A Daily Dose of Truth

A Daily Dose of Truth

Introduction

The attack on the Affordable Care Act continues. Why? Because attacks work – even if they are not completely true or, worse, false. Shame on us!

As people of faith – trusted messengers – it's our turn! With fewer financial resources, but with relationships that reach into the depth and breadth of our communities, it is our job to transcend partisan politics and economic self-interests, and to be the truth-tellers in support of a compassionate health care future with a system includes and works well for all of us.

We begin with the declaration that "truth is witness to the whole." We know that one short sound-bite taken out of context -- even if it's a fact -- does not necessarily represent the whole truth. We denounce the use of such sound-bites (from any party!) when they are intended to pervert truth for political gain. In the end, we acknowledge that a manipulation of facts to frighten and confuse vulnerable populations is just plain immoral.

We can change what's happening, but it means each of us must be willing to share the TRUTH when we hear it. We can and must make a difference because health care is, first and foremost, a people issue that should not be relegated to the caverns of political ideologies. In sharing TRUTH, we are not supporting one candidate over another. We are simply making sure that people make their choices based on truth that witnesses to the whole -- not on distorted perceptions based on mis-represented facts.

"A Daily Dose of Truth" will help you compare what you are hearing to the real TRUTH in the Affordable Care Act. Please help spread the message to the far reaches of our country -- via viral email, Facebook, telephone calls, chats with neighbors, and discussions in your communities of faith. Help us counter what is touted as true (with a little "t") with what is actually the TRUTH!

Note: "A Daily Dose of Truth" was originally written in 2010 to help dispel the incorrect information that was circulating about the Affordable Care Act. While dated, this "Daily Dose" series is still posted because of the relevance of these issues to the current discussion about the ACA. A modest attempt was made to update the language of these pages. However, the statistics represent the data at the time these documents were written, and the web links for further information have been removed because of uncertainty over whether the information used as the time is still available.

Faithful Reform IN HEALTH CARE

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#1 "A Daily Dose of Truth": Medicare in Health Care Reform

Truth is witness to the whole. One short sound-bite taken out of context -- even if it's a fact -- does not necessarily represent the whole truth. We denounce the use of such sound-bites (from any party!) when they are intended to pervert truth for political gain. In the end, we acknowledge that a manipulation of facts to frighten and confuse vulnerable populations is just plain immoral.

When health care reform was passed in March 2010, our nation's seniors became the beneficiaries of a strengthened, improved, and re-structured Medicare system. A number of provisions will improve Medicare services for enrollees and extend Medicare's solvency for another ten years.

Direct benefits of health care reform for Medicare beneficiaries

- **Prescription drugs.** The prescription drug coverage gap (the "doughnut hole") will be eliminated over ten years. In 2010, the coverage gap was reduced by $250 in the form of rebate checks that have already been sent to millions of beneficiaries who have reached the doughnut hole. In 2011, program enrollees received a 50% discount off the price of brand name drugs during the coverage gap. In ten years, the doughnut hole will be closed completely. Other provisions will expand assistance for some low-income beneficiaries enrolled in the Medicare drug program.
- **Preventive care.** For traditional Medicare beneficiaries, in 2011, co-pays and deductibles were eliminated from most preventive services. An annual comprehensive wellness visit and personalized prevention plan are added, which are not subject to coinsurance or deductibles.
- **Medicare Advantage plans.** The private-for-profit Medicare Advantage plans are prohibited from charging beneficiaries higher cost sharing for services than is allowed in traditional Medicare. Plans that offer extra benefits will be required to give priority to wellness, preventive care services, and cost-sharing reductions over benefits not covered by traditional Medicare.
- **Physician incentives.** Generous incentives are in the Affordable Care Act to increase the number of primary care physicians and to encourage primary care physicians to treat Medicare beneficiaries.
- **Low-income program.** Outreach and enrollment assistance will be increased to beneficiaries eligible for the Part D low-income subsidy program.

$500 billion savings to the system: **The $500 billion in cuts that were being denounced in attack ads were NOT cuts to benefits. They were cuts in waste, fraud, abuse, and in government subsidies for private-for-profit insurance (Medicare Advantage plans).**

- **Private-for-profit Medicare Advantage.** Payments to private-for-profit Medicare Advantage plans were restructured. Excess payments were rolled back, and performance bonuses reward quality plans. Part of the argument to privatize Medicare is that the private market can provide the same or more benefits at a lower cost than the federal government can do it. Supporters believe that competition will keep the prices down and the quality up. However, research showed that at one point the government was actually paying $1000+ more for Medicare enrollees in private plans than those in traditional Medicare. Further, only 20% of Medicare beneficiaries are in the private plans subsidized by the government, but 100% of enrollees are paying for those subsidies!
- **Waste, fraud, abuse.** Penalties will be enhanced on providers for waste, fraud, and abuse.
- **Hospital readmissions.** Reimbursements to hospitals with excess preventable readmissions and hospital-acquired infections will be reduced.
- **Coordinated purchasing.** Value-based purchasing for hospitals, ambulatory surgical centers, skilled nursing facilities, and home health agencies will be established.

THE TRUTH (with the "big T"): Because of the 2010 reform of U.S. health care, Medicare is strengthened; beneficiaries will receive increased benefits; and costs will be controlled by cuts in waste, fraud, abuse, and in government subsidies to private insurers.

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#2 "A Daily Dose of Truth": Health Care Reform and Home Sales

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Is there a new tax on home sales to help pay for health care reform?

Short answer: Beginning in 2013, a 3.8% Medicare tax was imposed on the PROFIT in home sales for families making more than $250,000/year ($200,000/individuals). If the home is a primary residence, per existing law, the first $500,000/families ($250,000/individuals) in profit will be exempt from the tax. Most home sales will not be affected by this provision in the health care reform law.

Longer answer: The Patient Protection and Affordable Care Act, amended by the reconciliation act H.R. 4872, provided for a 3.8% Medicare tax on unearned/investment income starting in 2013 (section 1402, revised to 1411, on page 33) for families making more than $250,000 per year ($200,000 for individuals). Investment income includes profit on property sales.

A family that makes $250,000 ($200,000/individual) and sells a home for a profit will be required to pay a 3.8% tax on that profit (not on the sale price, only on the profit) as part of their capital gains taxes. However, if the home is a primary residence, per existing law, the first $500,000/families ($250,000/individuals) in profit will be exempt from the tax. It is estimated that only the highest earning 2% of families will be impacted by this provision.

Why the confusion? Another example of a fact taken out of context, this myth about the impact on all home sales seems to have started with a March 28, 2010, Op-Ed written by Paul Guppy for a Spokane, WA newspaper. The author is the Vice President for Research at the Washington (state) Policy Center, "an independent, non-partisan think tank promoting sound public policy based on free-market solutions." The author's claim was immediately refuted by the government affairs director of the local realtors' association.

For more information

FactCheck.org provides a detailed analysis of this issue and numerous links to other sources of information. <http://www.factcheck.org/issue/health-care/>

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#3 "A Daily Dose of Truth": The Requirement to Buy Insurance in Health Care Reform

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Health care justice and the common good are best served when everyone is actually IN a nation's system of health care. And that's the whole point of the health care reform requirement for everyone to have insurance. With everyone IN, we'll all have timely access to the benefits of health care coverage rather than waiting until too late, or worse, getting no care at all. With everyone insured, society-at-large partners with the health care system, fairly distributing the responsibilities, costs, risks, and benefits.

The requirement to have insurance:

- **Protects** all of us from the costs of medical care for patients who can pay for insurance but refuse to do so. The subsidies will be designed so as not to impose a burden greater than any one person or family can bear.
- **Affirms** the government's rightful role in regulation and oversight on behalf of the public good. It is an effort to get everyone playing by the same rules, resulting in fair treatment for everyone fairly in return.

Exemptions to the requirement for insurance: Persons exempt from the requirement to have insurance will include: those whose faith communities object to insurance; those without coverage for less than 3 months; American Indians; undocumented immigrants; those with hardship exemptions (for whom the lowest cost plan available exceeds 8% of individual income); and those who earn too much to qualify for Medicaid but earn too little to file income tax.

Penalties for not purchasing insurance: The Congressional Budget Office and the Joint Commission on Taxation estimate that by 2016 only about 4 million persons (1% of the population) will choose to pay the assessed penalty rather than purchase insurance. Two-thirds of those would qualify for subsidies in the exchanges; the remaining third would be among the top 10% of income-earners in the U.S. **Those who choose not to purchase insurance will pay a penalty that will help cover the cost of maintaining the health system, including the cost of uncompensated care.** The penalties began in 2014 and increased each year: 2014 – the greater of $95 or 1% of taxable income; 2015 – the greater of $325 or 2% of taxable income; 2016 – the greater of $695 or 2.5% of taxable income; beyond 2016 – indexed to the cost of living.

What happens if the requirement to purchase insurance is repealed?

- Insurance costs would likely rise for everyone. In the negotiations leading to reform, this requirement was coupled with the ban on the insurers' practice of banning persons from coverage because of pre-existing conditions. The costs for adding persons with pre-existing conditions will escalate if the enrolling the sick is not off-set with healthy enrollees. *(A New York Times/CBS News poll this week continues to show the usual split between supporters and opponents of reform. However, once those who support repeal are told it would mean ending the ban on insurance exclusions for pre-existing conditions, only a quarter of repeal supporters hold their original position!)*
- The costs of uncompensated care will continue to increase costs system-wide. Very few people travel through life without accessing the health system at some point. The penalty for not purchasing insurance simply helps offset the medical costs for those who choose not to purchase insurance, but do not have the ability to pay for expensive care.

For more information: Faith Values & Responsibility in Health Care Reform (Faithful Reform in Health Care); Health Reform Hits Main Street (Kaiser Family Foundation video); A Broader Regulatory Scheme - The Constitutionality of Health Care Reform (*New England Journal of Medicine*)

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#4 "A Daily Dose of Truth": A Lot to Like in Health Care Reform

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Many people of faith have been guided by "A Faith-Inspired Vision of Health Care" as they have advocated for comprehensive and compassionate health care reform in the U.S. The statement envisions a society where all persons are afforded health, wholeness, and human dignity and a health care system that is inclusive, affordable, accessible, and accountable. Since health care reform became law on March 23, 2010, we already have made progress in working toward that vision.

VISION: An inclusive system of health care

- Children under age 19 can no longer be denied coverage because of pre-existing conditions.
- Young adults up to age 26 can stay on parents' policies that go into effect after 9/23/10, unless they are offered coverage at work.

VISION: An affordable system of health care

- Senior adults are receiving rebate checks when they reach the gap (doughnut hole) in their RX drug coverage.
- Key preventive care, such as mammograms, colonoscopies, immunizations, pre-natal and new baby care will be covered without co-pays or deductibles in new plans after 9/23/10.
- Prior authorization cannot be required for emergency care; higher costs cannot be imposed for out-of-network emergency care in new plans after 9/23/10.
- Small businesses are receiving tax credits for providing health care benefits for their workers.
- 46 states are using resources under the new reform law to pass or strengthen premium rate review laws.

VISION: An accessible system of health care

- Women now have direct access to OB/GYNs without a referral.
- Enrollees in new plans after 9/23/10 must have a choice of primary care physicians.
- Lifetime limits on insurance payouts will be eliminated, and annual limits will be greatly restricted.
- Expanded funding for community health centers will increase access to medical care in under-served areas.
- Persons who have been uninsured for 6 months because of pre-existing conditions now have access to Pre-Existing Condition Insurance Plans.

VISION: An accountable system of health care

- Insurance companies can no longer drop people from coverage because of illness.
- Members of Congress and their staff members will receive their health insurance from the same exchanges.
- Persons will have the right to external appeals of decisions made by insurers.

About the polling data: Attack ads, debates, and press conferences feature the opposition saying that the American people do not want reform. If just one aspect of polling is considered, it is true that many folks do not like the "caricature" of reform that is based on mis-representation and misunderstandings. However, polling data on some of the benefits outlined above consistently reflect a very different TRUTH about what the public thinks about reform.

There's no question that the public is confused, in part because health care reform is confusing. But there are many benefits in reform that are crystal clear, and when those facts are known, who would want to give them up -- either for themselves or their neighbors?

For more information: Health Reform Hits Main Street (Kaiser Family Foundation video); HealthCare.Gov; Polling Data (Kaiser Family Foundation)

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#5 "A Daily Dose of Truth": Making end-of-life decisions

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Since the beginning of doctor-patient relationships, doctors have consulted with families about treatment and care for patients who are faced with end-of-life decisions. Clergy are often involved in these conversations, as well as attorneys, because families struggle with heart-wrenching medical and moral decisions when medical treatment can no longer contribute to quality of life and human dignity. Further, the recommendation that all patients have living wills or advanced health care directives have left patients and families with questions that are best addressed by their doctors and other professionals.

Medicare benefits do not include payment for the time physicians spend in such consultations. With the limits imposed on many doctors for how much time they can actually spend with us, a provision to provide an "advance care planning consultation" was included in health care reform to compensate physicians for these conversations with Medicare enrollees.

However, after the August 2009 furor over "death panels," as these doctor-patient conversations were labeled by the opposition, the provision was dropped.

Health care reform was passed without this change to Medicare benefits. But most of us, not just Medicare beneficiaries, will continue to seek the counsel of our physicians as we make our own choices about the final days of our lives – while we still have the capacity to make such decisions for ourselves. And physicians will continue to consult with us because of their commitment to health, wholeness, and human dignity for their patients.

For more information:

- FactCheck.org – False Euthanasia Claims
- PolitiFact.com – PolitiFact's Lie of the Year: Death Panels

#6 "A Daily Dose of Truth": The "R" word (rationing)

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Efforts to help us make informed decisions about our health care are supported by the comparative effectiveness research (CER) that is conducted by the National Institutes of Health and the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ), among others.

The AHRQ website states that "comparative effectiveness research is designed to inform health-care decisions by providing evidence on the effectiveness, benefits, and harms of different treatment options. The evidence is generated from research studies that compare drugs, medical devices, tests, surgeries, or ways to deliver health care."

While CER has been a long-established but under-funded practice in the U.S., such research was propelled into national discourse when it received $1.1 billion in stimulus funds and the Federal Coordinating Council for CER was established. Now associated with the subsequent effort to reform health care, CER has become one of the targets of those who oppose reform - even though the results of the research will not be used to impose mandates on the delivery of health care.

For opponents to reform, this attempt to practice better stewardship in the distribution and use of our abundant health care resources has become synonymous with rationing. But, truth be told, which is what this series is all about, is that rationing already happens in U.S. health care.

We ration health care when:

- We exclude the nearly 50 million people who are uninsured from the system, leaving them without access to needed care in a timely manner.
- Insurers can deny coverage to people with pre-existing conditions, or deny payment for services, or cap annual or lifetime payments for claims.
- Some communities have access to an abundance of resources that are under-utilized (such as MRI machines) and other communities have none at all.
- Some employers offer health care benefits, and some do not.

Very simply, CER represents a commitment to REDUCE rationing because research will inform better stewardship in the use and distribution of our abundant health care resources. The commitment for greater funding for comparative effective research is intended to move us closer to a health system that includes and works better for all of us. When coupled with other provisions of reform, CER will help us achieve our vision of a society in which all of us are afforded health, wholeness, and human dignity -- and will lead to successfully designing a system in which our health care resources are shared equitably.

> *>>> Note: The latest flurry of emails about this issue seems to have emerged as a result of a speech by an orthopedist who supported a particular candidate in a Michigan electoral battle. He specializes in sports medicine, not health policy.*

For more information:

- U.S. Department of Health and Human Services, Agency of Healthcare Research and Quality: What Is Comparative Effectiveness Research?
- Kaiser Family Foundation – What is Comparative Effectiveness Research?
- PolitiFact.com – Analysis of claims made about comparative effectiveness research

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#7 "A Daily Dose of Truth" (#7): Small business & health care reform (including our faith communities)

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Many small businesses are among the early beneficiaries of health care reform. Already, some are receiving tax credits for providing health insurance for their workers. In fact, information reported in the Wall Street Journal indicates that "the percentage of employers with between three and nine workers and which are offering insurance has increased to 59% this year, up from 46% last year." Researchers seem to attribute this increase to the new health care law.

Here are the facts for small businesses, defined as having fewer than the equivalent of 25 full-time workers:

- A qualifying employer must pay average annual wages below $50,000.
- Small businesses and small non-profit organizations (including our communities of faith and congregations) may qualify for tax credits in 2010 through a reduction in their payroll taxes -- if they pay at least 50% of the premium cost for employees. (For non-profits, this would apply to payroll tax liabilities, such as FICA.)
- In 2010, the tax credit is 25% of the employer's contribution to the premiums. In 2014, the percentage goes up to 50% (35% for non-profits).
- The tax credit phases out gradually for businesses with average wages between $25,000 and $50,000 and for those with the equivalent of between 10 and 25 full-time workers.
- Employers will be required to include the value of the health insurance on W-2 forms, but the value of that coverage remains tax-free (beginning in 2011).

In 2014, the exchanges (health care marketplaces) went into effect to make affordable insurance options available for small businesses and individuals. Policies sold in the exchanges will offer standard and transparent benefit packages.

We know that small business owners, many of whom are members of our faith communities, struggle with rising health care costs. By assisting with those costs, the provisions of health care reform affirm the important place of small businesses in American society. When the small business workforce is strengthened, all of us win because jobs are created in our communities, workers have more options for jobs that provide good benefits, and the dignity of our labor and personal ingenuity is restored.

For more information:

- The Faithful Reform in Health Care document “What Health Care Reform Means for Faith Communities and Their Leaders” outlines faith community benefits and responsibilities.
- The HealthCare.gov website includes a special section of information for small businesses.
- The Small Business Majority website offers very explicit details about the tax credits, as well as an online calculator to help determine eligibility for the credits.
- The Internal Revenue Service addresses the “Small Business Health Care Tax Credit” on their web page dedicated to this topic, including guidelines for determining eligibility. The IRS Fact Sheet offers three simple steps to determine potential eligibility for the Small Business Health Care Tax Credit.

#8 "A Daily Dose of Truth" (#8):

The tax on “Cadillac” health insurance plans

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The Affordable Care Act includes an excise tax on insurers that will be imposed beginning in 2018 on premiums for "high-cost plans," often called "Cadillac" insurance. Such plans are often characterized by high premiums, low deductibles, and generous benefits. However, they can also be plans that are expensive simply because they cover sick, older, female, or high-risk workers, or are offered in areas where health care costs are particularly high.

Insurers will be assessed 40% of the excess value/costs of the premiums over:

- $10,200 for individuals
- $27,500 for families (average 2009 premium for employer-sponsored plans = $13,375)
- $11,850 (individual) / $30,950 (families) for retirees and those in certain high-risk professions.

Additional details:

- Separate dental and vision coverage will not be included in the determination of the value of the premiums.
- The premium threshold will increase by the rate of general inflation plus one percentage point until 2020, at which time the threshold will increase only at the rate of general inflation.
- Considerations that informed the inclusion of this excise tax:
- Health insurance provided by employers are tax-free benefits for workers. In fact, insurance benefits often are offered in lieu of salary increases.
- Persons who have to purchase their insurance in the private market do not currently receive a comparable tax break.

It is estimated that the federal government experiences over $200 billion per year in "lost revenues" due to the health-insurance related tax benefits, including: tax-free health insurance benefits for workers, tax breaks for employers who provide insurance, health savings accounts and flexible spending accounts. The Congressional Budget Office estimates the tax would raise about $32 billion in the first two years.

And one additional point of clarification:

This excise tax often leads to confusion over the provision that requires employers to report the value of health insurance on W-2 forms, which began in 2011. The value of that coverage remains tax-free until 2018 when the excise tax goes into effect only on high-cost plans.

> *Note: On this particular issue, it will be important to note the date of the information that is being circulated in opposition to the health care law. There were actually several versions of this tax considered during the deliberations. The final provision is actually found in the reconciliation bill which was signed into law in March 2010. The accurate final details of the provision are reflected in the information presented above.*

For more information

“Cadillac Plans Explained” – by Kaiser Health News, a project of the Kaiser Family Foundation

#9 "A Daily Dose of Truth": Repeal? Defund? Dismantle? Or move ahead?

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Media commentators and political operatives of every stripe and color have been busy since the mid-term elections to analyze just what the vote meant. Like usual, all of us are interpreting the results in ways that are consistent with our own world views. What is missing is a discussion based on any truth behind the polling data.

One set of data that seems to get fairly broad agreement from all sides indicates that the American public is still divided on health care reform: 48% want repeal the Affordable Care Act; 47% want to either leave it as is or expand it; the rest are too confused to have an opinion.

Leadership among those who are opposed to the law interpret this as a mandate to repeal the new law – even though exit polls show that jobs, not health care, are the primary concern of voters. Supporters respond that there is no mandate for anything because the same percentage of us like the bill.

So where is the truth?

- It IS true that much of the public remains confused – both supporters and opponents. Partisan disagreements, often based on myths and, at times, lies, have trumped earnest dialogue about what's really in the law.
- It is true that the facts of the Affordable Care Act have been grossly misinterpreted to incite fear of change and to intentionally confuse potential supporters.
- It is true that many of the provisions of the new law arose from opponents' earlier reform proposals, included in an effort to garner bi-partisan agreement.
- Most of all, it is true that there is broad support for a wide range of provisions of health care reform. When factual statements are made about the law in settings where dialogue can happen, opponents actually lean more favorably to it.

Can the inflammatory political rhetoric really lead to the repeal, de-funding, or dismantling of reform? Can the change in our state houses complicate what needs to be done at the state level? The truth is we really don't know for sure. Never before have we walked this particular road through a political environment that replicates today's reality. Never before have we embarked on such change in the context of the media capacities of this generation.

What we do know is major social change is never easy. Passing child labor laws, giving women the right to vote, guaranteeing civil rights for Africans Americans, establishing Social Security, Medicare, and Medicaid were every bit as difficult as enacting health care reform. The debates around none of these issues were done just because a law was passed. In fact, changes to all of these legislative efforts are what ultimately led to their sustainability.

The truth is that there will be a long and difficult road ahead which will be mitigated somewhat as more and more people realize how the Affordable Care Act can positively impact our health care future. But more important is that this environment gives justice-seekers the opportunity to help transform public discourse with hope and truth, thus transcending the fear and lies that undermine progress on behalf of the common good.

> >>> Note: Faithful Reform in Health Care is diligent about remaining non-partisan in its efforts to educate people of faith about health care reform. Unfortunately, this discussion has become very partisan. The inclusion of what can be perceived as partisan materials in this Daily Dose is done in an attempt to present the truth in and about the debate.

#10 "A Daily Dose of Truth": Opponents' Input into Health Care Reform

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When the Affordable Care Act was signed into law on March 23, 2010, we accomplished something that had never been done before. Comprehensive health care reform had passed all five Senate and House committees of jurisdiction and both Houses of Congress. Most steps along the way were marked with bi-partisan negotiation and input, even though the final Senate and House votes fell along party lines. The law's final language embraced a century's worth of ideas from Republicans, Democrats, and Independents.

Noted by many observers is that the post-reform opposition either focuses on provisions that current opponents have supported in the past, or neglects the provisions that were included to garner bi-partisan support. Just a few of those provisions are highlighted here; others will be addressed later.

The Affordable Care Act:

- **retains and builds on the private market system of health insurance.** Single payer health care was never on the table for discussion, and the public option was eliminated in the course of negotiations. Government participation in the new system is designed to protect the common good by enforcing protections in the private market for all of us, and by offering paths to coverage for those who have been excluded from the private insurance market.
- **requires that almost everyone have health insurance.** Such a requirement has been advocated by conservative policy analysts and health economists for two decades as a measure of shared responsibility. It was previously supported by Republican lawmakers who introduced similar legislation in the early 1990s. This requirement was a key to the Massachusetts reforms supported by former Gov. Mitt Romney (R). Democrats warmed to the idea only after sufficient premium subsidies were included to make the purchase of insurance more affordable for persons in the individual market.
- **supports the role of states** in making health care affordable and accessible for their residents. While enacting a federal vision for a system of health care that would include almost everyone, the new law preserves the long-held Republican principle for decision-making at the state level. The insurance exchanges (marketplaces) will be operated by states that choose to do so. The regulation of the private insurance market will remain a state responsibility within a federal framework that seeks fairness for everyone across state lines. States will have the opportunity to propose innovative alternatives to the federal plan if they can provide comparable coverage at a comparable or lower cost. Insurance may be sold across state lines.
- **funds state-based demonstration projects to address medical liability lawsuits.** Republican lawmakers have traditionally been the driving force advocating for reforming medical malpractice lawsuits. The new law does not impose federal regulation on this issue, but provides federal funding which may be used for state-based demonstration projects to lower the costs related to malpractice litigation.

In the end, when the Affordable Care Act was signed, Republicans did not get everything they wanted in health care reform, but neither did the Democrats. And that is what negotiation and compromise are all about. When the labels of political parties are removed, and when health care reform is discussed honestly and respectfully, there is broad agreement on how the provisions of reform move us toward a more inclusive, affordable, accessible, and accountable system of health care.

For more information: Republicans Turn Against Their Own Health Reform Proposals (Center for American Progress); The Republican Pledge on Health Care (health care excerpt from the Pledge to America posted by the Kaiser Family Foundation); The Six Republican Ideas Already in Health Care Reform (Ezra Klein article in the Washington Post); Reform's Big Secret: Health Bill's Full of GOP Ideas, article from the Daytona Beach (FL) News-Journal

#11 "A Daily Dose of Truth": The Ban on Exclusions for Pre-Existing Conditions

Truth is witness to the whole. One short sound-bite taken out of context -- even if it's a fact -- does not necessarily represent the whole truth. We denounce the use of such sound-bites (from any party!) when they are intended to pervert truth for political gain. In the end, we acknowledge that a manipulation of facts to frighten and confuse vulnerable populations is just plain immoral.

The provision in health care reform that prohibits insurers from denying coverage to persons with pre-existing conditions is one of the important patient protections that has broad bi-partisan support in Congress and with the general public. This provision is already in effect for children and will go into effect for all of us in 2014.

What does this provision mean in the Affordable Care Act?

Prior to the passage of health care reform, depending on the state, insurers could make their decisions about insurance coverage based on medical histories that included everything from teenage acne to cancer. They could (and did) deny comprehensive coverage, exclude the coverage of the pre-existing conditions within policies, or charge much higher premiums because of their judgments about a person's health history.

Now, effective September 23, 2010, children under the age of 19 can no longer be denied coverage in new plans in the individual market, or in employer-sponsored group plans. In 2014 none of us can be denied coverage because of pre-existing conditions. In addition, after 2014, in most cases, insurers will be prohibited from charging higher premiums for pre-existing conditions.

Until 2014, some persons will be eligible for federally subsidized insurance in state-based high risk pools (in 27 states) or in the Pre-Existing Conditions Insurance Plan for persons in the remaining 23 states and the District of Columbia.

Pre-existing conditions and the individual mandate

System reform -- in contrast to just correcting or tweaking selected deficiencies -- means that some actions are closely intertwined with other actions. The ban on denying coverage because of pre-existing conditions and the requirement for everyone to have insurance are two such inter-related provisions.

Politically, to get insurance industry agreement on covering persons with pre-existing conditions, it was necessary to expand the risk pool to include everyone in the system, especially millions of healthier and lower cost persons.

Practically, one of the goals of health care reform is to restrain the growth of costs. There is broad agreement among health care economists that adding people with pre-existing conditions to the system without expanding the risk pool to include healthy enrollees would drive up the cost of insurance for everyone.

Polls consistently indicate that the ban on denials for pre-existing conditions is a popular provision in the Affordable Care Act, even among persons who do not support the new law in its entirety. In the days ahead, as opponents continue to push for the repeal of the individual mandate, it will be important to consider how such an action will impact the ban on denying insurance because of pre-existing conditions.

> *Note: This ban on denying coverage got new attention this fall when former Governor and Fox News host Mike Huckabee compared insuring a person with a pre-existing condition to buying new fire insurance for a house that had already burned down.*

For more information:

- What is a Pre-Existing Condition? and Pre-Existing Conditions Insurance Plan - Information from the U.S. Department of Health and Human Services about pre-existing conditions and the Pre-Existing Conditions Insurance Plan
- The New Health Care Law and Pre-Existing Conditions - An AARP update on the 2011 improvements to the Pre-Existing Conditions Insurance Plan
- Key Insurance Market Reforms Not Achievable Without an Individual Mandate - Analysis from the Center on Budget and Policy Priorities