FREQUENTLY ASKED QUESTIONS ON HEALTH BENEFITS EXCHANGES & HEALTH INSURANCE REFORM

Health Benefits Exchanges

What is an exchange as envisioned by the health law?

It's a marketplace where individuals and small employers will be able to shop for insurance coverage. They must be set up by January 1, 2014. The exchanges will also direct people to Medicaid if they're eligible. For workers at big companies with group coverage, you can keep what you have with new protections against unfair insurance regulations that could limit your coverage if you get sick. And if you lose your job, move or decide to leave that company, you will know that there will be high-quality affordable health insurance options available for you on the exchange.

Would the larger firms that aren't eligible to participate in the Exchange be impacted by the proposed reforms?

No and Yes. Those businesses that are not eligible to participate in the Exchange will continue to purchase insurance as they have in the past. The state-regulated small group and large group markets will continue to exist and operate much as they do now. The ERISA regulated market of self-insured employer plans will also continue to exist and operate as they do now.

The Acts will require all insurance policies, including those sold to larger firms, to adopt many of the reforms that will apply to Exchange/SHOP policies including elimination of pre-existing conditions exclusions for children, prohibiting rescissions, eliminating lifetime limits, and restricting the use of annual limits.

Why create an Exchange or SHOP? What's the purpose?

The Exchanges and SHOP serve a number of purposes. First, they create larger individual and small employer insurance pools with many of the advantages (lower costs, lower premiums, more policy choices) that a larger pool enjoys. Second, they provide individuals and very small employers with access to the new policies written using the new uniform set of national rules which are more consumer-friendly. Third, the Exchange/SHOP will also provide a "one-stop shop" for researching, comparing and purchasing health insurance coverage subject to the new rules, making the process of finding an appropriate health insurance policy easier and more efficient.

Some have drawn a comparison with Expedia.com or Orbitz.com, which provide a similar service for purchasing airline tickets. Just as these travel websites list the array of private airlines, flights and pricing, an Exchange/SHOP will list all of the private insurance policy options available to individuals and small employers in a given community, supply tools to compare these policies, and provide a means of purchasing a policy.

Why would the new Exchange/SHOP rules be any better than those that are already in place?

The Exchange/SHOP underwriting and rating rules in The Acts are much more consumer-protective than most, if not all, of the current state individual and very small group underwriting and rating rules they

replace. Currently, most states have few or limited rules governing or restricting individual health insurance policy practices. As a result, those who are dependent upon today's individual insurance policies can be denied coverage, subject to pre-existing exclusions and experience sharp year-to-year increases in premiums. These same practices will not be allowed by the new rules spelled out in the Act.

Will all states have exchanges?

States have the option to set up their own exchanges, forming coalitions with other states to create regional exchanges- or opting out altogether. In that case the federal government will run the exchanges for their residents. Also, states can partner with the federal government to run the exchange beginning in January 2014, until they are ready to assume full responsibility.

How will the exchange operations be funded?

Congress appropriated funding for states to build exchanges; the operating costs of the exchange are funded entirely by federal funding through 2014. By 2015, exchanges have to be self-sufficient and have non-federal sources of funding for the overhead and administrative costs.

Who are the main customers of the exchange going to be in 2014?

The primary customers will be people who are uninsured, who want to buy insurance and who might be eligible for federal tax credits to help them cover the cost of the premiums. The other primary customers will be small employers who don't currently provide coverage because they say it's cost-prohibitive to do so. Small employers will get tax credits for obtaining coverage. The exchange will provide a selection of plans to choose from.

Will anyone be allowed to buy from exchanges?

No. Initially, exchanges will open to individuals buying their own coverage and employees of firms with 100 or less workers (50 or fewer in some states). Most Americans will continue to get insurance through their jobs, not via the exchanges. The Congressional Budget Office estimates 8.9 million people will use the exchanges in 2014 and most will be eligible for subsidies, which will average about $4,600 per person in 2014. Undocumented immigrants will be barred from buying insurance on the exchanges.

Will I be required to give up my current coverage?
No. Health plans in effect as of March 23, 2010, are grandfathered under the law and will be considered "qualified coverage" which means they meet the mandate to have health insurance that begins January 2014.

What credits or options will be available to me as an employer if I buy group insurance on the exchange?

The Small Business Tax Credit is available beginning with the 2010 tax year. Businesses with fewer than 25 full-time equivalent employees (FTE) and average annual wages less than $50,000 per employee may qualify. To receive the tax credit, an employer must have a group health plan and must pay at least 50 percent of the premium for employees.

The tax credit is equal to a percentage of what the employer pays and is based on the average premium in the small group market in the state. For tax years 2010 through 2013, the maximum credit in each year is 35 percent of the employer's contributions (25 percent for nonprofit employers). Beginning with tax year 2014, the maximum credit is 50 percent of the employer's contribution (35 percent for nonprofit employers). The full 35 percent/50 percent tax credit is available for a business with 10 or fewer workers (FTEs) and average annual wages of $25,000 or less. The tax credit phases out completely at 25 workers (FTEs) or average wages of $50,000.

Beginning in 2014, small business owners will be able to purchase insurance for themselves and for their employees through an exchange. Each state will be responsible for maintaining its own exchange system. Eligible employers who purchase coverage through the exchange may receive a tax credit for two years of up to 50 percent of their contribution.

Will exchanges be like travel websites or some existing health insurance sites?

In some ways. People will be able to compare policies sold by different companies. Purchasing insurance is complex and can be confusing, so information on the plan benefits will be standardized in an effort to make it easier to compare cost and quality. Plans will be divided into four different types, based on the level of benefits: bronze, silver, gold and platinum. For those individuals under 30 years old there will be a catastrophic plan offered in addition to the other 4 plans.

What will the coverage sold on the exchanges look like?

Plans will have to offer a set of "essential benefits." Those details, still being developed by the Federal administration, will include hospital, emergency, maternity, pediatric, drug, lab services and other care. Annual cost-sharing or the amount consumers must fork over before insurance payments kick in, will be capped at the amounts allowed for health savings accounts -- currently, nearly $6,000 for individual policies and $12,000 for family plans.

How much will the policies cost?

The premiums will vary by type of plan and location. Insurers won't be able to charge more based on gender or health status. They will be able to charge older people up to three times more than younger ones.

What if I can't afford the premiums?

People who earn less than 133 percent of the federal poverty level, $14,484 this year, will qualify for Medicaid in all states, under the law. Above that, sliding scale subsidies for private insurance on the exchanges will be available for residents who earn up to 400 percent of the poverty level, about $43,560 this year. Most people will be required to have coverage of some sort beginning in 2014.

Why does the law require me to purchase health insurance coverage?

The key goal of the health care reform law is to ensure that nobody can be denied coverage or be priced out of coverage due to a health problem. If you allow people to wait until they have a health problem to purchase insurance, the health insurance market simply will not work. There would be a small number of very expensive choices for everyone. So, the law requires that everyone have minimum coverage, creating a larger pool of both sick and healthy individuals.

Will the states negotiate premiums with the insurers?

The law doesn't require states to set or negotiate premiums. However, states may have some influence over prices. For example, states can decide whether to open exchanges to all insurers, or to limit the number. State insurance commissioners will be able to recommend whether specific insurers should be allowed to sell in the exchange, partly based on their patterns of rate increases.

Can I still have a Health Savings Account (HSA)?

Yes. The new law does not infringe upon the ability of an individual to contribute to a Health Savings Account (HSA), or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible plan that would complement the HSA.

Will all insurers have to offer policies through the exchange?

No. Insurers won't be required to sell through the exchanges.

Will all state exchanges be the same?

No. States can design their exchanges differently, an issue that's sparking debate in statehouses nationwide. Some states may choose to set additional standards for insurers beyond the federal law. Another important issue: The makeup and power of the governing boards overseeing the exchanges. Some states, such as Maryland, are considering barring insurance industry and sales agents from their governing boards. Others, like North Carolina, have pending legislation that includes representatives from those groups on their governing boards.

Who are these "navigators"? Are they the same as brokers?

Navigators are individuals who will help people understand their choices in the marketplace and help them choose a health plan. We don't have any federal rules or guidance yet, but the law is clear that brokers, certain trade and professional associations, unions and various types of community outreach workers can be navigators. A navigator cannot be a health insurance issuer, and cannot receive compensation directly or indirectly from a health insurance issuer.

How will administrative complexity be reduced for employers and individuals through the health insurance exchanges?

There are a number of provisions designed to reduce administrative complexity. These include:

The exchange will establish procedures to enroll small businesses and individuals; one simple enrollment form will be used.

The exchange will offer standardized benefit packages, and require insurers to describe benefits and policies in a standardized format that allows for easy comparison.

Individuals will be able to apply for coverage through the exchange, and will be informed if they qualify for Medicaid, CHIP or any other state or local public health program through one state-sponsored website. The exchange will determine whether an individual qualifies for a tax credit and/or subsidy to reduce cost sharing.

HHS is creating a single website where small businesses and individuals can find detailed information about coverage options in their state.

There are also a number of new requirements for insurers on standardized operating rules to simplify elements of health insurance administration such as eligibility verification, service authorizations, claims status, payment procedures, and referrals. These changes should reduce waste, administrative cost and hassle; they must be adopted by July 1, 2011 and fully implemented by January 1, 2013.

What is a health insurance co-operative/co-op?

The Acts authorize the creation of private health insurance co-operatives. A health insurance co-operative is a non-profit, non-government, consumer-driven health plan that would serve as an alternative to the private health insurance programs. A health insurance co-op would be owned and controlled by the people and small businesses that purchase health coverage from the co-operative – not by an insurance company or outside investors. As proposed, a health co-op will be subject to all exchange rules and state laws that apply to other insurance products, i.e. licensure, solvency, capitalization, and consumer protections. The co-op model has been successfully used by farmers, ranchers, utility providers and other businesses to provide services to their members.

Health Insurance Reform

How does the health care bill reform health insurance markets?

The Acts' health insurance provisions reform the nation's currently dysfunctional individual and small group health insurance markets. They do so by:

- Creating a mechanism – Exchanges for individuals and SHOP for small employers - to create larger insurance pools and simplify the onerous task of shopping for the best insurance policy, whether you're an individual, a family or an employer; and
- Replacing the existing set of 50 different state laws governing health insurance with a uniform set of more consumer-protective underwriting and rating rules.

The Exchanges and SHOP will be "one-stop shops" for finding out what policies are available in a given community, comparing different policies and purchasing both private individual and small business insurance products. The Exchange and SHOP will be open to any insurer who offers a product that meets and abides by the underwriting and rating (i.e. pricing) rules set out by the legislation.

In addition, the legislation spells out new underwriting and rating rules policies that would be more consumer-protective than is currently the case under state law. These new rules would be on par with what most people think of when they hear the term "group policy".

Could I be denied coverage under the new rules?

No**.** The Acts' underwriting standards require all policies be "guaranteed issue." Insurers cannot turn anyone down for reasons related to pre-existing conditions, current health status, previous claims, age, type of employment, etc.

Could my insurer decide to not renew my policy?

No. The Acts guarantee that your insurance provider must renew any policy that it has issued and for which you have paid.

Can an insurer rescind or cancel my insurance policy?

No. The Acts ban policy rescissions or cancelations without good cause, i.e. failure to pay premiums associated with a policy, fraud, etc. Health status or health claims are not a basis for cancelation or rescission.

Would there be waiting periods to receive insurance coverage?

No**.** The Acts limit the length of any waiting period to 60 days. In many cases, there will be no waiting period.

How will pre-existing conditions be handled?

The Acts bar the use of pre-existing conditions as an underwriting factor, so no one can be rejected because of those conditions. Moreover, pre-existing conditions may not be used as a factor in setting premium prices.

How will premiums be determined?

The Acts reduces the number of factors that insurers can use to determine premium costs:

- Age (How old is the insured?),
- Location/geography (Where does the insured live?),
- Type of policy (What plan is the insured purchasing —individual, couple, parent/child, or family?), and
- Coverage level (How high are the plan's deductibles? How comprehensive is the plan's coverage?)
- Tobacco usage

What's an "individual mandate"?

The Acts impose an "individual mandate" or directive that all individuals have health insurance coverage of some sort. An individual is also responsible for providing insurance both for himself/herself and any dependent family members.

What's the purpose of or rationale for an individual mandate?

Health policy experts agree that the current system is fundamentally flawed, as it shifts the costs of providing care among both the insured and the uninsured. The insured, medical service providers and taxpayers "pay for" services provided to the uninsured since it is unlawful or unethical to refuse treatment in many situations. At the same time, the uninsured that have the financial resources to pay for services are charged higher prices for the services they receive as they have no power to negotiate a lower fee as the insurers can.

More importantly, the basic concept of insurance is to spread risk among the largest number of participants. Health care costs can be reduced only if the costs and the risks are spread among the largest possible populations. Thus, the mandate includes younger and healthy individuals who might otherwise choose to be uninsured. Increasing the size of the risk pool can reduce per capita claims costs, administrative costs and premiums.

Finally, an individual mandate is intended to keep individuals from "gaming the system" by waiting until they need medical care to purchase coverage for their unexpected health care costs.

Isn't there some other option besides a mandate?

Probably not. A mandate is thought to be the sole *practical* mechanism for assuring that nearly all have insurance. A mandate is also perceived as the best way to assure that the private sector will continue to provide insurance and that there will be robust competition for it. The only other practical way to assure that all have coverage is to have a government program as the sole source of health coverage. Such a system is commonly referred to a "single payer" health care system. There was little political support for turning the entire health care system over to the government.

How does one satisfy the mandate?

The mandate can be satisfied with health insurance obtained via the Exchanges/SHOPs, through an employer plan, through a spouse's employer-provided plan and an existing insurance policy. Coverage obtained through retiree plans, veterans programs, Medicare, Medicaid, SCHIP (Children's Health Insurance Program), and available to active duty military will also satisfy the mandate as will other designated types of government-sponsored health plans.

What would be done about those individuals and families who cannot afford to purchase coverage, but are legally required by the individual mandate to do so?

The Act provides affordability enhancements. These enhancements take the form of credits that will be used to help pay premiums for lower and moderate income individuals and families. These credits will be distributed on a sliding scale based on income, meaning that the less money you earn, the more subsidy you would receive. Examples are provided below.

Can you illustrate how the credits to enhance affordability will work?

The Act creates a credit that would be used to reduce health insurance premiums for low- and middle-income Americans who purchase coverage through the Exchange. The amount of a credit an individual or family might receive will depend on family size and household income. Family size and income will be compared with the Federal Poverty Level (FPL) and the credit computed based on those two factors.

As a rule of thumb, families can anticipate that the greater their income, the less the credit; the larger their family, the greater the credit. FPL rises based on size of family. Hence, the poorest, largest families will receive most premium credit. The credit will phase out at 400 percent of FPL. Under current law, an individual with income up to $43,000 and a family of 4 with up to $88,080 of income can receive some premium credit.

More specifically, taking the affordability credits into consideration, the maximum proportion of income that individuals will pay for health insurance increases with income, on a sliding scale:

Up to 133% FPL — 2% of income
133 – 150% — 3% - 4%
150% - 200% — 4% - 6.3%
200% - 250% — 6.3% - 8.05%
250% - 300% — 8.05% - 9.5%

300% - 400% — 9.5%

Information about the FPL can be found at http://aspe.hhs.gov/poverty/index.shtml.

Note that individuals will pay a penalty if, even with this premium credit, they do not acquire health insurance.

Are there any exceptions to the individual mandate?

Yes. The approved measure provides hardship exceptions for those individuals and families whose incomes are too small to be able to afford the premiums required to pay for a basic insurance policy. More specifically, individuals or families who find that the least expensive policy available requires more than 8% of household income would be exempted from the mandate.

Are insurance mandates something new?

Yes and No. While a health insurance mandate is a new application of a mandate, mandates currently exist for other forms of insurance. For example, state and local governments commonly require all car owners/licensed drivers to have liability insurance. While not a statutory requirement, hazard insurance is usually a condition of obtaining a mortgage. Federal flood insurance is required by statute for federally-related mortgages in federally-designated flood zones. Part of the monthly payment for a loan backed by the Federal Housing Administration is an insurance premium that FHA requires.

How would an individual mandate be enforced?

Mandates will be enforced by requiring individuals to provide proof of insurance when filing their federal tax returns. Federal guidelines will specify the format for the proof of insurance. It can also be expected that the Exchanges/SHOPs will provide the proof required for those enrolled in Exchange/SHOP plans and that employers who provide insurance to their workers will confirm the insurance as an information item on the IRS Form W-2 provided each year to their employees.

In addition, tax penalties will be imposed on those who cannot prove coverage. These penalties will be phased in over time as follows:

2014 — greater of a flat fee of $95 or 0.5% of taxable income
2015 — greater of a flat fee of $325 or 1.0% of taxable income
2016 — greater of a flat fee of $695 or 2.0% of taxable income

The maximum for a family without insurance when fully phased in would be the greater of $2,085 or 2.5% of household income.

What type of health services would be available under these new plans? Would I lose access to types of services I have now?

Insurance policies will be required to cover a comprehensive range of health services in order to satisfy

the new requirements. The list is more inclusive than current state benefit mandate laws. Required covered benefits include:

- hospitalization
- physician/other health professional services
- prescription drugs
- preventive services
- maternity care
- well baby/child care
- pediatric and non-pediatric dental, vision and hearing
- services and equipment
- outpatient hospital services
- outpatient clinic services
- emergency room services
- rehabilitation services
- mental health services
- substance abuse disorder services

Will there only be one type of insurance plan available through the Exchange?

No. The approved Acts spell out an array of insurance policies that participating insurers may offer via the Exchange.

Insurers who choose to participate in the Exchange can offer four levels of coverage – a Bronze, Silver, Gold and Platinum plan - that all offer the same types of coverage but that vary in terms of their deductibles or co-pays.

What will my policy cost? Who determines the cost?

The price of a policy will be determined just as it is today by the insurer who offers the policy. Premiums will be subject to the new rating rules and all pricing will remain subject to the review/approval of the state insurance commissioners.

As under current practice, policy premiums will depend upon a number of individualized factors. These include the number and ages of individuals covered the type of policy chosen, deductible levels, and the community where the covered individuals reside. Tobacco users may be subject to an additional surcharge on top of premiums. Thus, it is impossible to determine the cost of a policy at this time. A major goal of the reform effort is to reduce costs for consumers, health care providers and the insurance providers (including Medicare).

The Acts pursue the goal of reducing costs for consumers by making rating rules (i.e. pricing rules) more consumer-protective and merging the individual and small group insurance markets into one pool where risks could be spread across larger numbers of participants. Larger risk pools should lead to greater administrative efficiency and reduced costs, as well. Even the individual and employer mandates, while potentially burdensome during the transition to the new rules, are designed to reduce costs over the long term. In theory, as more individuals and families have health insurance, those with insurance will

not be subsidizing those without insurance but to whom health care providers are often required to provide uncompensated care as is now the case. This phenomenon, known as “cost-shifting”, will be eliminated. The Acts also provide for credits for low and moderate income individuals and families, as well as small employers, which will help make coverage more affordable.

How do the Acts handle prescription costs?

Prescription drug coverage is specifically listed as one of the “essential benefits” that must be covered by a “qualified” insurance policy both within the Exchange and by any new traditional market policy within five years after enactment (House). The size or amount of any deductibles or co-pays will depend on the policy option chosen. Out of pocket prescription costs would be counted as part of a plan’s limitations on annual out of pocket expenses.

Will healthy lifestyle discounts/incentives or higher premiums for unhealthy choices such as smoking be allowed?

The Acts allow insurers to offer incentives for healthy lifestyles, wellness programs and other preventive measures. In fact, wellness and health lifestyle incentives are seen as a key means of incentivizing healthy behavior. Under the Reconciliation Act, tobacco users can be assessed a $200 annual surcharge on their premiums. Like many issues, incentives, discounts or higher premiums would depend on the insurance coverage plan an individual selects.

Will health savings accounts (HSAs) still be available?

For the most part, the Acts are silent on the treatment of existing health savings accounts but do acknowledge HSA policies as acceptable coverage. (A health savings account allows individuals who purchase some types of high deductible health insurance to also set aside tax-free amounts to cover the cost of routine health care.)

Will the government decide what medical procedures/treatments would be allowed? Wouldn’t there be rationing?

No. The bill does not give the federal government any authority to decide what treatments would be allowed. Decisions as to whether a particular covered benefit is an appropriate one for a patient are left to the policy holder and his/her health care professional.

The only role the federal government has is to spell out what services insurers are required to include in policies, just as state law spells out what services must be covered by state-regulated policies.

I have heard many people worry that health care will be "rationed" under health reform. I won’t be able to get certain tests or procedures. What if I want those tests and what if they detect something that could save my life?

Health Insurance Reform will end current forms of rationing, not expand it.

First, there is widespread rationing in today's system. Right now, decisions about what doctor you can see and what treatment you can receive are made by insurance companies, which routinely deny coverage because of cost or the insurance company rules. Health reform will do away with many of those rules that result in rationing today.

Health Insurance Reform will prevent insurance companies from denying coverage because you have a pre-existing condition; prevent them for canceling coverage because you get sick; ban annual and lifetime limits on coverage, which often force people to pay huge sums out of pocket if they develop a serious illness; and prevent discrimination based on gender.

With health insurance reform, we will also put treatment decisions back into the hands of doctors in consultation with their patients.

One of the reasons we spend too much on health care today is that our incentives are perverse: Doctors are paid by the procedure, rather than for quality. We want reform that rewards quality of care not quantity of procedures. Having dozens of procedures doesn't necessarily make you better. In fact they can make you worse. Right now roughly 100,000 Americans die every year from medical errors, which, in many cases, were the result of treatments that were wrong for them. We want to reduce preventable hospital re-admissions that are frequently caused because patients are not getting the right care in the first place. We want to give doctors the ability to make the best treatment decisions for you and your family.

Isn't health reform going to put more burdens on federal and state governments because we will be covering more people without insurance?

Controlling health spending is critical for the fiscal health of the federal government and the states. For example, health care spending today consumes 30 percent more of state and local budgets than it did 20 years ago, forcing governments to choose between cutting services and raising taxes.

And the Council of Economic Advisors recently released a sobering report on the impact of health care spending on the federal government. It found that if we do nothing by 2019,

- Health care expenditures will be 21 percent of GDP—one fifth of our economic output.
- Spending on Medicare and Medicaid will be 8 percent of GDP.
- Nineteen percent of the non-elderly population, or 54 million Americans, will be uninsured. The cost of caring for the uninsured burdens all of us. Families with insurance pay a hidden tax of $1000 to cover the cost of uncompensated care in this country.

For working Americans who rely on employer-sponsored health insurance, rising costs mean that an even greater proportion of their compensation will be in the form of health benefits rather than take-home pay. In ten years, the estimated percentage of average total worker compensation that comes in the form of health insurance will be 26 percent.

In addition:

- Resources that are devoted to health care cannot be used to provide the other goods and services that Americans want, including education, investment, and infrastructure.
- The federal deficit will continue to rise and, if meaningful health care reform is not enacted, more painful choices about how to deal with our unsustainable fiscal situation will be unavoidable in the future.
- We have to expand coverage and bring down costs for families as well as transform health care so that it costs less and delivers high quality in years to come. Adding more people to a broken system will only cost us more in the long run.

This legislation is going to cost more than a trillion dollars: how can we afford that?

The majority of the initiatives that would pay for reform will come from cutting waste, fraud, and abuse within existing government health programs; ending big subsidies to insurance companies; and increasing efficiency with such steps as coordinating care and streamlining paperwork. We want to take money that is already being spent on health care and re-allocate it toward reforms that lower costs and assure quality affordable health care for all Americans.

The cuts we are talking about involve spending that currently does not improve care for Americans. For example, we would save $177 billion in unwarranted subsidies to the insurance industry in the next ten years and put that money into actual care for people. These and other reforms will strengthen and stabilize Medicare.

But it's not enough to stop there. Health insurance reform must also encourage the kinds of reforms we know will save money in the long run: preventive care; computerized record-keeping; and comparative effectiveness studies to expose wasteful procedures and hospitalizations and give doctors the tools to make the right treatments for you.

We currently spend more than $2 trillion dollars a year on health care. Health insurance reform will make a short-term investment of roughly $100 billion a year to lower costs and relieve the crushing financial burden that is eating into family budgets, forcing families into bankruptcy, making it hard for businesses to expand and grow, and preventing the government from using your tax dollars to create jobs, improve education, rebuild our infrastructure. Health insurance reform would be fully paid for over 10 years, and it would not add one penny to the deficit.

Let's also remember that we can't afford not to reform health care. The cost of inaction is too high. Health care spending has grown in recent years three times faster than average wages. Premiums have doubled in this decade. Out of pocket costs for people with insurance have gone up by 32 percent. Businesses are buckling under health care costs. One out of every six dollars in this country is spent on health care. Soon it will be one in five. If we do nothing, in 30 years, one third of this country's economic output will be tied up in the health care system. Health care is the fastest-growing item in the federal budget. It is absolutely unsustainable. These costs are crushing families and businesses, keeping wages flat, stunting our economic growth, strangling our government. We have to bring costs under control now.

Why should people with insurance pay to cover those who don't have it? They are already paying for the uninsured.

American families with insurance pay a hidden tax of roughly $1000 for the cost of caring for people without insurance. As more Americans become insured, that hidden tax will begin to disappear. In addition, covering everyone will put downward pressure on costs. Bringing younger, healthier people into the system will spread the risk. As more Americans become covered, insurance companies will compete for their business. That will begin to lower costs. And health insurance reform will create stability and security for everyone. If you lose or change jobs you will have the peace of mind of knowing that you will always be able to find an affordable health insurance option for your family.

You keep talking about expanding insurance coverage by cutting Medicare. Why would health reform be good for seniors?

The savings being proposed from Medicare won't harm patient care. In fact it will improve it. We are talking about eliminating billions of dollars in overpayments to insurance companies that do nothing except benefit the insurers' bottom lines. We will go after waste, fraud and abuse that do not improve care for seniors. Not only will these changes enable us to improve the quality of care for seniors, they will stabilize Medicare and put it on better financial footing.

What's clear is that if we don't begin to rein in escalating health care costs, Medicare will be threatened over the long-run.

Health reform will benefit seniors in many ways:

- We are committed to shrinking the donut hole in Medicare Part D that has forced so many seniors—more than 4 million every year—to pay exorbitant costs out of pocket or go without the drugs they need.
- We are also committed to creating a pathway for the approval of generic biologic drugs. Cutting-edge biologic medications are currently very expensive and are out of reach for many seniors. It is important to make generic versions of these drugs available as soon as possible.
- For those of you who retire between the ages of 55 and 64, health reform will provide financial assistance to employer health plans that cover early retirees, bringing down health costs and premiums by as much as $1,200 per family per year for some plans.
- We want to strengthen preventive care under Medicare—no co-payments for checkups and wellness visits. Much of the money we spend on health care goes to treat chronic diseases which could be prevented from becoming more serious if patients received more preventive care. Preventive care is especially important for seniors, because it will increase the chance that your doctor can catch an illness in its early stages.
- Most importantly, by reducing waste and improving the efficiency of Medicare, the Administration will strengthen the program to be sure it is always there for you and the generations to come. As you know, the Medicare Trust fund is projected to run out of money in about 8 years. Health insurance reform would extend the life of the fund for additional years—through at least 2022—and give it greater stability and security.

A lot of seniors seem to be concerned about a provision in the House bill that would provide counseling for end of life care. They think it sounds like the government will come along every five years and require you to talk about how you want to end your life.

This provision, which has been supported by the AARP, would allow senior citizens access to a professional medical counselor who will provide them with any information they might need about preparing a living will, providing medical power of attorney, and—if they are seeking this kind of advice—end of life decisions. These counseling sessions are ***not mandatory***; they are simply made available to those who wish to use the service because they are unable to receive the information from another source. This means that if a senior is seeking such advice and guidance, Medicare would cover it. This measure would allow Medicare to compensate doctors for discussing with their patients the most difficult care choices—those that happen at the end of life. It would actually empower individuals to make the best decisions for themselves and their families, and better ensure that their wishes will be followed.

What are the benefits of the public option?

Health reform must be built on three fundamental principles: It must lower the skyrocketing cost of health care; guarantee choice of doctors and plans; and assure quality affordable health care for every American. A public option would achieve those goals and give the American people more choices. It would foster greater competition; lower costs; and give consumers a greater variety of affordable choices.