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True or false? Top 7 health care fears

Is the IRS going to hunt you down? Will your doc have a waiting line?

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The sweeping health care overhaul signed into law his month by President Barack Obama is more than 2,000 pages long and has been dissected by analysts, politicians and pundits. It's no wonder that some consumers are confused – and perhaps frightened – about how the law might affect them. Some concerns were raised during the congressional debate or have been swirling around the Internet.

Kaiser Health News checked out some of the most common claims:

1. Comparative effectiveness research will lead to the rationing of care for the elderly.

Verdict? Not true.

The law creates a nonprofit Patient-Centered Outcomes Research Institute charged with examining the "relative health outcomes, clinical effectiveness, and appropriateness" of different medical treatments by evaluating existing studies and conducting its own. The institute would be governed by a 19-member board that includes patients, doctors, hospitals, drug makers, device manufacturers, insurers, payers, government officials and health experts.

The law states that the institute does not have the power to mandate or even endorse coverage rules or reimbursement for any particular treatment. Medicare may take the institute's research into account when deciding what procedures it will cover, so long as the new research is not the sole justification and the agency allows for public input.

This is a shift from Congress' position when it created the Medicare Part D drug benefit in 2003; back then it banned any use of comparative effectiveness research in determining what would be covered.

Many experts believe that as health costs continue to mushroom, Medicare and private payers will incorporate the institute's work into their coverage decisions. Others say history suggests that's unlikely. "The graveyards of Washington, D.C., are littered with government agencies that tried to do comparative effectiveness research," said Michael Cannon, director of health policy studies at the Cato Institute, a libertarian think tank in Washington.

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--Jordan Rau

2. Cuts in the Medicare Advantage plans under the health care overhaul "will cause massive disruption for the more than 10 million seniors" and many of them will lose coverage.

Verdict? Partially true.

That was the warning in a **statement** from America's Health Insurance Plans, a lobbying group, days before the health overhaul cleared Congress, echoing a Republican criticism.

The new health law will cut $136 billion in spending on the Advantage program by 2019, which currently pays private plans to administer Medicare benefits and pays them about 14 percent more than the per-patient cost of the traditional Medicare program. Plans use that subsidy to lure members with lower premium costs or extra benefits not normally paid for by Medicare, such as vision care or better prescription drug coverage. Some Democrats and analysts have argued the higher rates are wasteful.

Even experts who support the change concede that the impact of the cuts could be evident. Robert Berenson, a scholar at the Urban Institute and former Medicare official, said some Advantage plan members will notice skimpier benefits, "but the Republicans have really exaggerated that this will wipe out the Advantage plans."

Marsha Gold, a health policy analyst for the private research group Mathematica, said, "Over time, there will be less rich benefits or higher p

remiums, but it's going to be gradual," noting that the largest cuts do not begin until 2015.

The three-quarters of beneficiaries who receive traditional Medicare benefits would not be affected by the change. However, for those in Advantage plans, they may have fewer to choose from. "You are going to start seeing companies dropping out," said Robert Moffit, a policy analyst at the Heritage Foundation.

--Christopher Weaver

3. The IRS will be hiring thousands of new agents to check that people have health insurance and people who don't will be sent to jail.

Verdict? Mostly not true.

This **claim** arises from a provision of the health care law that would require Americans to purchase health insurance or else face fines. The Internal Revenue Service will be tasked with enforcing this provision.

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The **Congressional Budget Office** said the number of new employees the IRS will need has not been determined, though it did estimate the agency's cost could reach approximately $10 billion over the next 10 years.

House Ways and Means Committee Republicans used the CBO estimate in a **report** on the bill's effect on the IRS. In that report, Rep. Dave Camp, R-Mich, said, "the IRS could have to hire more than 16,000 additional agents, auditors and other workers just to enforce all the new taxes and penalties." Camp called such an increase in personnel, "a dangerous expansion of the IRS' power." The IRS currently has about 93,000 employees.

The CBO report, however, identifies the $10 billion as needed for "administrative costs," and does not state that all of the funds will be used for new employees.

IRS Commissioner Douglas Shulman told a March 25 House Ways and Means Committee **hearing** that his agency will report back to Congress on the number of additional staff members or funds it will need "to serve the American people." He noted that under the new law, the IRS will not audit taxpayers to verify whether they have insurance. That responsibility, he said, lies with the Department of Health and Human Services, which will work "with the insurance companies to determine" if consumers have "acceptable coverage." He also said that no taxpayers would be required to pay any liens, levies or go to jail for not telling the IRS about their insurance situation.

--Maggie Mertens

4. When health care reform kicks in, consumers will have longer waits to see a primary care doctor.

Verdict? Partially true.

With estimates that 32 million more people will have health insurance by 2019, concerns that there will be longer waiting times to see doctors are not entirely unfounded. Even before health reform legislation passed, the U.S. faced a shortage of family doctors that was expected to grow to around 40,000 by 2020, according to the **American Academy of Family Physicians**. Lori Heim, president of the AAFP, says that number is likely to increase significantly.

The new legislation contains several incentives aimed at curbing the shortage by encouraging medical students to go into primary care rather than choosing other specialties, such as cardiology or orthopedics, which are generally more lucrative. In addition, the legislation temporarily raises Medicaid reimbursement rates for primary care doctors and offers special loan repayment programs to students who choose primary care. Heim said these incentives should help but won't eliminate the impact of the new patient load. "All of them fall short for what it's going to take to truly build a primary care workforce that's going to

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take care of everyone," she said.

Patients most likely to be affected by the shortage are those seeking a primary care physician for the first time, said Stuart Altman, a professor of national health policy at Brandeis University's Heller School. Those who already have an established doctor – and some uninsured patients do have relationships already with physicians -- are not likely to see much of a change unless they have to shop for a new one.

Altman points to the recent **experiences** of Massachusetts, which approved universal health care in 2006. The state was already facing a primary care shortage when the law was implemented. By 2009, a **survey** by the Massachusetts Medical Association found that more than half of internists and 40 percent of family doctors were not accepting new patients, the lowest acceptance rates since the survey was started eight years ago.

Fitzhugh Mullan, a professor of health policy and pediatrics at The George Washington University, agreed that in the short term, the influx of newly insured patients will put pressure on the health care system. But he said that in the long term, "it will cause us to increase and rebalance our workforce" to make it more efficient. He says the rebalancing will include an increase in the number of physician assistants and nurse practitioners, who can be trained more quickly than doctors, to fill the primary care gap and reduce wait times.

--Jenny Gold

5. The new health law will end TRICARE and force military families to buy different insurance.

Verdict? Not true.

The future of **TRICARE**, the health care system for about 9.6 million active duty military and retirees, their families and survivors, was a hotly debated issue before the March 21 House vote on health overhaul legislation. Conservatives, Republican members of Congress and at least one prominent veterans group said the bills did not guarantee that TRICARE's benefits would be considered "qualifying coverage" and thus meet the requirements for a health plan under the bill. They argued that military beneficiaries might have to leave the plan or pay penalties if TRICARE was not deemed to meet the new law's standards.

Thomas J. Tradewell Sr., the national commander of the Veterans of Foreign Wars of the U.S., **accused** President Barack Obama and congressional Democrats of "betraying America's veterans."

But the White House, Pentagon, Department of Veterans Affairs, congressional Democratic leaders and other military associations say TRICARE **meets all the law's requirements** and military personnel and their families can continue to get full benefits under the familiar military health plan. Even some opponents of the health reform bill agreed that TRICARE would not be

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jeopardized.

Some of the confusion appears to stem from the different approaches taken to TRICARE in the c ompeting Senate- and House-passed reform bills. The Senate measure, which passed on Christmas Eve and was sent back to the House for a final vote, did not mention TRICARE by name, though the original House bill did.

Five House committee chairman issued a letter saying that TRICARE coverage "would satisfy the requirements" of the bill. Kathleen Sebelius, secretary of Health and Human Services, also sent **a letter** to Sen. Max Baucus, D-Mont., reassuring him that TRICARE coverage meets "the minimum essential coverage definition."

The united defense brought a **letter of apology** from Tradewell. "I apologize for using too harsh a word…," he said. “But I did not apologize for our strong advocacy on the issue."

--Lexie Verdon

6. Federal government employees will be forced to switch their health insurance coverage and participate in the exchanges.

Verdict? Mostly not true.

President Barack Obama has repeatedly stated that people who like their health insurance can keep it. However, that doesn’t apply to a small group of federal employees.

Currently, government employees and qualified retirees can get health insurance through the Federal Employees Health Benefits Program (FEHBP), a "marketplace" with more than 250 plans, with at least 10 national fee-for-service plans. Government employees, including members of Congress, the president, vice president, cabinet members and White House staff all participate in FEHBP. That won’t change – except for members of Congress and their personal staffs. In 2014, they will instead have to enroll in the new insurance exchanges.

Some Republicans, led by Sens. Charles Grassley of Iowa and Tom Coburn of Oklahoma, argued that all members of Congress and staff should be subject to the same coverage that they set up for other Americans.

The provision has provoked confusion, sparked emotions and even caused the White House to **announce** that the president will voluntarily participate in the exchange, although he would not be required to do so by the new law. Walton Francis, a health economist and main author of "CHECKBOOK's Guide to Health Plans for Federal Employees," said the requirement will be controversial and may come up again for consideration: "My guess is the FEHBP exclusion for these members and their staff will probably not survive." he said.

--Jessica Marcy

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7. Illegal immigrants will get free health care. Verdict? Mostly not true.

Illegal immigrants already are generally barred from receiving Medicaid benefits, and the new health law excludes them from receiving premium subsidies. They are also explicitly banned from purchasing insurance with their own funds on the exchanges created in the legislation. Anyone trying to purchase health insurance through those marketplaces must provide proof of citizenship or legal resident status.

But some commentators have argued that undocumented immigrants will get free or subsidized health care when the reforms are in place, that the enforcement provisions are weak, and undocumented immigrants might find ways to circumvent the law. Dan Vale of the Federation for American Immigration Reform said that while the bill prohibits undocumented immigrants from buying insurance from the new exchanges, it uses "a 'loosey-goosey' verification policy" that "doesn't require a photo ID."

However, Sonal Ambegaokar of the National Immigration Law Center said the process outlined in the Senate bill is likely to be similar to what officials currently use in the Medicaid program. According to Amebegaokar, "There is a history of verification processes for public programs; we've had this for many years in Medicaid and we have strict citizenship requirements. And we have yet to see a flood of immigrants in Medicaid."

The Pew Hispanic Center **estimates** that of about 12 million undocumented immigrants live in the United States and more than half of them don't have insurance. Nonetheless, the vast majority — nearly 80 percent — of the uninsured are U.S. citizens, according to the **Kaiser Family Foundation**. (KHN is a program of the foundation.)

Advocates for immigrants argue that many undocumented residents will simply remain uncovered. The Congressional Budget Office estimates that of the 23 million people who will continue to be uninsured in 2019, 8 million will be undocumented immigrants. Without health insurance, many of them will continue to receive care in free or subsidized community clinics. In addition, the new law doesn't change the requirement that hospitals offer emergency services to all patients, including illegal immigrants.

--Kate Steadman