

CROSSROADS

The United States' Health Care Reform Bill – A Translation

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This spring, North Americans were treated to an unusually large dose of political theater as pundits, politicians, and large mobs of protesters expressed strong opinions on the subject of Health Care Reform in the United States. After a marathon-long debate and a midnight, cliff-hanger of a vote in the U.S. House of Representatives, President Obama signed H.R. 4872, the Reconciliation Act of 2010, into law on March 23. Though the bill has been signed into law, the debate is far from over. The opinion pages of just about every newspaper in the United States resonate with calls for repeal, calls for expansion, words of optimism, prophesies of doom, and strongly-worded judgments that span every point on the political compass.

Through the countless hours of television coverage and millions of words in print, very little has been said about the contents of the bill itself. What does it say? What does it do? Health-care providers, insurance companies, large and small employers, and individuals in the United States will soon be operating under a new set of laws. What, specifically, are these laws, and what is new about them?

The text of the bill that President Obama signed on March 23 runs to some 2,300 pages. The pages are double-spaced and have wide margins, but still, the bill contains something on the order of two million words. Many of these words have little or nothing to do with health care. Among those that are relevant to health care, many amount to little more than rhetoric. But there are some parts of this

bulky tome that may affect the way in which people in the United States buy their health insurance, and how health insurance companies operate in the United States.

These are the parts of H.R. 4872 that might make the bill as significant as it has been purported to be; they include new regulations on health insurance policies, new insurance “marketplaces,” and a national health insurance coverage mandate.

REGULATION OF HEALTH INSURANCE COMPANIES

Some of the sections of H.R. 4872 that most directly address the weak state of the current United States health-care system are those that impose new restrictions on the practices of health insurance companies.

Starting this year, any health insurance policy that is not grandfathered will be expected to meet a set of requirements, thereby deeming it a Qualified Health Benefits Plan, or QBHP. The legislation sets minimum levels of coverage that a plan will have to provide in order to be a QBHP, and sets up a mechanism to prevent insurance companies from making excessive profits by overpricing a QBHP. (What constitutes an excessive profit, however, is left open to negotiation.)

Other parts of the new law attempt to regulate the health-insurance market so that four or five years from now, almost all available health-insurance policies will be QHBPs. It is mainly through this mechanism that the American government will try to change some of the policies and practices that have become customary among health-insurance providers. Cited below is a sampling of the rules that insurers will have to follow when offering a QHBP. Some of these rules

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will apply immediately to existing policies; others will not come into full force until 2014 or later.

An insurer will no longer be able to cancel a policy for any reason other than non-payment of premiums. Currently, it is not uncommon in the United States for an insurer to unilaterally cancel a health-insurance policy as soon as the policy holder begins asking for payments due to illness. While this business model of cost-minimization obviously benefits the insurer, it is less clear how this practice benefits the policy holder. The new law should make it more difficult for an insurer to use unilateral policy cancellation as a routine way to maximize profits.

A QBHP cannot have a lifetime limit on the amount it will pay in benefits. Insurance companies in the United States have found that setting an upper limit on the amount that can be paid out on any particular policy is an effective way to control costs and reduce risk. Holders of such policies who suffer illnesses or injuries that keep them under medical care for more than a few days have found that this practice leaves them dissatisfied.

A QBHP may not require any co-payments for preventative care or well-baby care. Co-payments for other types of care will continue, but they will be regulated. The new law attempts to keep co-payment amounts at or below thirty percent of the value of the service, with a co-payment cap of \$5,000 per person per year.

Dependent children will be able to remain covered by their parents' health insurance policy until age 26. Also, children may not be denied coverage due to pre-existing conditions.

The new law will eventually make it illegal for an insurer to use a pre-existing condition as a reason to deny coverage to anyone. This, however, will not take effect until 2014 at the earliest.

The new law sets up a means by which disputed health insurance claims can be handled by a theoretically disinterested third party. Insurers will be required to allow such adjudication only for QBHPs that are purchased through the Health Exchange (described below), but the expectation seems to be that, five years from now, very few health plans will fall outside this category.

THE HEALTH EXCHANGE

Having defined a QHBP and set forth some of the rules by which insurers are expected to operate, the law goes on to define (rather abstractly) a sort of marketplace, called the Health Exchange, where insurance companies,

under governmental supervision, are expected to offer QHBPs for sale. The key feature of this new marketplace is that ordinary individuals will be able to go to the Exchange and buy approved health-care plans at reasonable prices that can, at minimum, commensurate with the group rates that insurance companies charge when selling policies to large employers. (These prices are on the order of \$5,000 to \$10,000 per person per year.)

Currently, companies that offer health insurance in the United States are reluctant to sell policies to individuals. They prefer to sell group policies to large employers, who then include health coverage in the benefits package offered to employees. Unemployed individuals, contract-workers, or those who work part-time (for example, Wal-Mart employees with 35 hour work weeks), however, do not have access to this kind of employer-provided coverage. If such a person is going to have any health insurance at all, he has to shop for a policy on his own. Presently, this is a very difficult task. Individual health insurance policies tend to come with extravagant price tags and limited coverage. For some people, and in some whole states, they are not available at all.

Four years from now, when the Health Exchange is in place, the individual consumer will, in theory, be able to step up to the counter and compare a variety of health plans which are offered by private insurers, approved by the government, and neatly labeled and categorized as "basic," "enhanced," "premium," or "premium-plus" (or, going in the opposite order, Platinum, Gold, Silver, and Bronze). The writers of the law seem to envision a system in which all or most individual health insurance plans are sold and bought through the Health Exchange, where the government will exercise some control over both the quality and price of the product. This, however, would constitute a monopoly; therefore, the law allows for insurance companies to continue business interactions outside of the Health Exchange model. Given these circumstances, it is unclear as to why a profit-seeking insurer would choose to offer products through the more regulated Health Exchange.

An early version of the bill included a "public option," which was a sort of generic health insurance plan to be offered by the federal government through the Health Exchange. The public option would have ensured that there was at least one reasonably-priced product on the shelves at the Health Exchange. This offer would bring

customers into the Health Exchange, and their presence there might prompt private insurance companies to offer plans to compete with the public option. The Congressional compromise process, however, killed the public option early on; whatever we find on the shelves at the Health Exchange, then, (if we find anything at all) will be supplied by private insurance companies.

Of course, the Health Exchange is unlikely to have an actual counter or shelves. In fact, it's not at all clear what the Health Exchange will look like, or how consumers will interact with it. An early version of the health care bill uses a couple of hundred pages to set up a team of bureaucrats whose job will be to define just what the National Health Exchange will look like when it is finally called into existence in 2014. Since the Health Exchange does something and deals with people, it must, after all, take some concrete form in the familiar world of buildings, telephones, and websites. For the present time, though, the bill only provides a set of plans to form a development committee. And even this has mostly slipped away: before the bill was passed, further Congressional compromises eliminated the National Health Exchange and replaced it with fifty State Health Exchanges. It is now up to each of the state governments to make the initial plans to establish committees to make further plans to call forth the substance of its own particular idea of what a Health Exchange should be.

THE MANDATE

"This law will extend health care to 32 million Americans." That was the headline proclamation from the supporters of H.R. 4872 when the bill cleared its last hurdle on March 22. Currently, some 46 million Americans do not have health insurance; the new law will undoubtedly decrease that number by the brilliantly simple measure of making it illegal not to have health insurance. A section of the law with the subtitle "Individual Responsibility" (presumably the irony is unintentional) requires every American (except Native Americans and those with certain religious beliefs) to be covered by a government-approved health insurance plan or to pay a fine of up to 2.5% of annual income. Uninsured people whose annual income is less than \$27,800 will pay a fine of \$695, to be sure they get the message.

The new law does recognize that, among the tens of millions of Americans living without health insurance, many are doing so not out of

capriciousness, but because private insurance companies either will not offer them affordable policies, or, if they happen to be high-risk individuals, will not offer them policies at all.

Health Care Reform addresses the first of these difficulties by providing "Individual Affordability Credits" - a package of subsidies and tax credits intended to ensure that, even with the new mandate, no one has to pay more than approximately 10% of his annual income to a health insurance company. For low-income Americans, the percentage paid is decreased further: those earning just above the Federal Poverty Level will be able to fulfill their individual responsibilities at a cost of no more than 3% of their annual incomes.

There are, still, those individuals who are unable to obtain any type of insurance plan. A person who is in poor health or who has an unfortunate medical history may find that no insurance company will sell him a policy at any price. It is for these people that the health care law makes its closest approach to providing public insurance. From 2010 until 2014, the federal government will offer health insurance through a temporary National High-Risk Pool. People who can document a pre-existing medical condition and who have had no health insurance coverage for six months will be eligible to buy a basic health insurance policy through this program. The out-of-pocket costs for such a policy will be capped at approximately \$6,000 per year, giving it a price tag that is more or less in line with the policies that the private insurance companies offer to healthy people. The National High-Risk Pool is scheduled to disappear in 2014 because all fifty State Health Exchanges are expected to be up and running with policies for sale by this time, and even high-risk people cannot be turned away from a Health Exchange.

CONCLUSIONS

The thousands of pages of H.R. 4872 include many other changes to federal law, most (but not all) of which relate to health care. There is a section on "Additional Redistribution of Unused Residency Positions" in Medicare hospitals. Money is allocated towards a medical research institute, which, to distinguish it from ordinary research institutes, is called a "Patient-Centered Outcomes Research Institute." A whole pack of laws on college financial aid went along for the ride.

The parts of the Health Care Reform law that will most significantly affect the system of health insurance and health care in the United

States are those we've described: the attempt to regulate insurance companies, the establishment of standards for State Health Exchanges and a Qualified Health Benefits Plan, and the Individual Responsibility mandate. It remains to be seen how significant the effects of this legislation will be. Nancy Pelosi compared the creation of the Health Care Reform law to such historical milestones as the establishment of Social Security and Medicare. The large number of Americans whose health insurance is provided by their employers, however, will probably see little or no change in either their costs or benefits. The writers of the bill made a point of saying, in effect, "If you are comfortable with the plan you have, you may keep it." Insurers will have several new regulations to consider, state governments will have new bureaucracies to set up, and uninsured Americans will either have to

do shop for health-care policies or pay the fines. Whether these small impositions will lead to epochal changes in health care in the United States remains to be seen.

Meanwhile, the topic of health care reform has exposed deep political divisions in the Congress as well as the general population of the United States. The rhetoric surrounding H.R. 4872, typically a cloud of hyperbole quite unrelated to the contents of the law itself, has become a favorite campaign weapon, brandished by partisans of both sides at every opportunity. Discovering the true effects of the new law will be a long and uncertain process. In the short term, most of us can sit back and enjoy watching the sparks fly whenever anyone utters the politically-charged phrase "health care reform." The sparks may not be particularly illuminating, but they do make for a good show.