

Here are frequently asked questions about health insurance reform legislation.

QUESTION #1: REP. ISRAEL, I'VE HEARD SO MUCH CONFUSION ABOUT THIS BILL. CAN YOU CLEARLY EXPLAIN HOW IT WILL WORK?

ANSWER : First, the bill gives you new CONSUMER PROTECTIONS. The bill stops your insurance company from denying you treatment for a pre-existing condition, capping your benefits over the course of a year or your lifetime, or cancelling your policy after you get sick. In short, everybody will be able to get health insurance – regardless of their health history – and the health insurance you get will not have loopholes or fine print that lets the insurance companies off the hook from paying for your care.

Second, EXPANDS HEALTH INSURANCE TO 30 MILLION AMERICANS. Just like auto insurance, most Americans will be required to have a health insurance policy. If they can't afford it, the government will help by providing tax credits. Small businesses that provide health care to their employees will also receive tax credits. The addition of 30 million premium-paying customers (many who are young and healthy) to the insurance pool will create new revenues for health care and reduce the costs of taking care of uninsured people in hospital emergency rooms.

Third, creates a new PRIVATE-SECTOR INSURANCE EXCHANGE to allow more choice among insurance companies. Right now, if you lose your job, you have no health insurance options other than expensive COBRA. Under the new law, you will be able to shop for new coverage in an Insurance Exchange. Many private insurance companies will compete against each other for your premium dollars. Also, right now if you are a small business you don't have a level playing field to shop for insurance for your employees. Under this bill, you will be able to enter that private insurance exchange where private companies will compete.

QUESTION #2: OKAY STEVE, IF THIS BILL WORKS SO WELL, WHY DON'T MEMBERS OF CONGRESS DROP THEIR HEALTH PLANS AND JOIN?

ANSWER : In fact, the bill specifically requires that Members of Congress on the Federal Employee Health Benefits Plan now receive their health insurance from the new Health

Insurance Exchange.

QUESTION #3: WHY DO WE NEED THIS BILL?

ANSWER : Because the cost of doing nothing is unsustainable.

For eight years, from 2000 to 2008, we ignored this problem. In the same period of time, employer-based insurance premiums doubled...insurance company profits quadrupled...and six million more Americans went uninsured. In fact, today, the leading cause of personal bankruptcy is un-payable medical bills. On Long Island alone, businesses are getting hit with double digit premium increases. They are making choices between scaling back the care they provide or scaling back the workers they pay. Last month, a health insurance company in California raised its premiums by a whopping 40%. If these trends continue, the cost of your family premium on Long Island will be over \$2,000 a month by 2020! So we must act.

QUESTION #4: HOW WILL THIS BILL HELP LONG ISLAND?

ANSWER : This bill will improve coverage for 485,000 of my constituents with coverage through their employer with protection from insurance company abuses, give tax credits to as many as 81,000 families and 21,000 small businesses to make health care affordable, and extend coverage to 29,000 uninsured residents of the towns I represent.

QUESTION 5: HOW WILL THE BILL REDUCE THE COST OF HEALTH CARE?

ANSWER : Because our population is aging and medical technologies are improving, the cost of health care is expected to rise. This bill is intended to slow the rate of that increase. Here's how:

(A) Competition: By creating a new Health Insurance Exchange and requiring insurance companies to compete against each other for your premium dollars, they will become more price sensitive. That lowers costs.

(B) Eliminating Overpayments to Insurance Companies: The bill also eliminates various areas of waste, abuse and overpayment in Medicare. Right now, the federal government pays Medicare Advantage plans 14% more than traditional Medicare services for the same thing! They promised to use that money to equalize premiums between Suffolk County and the rest of the nation. And instead, they pocketed the subsidy. This bill will end hundreds of billions in overpayments to insurance companies and use it to help pay for reform.

(C) Paying for Healthier Patients: Our current system of paying for health care is too often based on procedures and not outcome. The bill tries to lower health costs by putting more value in the quality of your health care. It also funds innovative cost-reduction programs. For example: Accountable Care Organizations – where doctors work together in teams like at the Mayo Clinic – have been shown to lead to more efficient care and healthier patients. This bill would allow doctors in such organizations to share in the cost savings they produce. Reform would also try other payment methods such as paying doctors per patient rather than per

service.

(D)Discouraging Health Care System Overuse: The bill includes new disincentives on extravagant insurance family policies exceeding \$27,500 and individual policies exceeding \$10,200 (twice the national average) to encourage employers to choose less expensive plans.

QUESTION # 6: WHAT ABOUT THE COSTS OF THIS BILL AT A TIME OF DEFICITS?

ANSWER : This has been one of the most mischaracterized elements of the debate. In fact, the nonpartisan Congressional Budget Office certified that this bill will actually reduce the debt by \$143 billion in the first ten years and over a trillion in the next ten years. The bill is fully funded by the cost-savings and revenues described in Question 5.

QUESTION #7: WILL MY TAXES GO UP TO PAY FOR THIS?

ANSWER : Your federal income taxes will not go up to pay for this no matter how much you earn. If your family earns less than \$250,000 you will not see any increase in your Medicare payroll taxes. Starting in the year 2013, if your family earns more than \$250,000, you will experience an increase of less than 1% ON THE AMOUNT EXCEEDING \$250,000 in your Medicare payroll tax. This chart should help:

IF you make:

Your additional Medicare HI tax liability is:

Less than \$25,000

\$0

Between \$50,000 and \$75,000

\$0

Between \$75,000 and \$100,000

\$0

Between \$100,000 and \$125,000

\$0

Between \$125,000 and \$150,000

\$0

Between \$150,000 and \$175,000

\$0

Between \$175,000 and \$200,000

\$0

Between \$200,000 and \$250,000

\$450 for individuals, \$0 for families

Between \$250,000 and \$300,000

\$900 for individuals, \$450 for families

Between \$300,000 and \$350,000

\$1,350 for individuals, \$900 for families

Between \$350,000 and \$400,000

\$1,800 for individuals, \$1,350 for families

Also, in 2013, if you're a joint filer with nonwage income (such as, taxable dividends and investments) above \$250,000 there will be a 3.8% surtax only on the amount over \$250,000. Nontaxable income including retirement vehicles like IRA's, 401k's and TSPs are excluded.

For example, a taxpayer and his spouse have earned income of \$240,000 as well as unearned income of \$40,000. They will owe an additional \$270 ($\$30,000 \times 0.9\% = \270).

QUESTION #8: WHAT ABOUT THE TAX ON SO-CALLED "CADILLAC PLANS?"

ANSWER : For most people, the cost of their health insurance is shared between them and their employer, who pays them partially in health benefits. Those benefits are not taxed, and the tax advantage of paying people in health benefits instead of cash salary has led over time to the creation of some very generous health plans that encourage the overuse of health care. The excise tax on super-expensive plans is an effort to reduce medical inflation.

Here's how it would affect eligible families:

First, there will be no excise tax on super-expensive plans until the year 2018.

Second, the tax will only apply to family health insurance plans whose premiums will exceed \$2,300 per month (the current average family plan costs about \$1,025 per month) or individual plans whose premiums will exceed \$850 (the current average individual plan costs \$365 per month). In other words, the average plan costs less than half of what the tax applies to!

Third, for those super-expensive plans that are above the threshold, it is likely that employers and insurance companies will tailor the plans to avoid the tax. That is precisely the intent of this provision. And, by spending less on insurance, those employers can use the savings for salary increases instead.

QUESTION #9: WHAT ABOUT TORT REFORM? WHY ISN'T THAT IN THE BILL?

ANSWER : If you believe that tort reform is the magic bullet that will reduce health costs, you'll be disappointed by this bill. But if you believe that tort reform is part of a comprehensive approach to rein-in out of control spending, there are elements of the bill you will like. The bill funds a variety of tort reform initiatives by the States; and I support those initiatives. For example, I believe that when medical malpractice suits are filed, an independent physician should be required to sign a Certificate of Merit indicating that the suit is not frivolous. I also believe that states should be able to establish a sliding scale Fee Schedule that ensures that an attorney receives reasonable fees and the patient receives the bulk of the award. Also, the bill incentivizes alternatives to lengthy and expensive trials. However, I cannot support a national

tort reform standard that essentially "federalizes" state courts. States should determine these matters, not Members of Congress. I find it ironic that some of the same people who argue vehemently for "States-rights" want to surrender state and local judicial systems to Washington. Additionally, while an argument can be made that physicians do practice defensive medicine by administering unnecessary tests, I have not seen any credible evidence that tort reform by itself will reduce the cost of health care. The bottom line: responsible tort reform by states that emphasizes patient safety should be part of the solution. But it is not the only solution. We do need a national dialogue with physicians and attorneys to focus on long-term approaches that a) ensure patient protections and safety and b) relieve high medical malpractice costs.

QUESTION #10: ISN'T THIS JUST A GOVERNMENT TAKEOVER OF HEALTH CARE?

ANSWER : First, the bill that passed simply provides funding for Americans to shop for private insurance. It does not create a government run health insurance program. People may be confused about the so-called Public Option – a proposal to create a government administered health insurance plan to compete with private insurers. While I supported a Public Option, it was removed from the final bill in an attempt at compromise.

Second, the government says you have to get car insurance. But, that's not a government takeover of the auto insurance industry. In fact, car insurers compete robustly for your business. Just turn on your television set and watch the Geico salamander or the saleswoman for Progressive and you know what I mean. In this bill, health insurance companies in the private sector will compete for your business...for small business employees...and for thirty million people who must now have insurance.

QUESTION #11: I OWN A SMALL BUSINESS. HOW AM I AFFECTED?

ANSWER : Even when they're providing the same plans, the cost of providing health care to employees is 18% greater for small businesses than for large businesses. This bill will reduce that. Here's how:

(A) Starting this year, small businesses of up to 25 workers can take advantage of tax credits covering up to 35% of the cost of providing health care. In 2014, the tax credit will expand to 50%.

(B) This bill will allow employees of small businesses to shop for insurance on a new Health Insurance Exchange. Insurance companies will compete for their premium dollars. This will allow lower rates that currently only large groups and firms get, stable pricing from year to year, lower administrative costs, and a choice of quality plans.

(C) There is NO mandate on small businesses to provide or pay for insurance for their employees.

QUESTION #12: HOW WILL THIS AFFECT MY MEDICARE ADVANTAGE?

ANSWER: If you have a Medicare Advantage plan, the private insurance company that

administers it, will have to make good on its original promise to provide Medicare services at better prices. This bill will NOT end the MA program, as some opponents of reform have claimed.

Medicare Advantage (MA) plans are paid on average 14% more than it costs to provide care through the traditional fee-for-service Medicare program. These overpayments drain the Medicare trust fund, raise premiums for all Medicare enrollees, and cost taxpayers \$12 billion a year.

Health insurance reform will end those overpayments to insurance companies, and plans will have three years to transition to the reformed payment system.

QUESTION #13: I ALREADY HAVE INSURANCE. HOW DOES THIS PROTECT ME?

ANSWER : For people that already have insurance, this bill means being able to focus on your health instead of your insurance when you're going to the doctor.

- (A) No more pre-existing condition exclusions.
- (B) No more lifetime limits on coverage.
- (C) No more annual limits on coverage.
- (D) Insurance companies must offer you a policy if you apply for one.
- (E) Insurance companies cannot fail to renew your policy because you got sick.
- (F) Your children can stay on your insurance until they turn 26.

QUESTION #14: STEVE, I AGREE THAT NO HEALTH INSURANCE COMPANY SHOULD BE ABLE TO DENY COVERAGE BASED ON PRE-EXISTING CONDITIONS. WHY DON'T YOU JUST PASS THAT?

ANSWER : If insurance companies are simply forced to cover all conditions – without any other element of the new law – several things will happen.

First, many people won't buy insurance until they need it. They'll purchase their policies only after they get a bad diagnosis. The result: insurance companies will be forced to cover the newly-ill who never paid premiums. And they'll recover those losses by increasing premiums for those who had paid for years. That's not fair.

So we have to do more than simply stop bad behavior by insurance companies. We have to require that everyone – including healthy people who currently don't have insurance – pay their fair share. We create a new private-sector Insurance Market Exchange where insurance companies will compete for new business. The pieces are interconnected.

QUESTION #15: BUT, STEVE, DIDN'T THE DEMOCRATS JUST RAM THIS THROUGH CONGRESS USING TRICKS LIKE RECONCILIATION?

ANSWER : People with good intentions can disagree about the merits of the bill, but, at the end of the day, the American people deserve an up or down vote.

First, Reconciliation is a regularly used process to reduce the federal budget. In fact, out of the 22 times it's been used, Republican Presidents or Republican controlled Houses or Senates have been involved 20 times. President Bush's tax cuts in 2001 and 2003 were passed under reconciliation because they couldn't survive a filibuster. Popular programs today – like COBRA's health insurance for the unemployed and SCHIP's health insurance for children – were passed using reconciliation.

Second, the only way to fix the odious provisions that made it through the Senate's version of health insurance reform is reconciliation. So for people who opposed the Nebraska Bail-Out, the special exemptions from excise taxes, and the sweetheart deals contained in the Senate bill, the only way to kill them was in Reconciliation. A vote for reconciliation was a vote to kill those deals. A vote against Reconciliation was a vote to preserve them. It's that simple.

Third, about 75% of the House and Senate bills were similar. Only about 150 pages out of the 2700 pages in the original bill were subject to reconciliation.

QUESTION #16: THIS PROCESS MOVED TOO QUICKLY, AND THE AMERICAN PEOPLE HAVE NOT HAD A CHANCE TO LEARN EVERYTHING ABOUT THE BILL!

ANSWER : This has been the most open and transparent debate about healthcare that Congress has ever had.

(A) In the House: There were 79 bipartisan hearings and markups on health insurance reform. In all, they lasted over 100 hours and heard from 181 witnesses from both sides of the aisle. Committees considered 239 Republican and Democratic amendments and accepted 121.

(B) In the Senate: The Finance Committee held more than 53 hearings on health insurance reform, and spent 8 days marking up the legislation – the longest markup in 22 years – during which they considered 135 amendments. The Health, Education, Labor and Pension (HELP) Committee held more than 47 bipartisan hearings and considered 300 amendments during a 13 day markup. The Senate then spent 25 consecutive days in session on health reform, the second longest consecutive session in history. In total, it has spent more than 160 hours considering the health reform legislation, and its bill includes 147 Republican amendments.

(C) On the Wednesday before our vote, the entire bill was placed on the internet. Members of Congress and all Americans had 72 hours to review the bill. Compare that to the Medicare Prescription Drug bill that was bulldozed through the House and Senate in 11 days in 2003.

QUESTION #17: BUT, YOU ARE NOT LISTENING TO THE AMERICAN PEOPLE WHO DON'T WANT THIS BILL. HOW COULD YOU VOTE FOR SOMETHING SO UNPOPULAR?

ANSWER : First, I have heard from constituents on all sides of this issue. Some tell me that they are opposed to it at all costs, while others tell me it doesn't go far enough.

I don't cast my vote based on polls. But for those who believe I should, in a poll published on

March 16 by NBC/Wall Street Journal Poll 46% supported reform while 45% opposed it. And, a Newsday poll found that more people (47%) supported reform than opposed it (43%) with almost three-quarters (74%) of Long Islanders supporting a public option in health care.

So when people say, “Listen to the majority” what they really mean is, “Listen to me and what I believe the majority wants.”

This is just like when Medicare became law. When Medicare passed, only 42% of the American people supported it in a Gallup Poll. If we had deferred to the majority in that poll, there would be no Medicare today. And today, Medicare is the backbone of economic security for America’s seniors. Frankly, if I were a Member of Congress in 1965 and the choice was between voting for Medicare and risking my seat or voting against Medicare and saving my seat, I would have voted for Medicare.