomes up to around \$80,000 for a family of four).

Of 473,000 Arkansans lacking coverage in 2008, virtually all would be eligible for federal assistance.

Both bills contain programs to improve quality and consumer information. "Pay-for-performance" initiatives such as penalties for hospital-acquired infections move the payment system toward rewarding good outcomes, not high treatment volume. Chain restaurants have to disclose calorie content (Senate). Nursing home information becomes more available (House).

Insurers must offer coverage fitting into four tiers: bronze ("minimum essential" benefits), silver, gold, and platinum (most comprehensive). Interstate sales are allowed. Medium and large employers must provide coverage for employees. Small employers are exempt, or subsidized if they provide coverage.

GUEST COMMENTARY



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Everyone must have "minimum essential" coverage. This could be public (Medicare, Medicaid, VA, etc.), employment-based, or existing coverage, or coverage bought through state- or regionally-operated "exchanges."

"Exchanges" are key new institutions. They certify and rate health plans, present insurance alternatives in standardized format through Internet portals, enroll individuals and take applications for subsidies — "Travelocity for health insurance." Exchanges can negotiate prices with insurers (House) or require insurers to justify premium increases (Senate).

Public Option: No Big Deal

Debate rages about whether exchanges should offer a "public option," and if so whether states could opt in or out. The debate's more about symbolism than practical health care. Here's why.

Advocates of "public option" see it as symbolic of America caring for all its people. Many hope it would outperform private health insurers, thought responsible for abuses, and cause them to shrivel. Opponents of "public option" view it as symbolic of bureaucratic big government encroaching on individual freedoms.

In fact, if enacted, it's likely to be no big deal either way. The Congressional Budget Office (CBO) estimates that of 31 million newly covered Americans, only three or four million would likely choose "public option" insurance. Why? Higher premiums.

Although (like Medicare) it would be more administratively efficient than private insurance, the public plan would likely enroll people with greater medical needs and limit services less aggressively, projects the CBO. Higher cost means higher premiums.

Absent public option, private insurers would have to cover those with greater medical needs.

A nationwide majority supports public option, but even among Democrats it's only seventh highest priority. No politician should have to die on the public option sword.

Abortion Funding

The House bill forbids people receiving federal subsidies from choosing a plan covering elective abortions. The Senate bill, less stringent, excludes abortions from "minimum essential" coverage and segregates federal premium subsidies from abortion payment unless states choose to require abortion coverage in the public option.

Careful drafting should allow compromises so neither side feels, "We lost."

Financing It

Reform doesn't come cheap. Who pays?

Both bills hit the well-off. The House places a five percent surtax on couples earning more than \$1 million. The Senate adds half a percent to Medicare payroll tax for the wealthy. It also taxes high-benefit "Cadillac" health plans. Savings are promised, vaguely, from Medicare payment reforms. The Senate's phase-in for subsidies and tax credits is longer, to diminish deficits.

Why no cost savings from medical malpractice reform? My next column addresses that issue.

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